UnitedHealthCare Insurance Company, Inc.

http://www.uhcfeds.com

1-877-835-9861

2016

Choice Plus Advanced - A Value Plan

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 7 for details.

IMPORTANT
- Rates: Back Cover
- Changes for 2016: Page 13
- Summary of benefits: Page 84

Serving:

Chicago, Illinois

San Antonio, Texas

District of Columbia

Northern Virginia

State of Maryland

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 12 for requirements.

L91 -Self Only

L93 -Self Plus One

L92 - Self and Family

We are accredited by NCQA

Federal Employees Health Benefits Program

Authorized for distribution by the:

United States Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-887

Important Notice from UnitedHeathcare Insurance Company About

Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the UnitedHealthcare Insurance Company Plan's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227), (TTY)1-877-486-2048.

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Introduction

This brochure describes the benefits of under our contract (CS-2947) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer Service may be reached at 1-(877) 835-9861 or through our website: www.uhcfeds.com.

The address for administrative offices is: UnitedHealthcare Insurance Company, Inc., Federal Employees Health Benefit Plan, 6220 Old Dobbin Lane, Suite 100, Columbia, MD 21045.

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. If you enroll in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits. You do not have a right to benefits that were available before January 1, 2016, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2016, and changes are summarized on page 13. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means UnitedHealthcare Insurance Company.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authoirzed health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services that you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at (877) 835-9861 and explain the situation.
- If we do not resolve the issue

CALL THE HEALTH CARE FRAUD HOTLINE

877-499-7295

OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
- Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise);
- Your child over age 26 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1.Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2.Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask your pharmacist about the medication if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3.Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4.Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5.Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
- "Exactly what will you be doing?"
- "About how long will it take?"
- "What will happen after surgery?"
- "How can I expect to feel during recovery?"

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

- www.ahrq.gov/consumer/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen. These conditions and errors are called "Never Events." When a Never Event occurs, neither your FEHB plan nor you will incur cost to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital-acquired conditions or for inpatient services needed to correct Never Events, if you use UnitedHealthcare preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

FEHB Facts

Coverage information

No pre-existing condition limitation	We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.
Minimum essential coverage (MEC)	Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.
Minimum value standard	Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.
Where you can get information about enrolling in the FEHB Program	See www.opm.gov/healthcare-insurance for enrollment information as well as: • Information on the FEHB Program and plans available to you • A health plan comparison tool • A list of agencies that who participate in Employee Express • A link to Employee Express • Information on and links to other electronic enrollment systems Also, your employing or retirement office can answer your questions, and give you a brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you: • When you may change your enrollment • How you can cover your family members • What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire • What happens when your enrollment ends • When the next Open Season for enrollment begins We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.
Types of coverage available for you and your family	Self Only coverage is for you alone. Self Plus One coverage is an enrollment that covers you and one eligible family member. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support. If you have a Self Only enrollment, you may change to a Self and Family or Self Plus One enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One and Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events . If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

Family member coverage

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage and same sex domestic partners) and children as described in the chart below. A Self Plus One enrollment covers you and one eligible family member as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/healthcare-insurance.

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or

- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2016 benefits of your old plan or option**. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2015 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

When FEHB coverage ends

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment; or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

Upon divorce

If you are divorced from a Federal employee, or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get information about your coverage choices. You can also vist OPM's website at www.opm.gov/healthcare-insurance/healthcare/plan-information.

Temporary Continuation of Coverage (TCC)

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, etc.

You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance . It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

We also want to inform you that the Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules.

Converting to individual coverage

You may convert to a non-FEHB individual policy if:

• Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);

• You decided not to receive coverage under TCC or the spouse equity law; or

• You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

Health Insurance Marketplace

If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this Plan Works

This Plan is an open access value plan that provides you the freedom to choose from any health care professional in the UnitedHealthcare Choice Plus network, including specialists, without a referral or choosing a primary care physician (PCP). You have the opportunity to save money by making more informed decisions about the providers you choose, by selecting physicians that have been recognized for delivering quality, cost-efficient care as well as certain lower-cost facilities. Since Choice Plus Advanced is an open-access product, you can seek care from any provider but you may pay more out-of-pocket costs when you do not select from certain network providers and facilities.

We emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join any plan because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

General features of our Value Option

We have Open Access benefits

Our plan offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from you primary care physician or by another participating provider in the network.

We have Point of Service (POS) benefits

Our plan offers Point-of-Service (POS) benefits. This means you can receive covered services from a non-participating provider. However, out-of-network benefits may have higher out-of-pocket-costs than our in-network benefits.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Preventive care services

Preventive care services are generally covered with no cost sharing and are not subject to copayments, deductibles or annual limits when received from a network provider.

Annual deductible

The annual deductible must be met before Plan benefits are paid for many services other than preventive care services.

Health education resources and accounts management tools:

myuhc.com gives you the the ability to:

- Review eligibility and look up benefits
- Check current and past claim status
- Find a doctor or hospital, including UnitedHealth Premium designated physicians.
- Print a temporary ID card or request a replacement card
- Compare hospitals in quality, efficiency, and cost – all at the procedure level
- "Chat" with a nurse in real-time
- Take a health assessment and participate in Health Coaching Programs

- Use the Personal Health Record to organize health data and receive condition specific information to better manage their health
- Learn about health conditions, symptoms and the latest treatment options

myHealthcare Cost Estimator

Changing the way you access health care information for the better, my Healthcare Cost Estimator (myHCE) allows you to research treatment options based on your specific situation. Learn about the recommended care, estimated costs and time to treat your condition. The care path allows you to see the appointments, tests and follow up care involved, from the first consult to last follow up visit. You can also learn about estimated costs ahead of time to help you plan. Create a custom estimate based on your own plan details and selected.

Health4Me

If you are always on the go, the UnitedHealthcare Health4Me™ app provides instant access to your family's important health information anytime/anywhere. Whether you want to find a physician near you, check the status of a claim or speak directly with a health care professional, Health4Me is your go-to resource. It is available for download now on the app store for iPhones® or Google® Play for Androids

Your rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB website (www.opm.gov/healthcare-insurance) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- UnitedHealthcare Insurance Company has been in existence since 1972
- Profit status – for profit

If you want more information about us, call (877)835-9861 or visit our website at www.uhcfeds.com or if already a member www.myuhc.com.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area:

San Antonio, Texas including the following counties: Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall

Chicago, Illinois including the following counties: Iroguis, Kankakee, Will, Grundy, LaSalle, Kendall, DeKalb, Kane, DuPage, Cook, Lake, McHenry, Boone, Winnebago

District of Columbia

State of Maryland (all of the State of Maryland)

Northern Virginia: **Counties of:**

Arlington, Clarke, Culpeper, Fairfax, Fauquier, Frederick, Greene, King George, Loudoun, Madison, Orange, Page, Prince William, Rappahannock, Rockingham, Shenandoah, Spotsylvania, Stafford and Warren.

Cities of: Alexandira, Fairfax, Falls Church, Fredericksburg, Harrisonburg, Manassas, Manassas Park and Winchester.

Section 2. How we change for 2016

Program-wide changes

- Self Plus One enrollment type has been added effective January 1, 2016
- We have removed the exclusion for services, drugs or supplies related to sex transformations from Section 6.

Changes to this Plan:

- Your share of the non-Postal premium will decrease for Self Only coverage and increase for Self and Family. See back cover for rates.
- This plan will provide coverage only for diagnosis and treatment of causes of infertility. No coverage will be provided for assisted reproduction services/supplies, in-vitro reproduction services/supplies or other services/supplies associated with infertility. Please refer to page 28.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at (877) 835-9861, TTY:(301-360-8111) or write to us at UnitedHealthcare Insurance Company, Federal Health Benefits (FEHB) Program, at P. O. Box 30432, Salt Lake City, UT 84130-0432. You may also print temporary cards and request replacement cards through our website: www.myuhc.com.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance. If you use our point-of-service program, you can also get care from non-Plan providers but it will cost you more. If you use our Open Access program you can receive covered services from a participating provider without a required referral from you primary care physician or by another participating provider in the network.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

UnitedHealth Tier 1 Premium Designated providers allow you to reduce your out-of-pocket expenses without compromising on quality. By using Premium Tier 1 physicians, you save on co-payments and coinsurance. UnitedHealth Premium Tier 1 physicians have received the Premium designation for either Quality and Cost Efficiency or Cost Efficiency and Not Enough Data to assess Quality. Look for the UnitedHealth Premium Tier 1 Symbol to quickly and easily find these physicians. You can find the physicians designation quickly and easily on www.myuhc.com or at www.UnitedHealthPremium.com.

UnitedHealth Tier 1 Premium doctors:

- Follow evidence-based guidelines for care
- Are more likely to be aware of the latest research and clinical trials
- May have lower surgery repeat rates

Quality guidelines are based on standards from organizations such as:

- American College of Cardiology
- Ambulatory Care Quality Alliance
- Agency for Healthcare Research and Quality (a division of the U.S. Department of Health & Human Services)

- **Plan facilities**

Plan facilities are hospitals and other facilities that we contract with to provide services to our members. This plan allows you to save money by choosing a lower cost place of service.

A freestanding facility is an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims as a freestanding entity and not as a hospital. You will have a lower out of pocket expenses when you use a freestanding facility instead of a hospital for outpatient services. Outpatient services are health services or treatments that do not require an overnight hospital stay. Outpatient care received in a hospital will typically cost you more. Talk to your doctor about the options available to you for these services.

- **Non-network providers and facilities**

You can access care from any licensed provider or facility. Providers and facilities not in the UnitedHealthcare Choice Plus network are considered non-network providers and facilities.

What you must do to get covered care

It depends on the type of care you need. You can go to any provider you choose to but it will cost you less to get care from our Premium designated providers and in network providers. We must approve some care in advance.

- **Transitional Care**

Specialty care: If you have a chronic or disabling condition and

- lose access to your specialist because we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan, or
- lose access to your PPO specialist because we terminate our contract with your specialist for reasons other than for cause,

you may be able to continue seeing your specialist and receiving in-network benefits for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist and any in-network benefits continue until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Network primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are hospitalized when your enrollment begins

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 877-835-9861. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

The pre-approval processes for inpatient hospital admissions (called precertification) and for other services, are detailed in this Section.

- **Your hospital stay**

The approval processes for inpatient hospital admissions (called precertification) and for other services, are detailed in this Section.

- **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

For certain services,your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. Your physician must obtain precertification for some services, such as, but not limited to the following services:

- Certain out of network services

- Non Emergency ambulance
- Dental proocedures in a faciltiy
- Certain Durable Medical Equipment supplies over $1000
- Transplants
- Clinical trials
- Angioma/Hemangioma (with pictures)
- Blepharoplastic (with pictures)
- Breast implant removal, breast reconstruction for non-cancer diagnosis, breast reduction
- Corony artery bypass graft
- Congenital anomaly repair
- Dialysis
- Discetomy/fusion
- Genetic testing for hereditary breast and ovarian cancer syndrome
- Human Growth hormone
- Gynecomastia surgery
- Hysterectomy
- Infertility services
- Impanted spinal cord stimulators
- Inpatient hospitalization
- Joint replacement
- Morbid obesity surgery
- Magnetic resonance imaging (MRI) (brain, chest, heart, musculoskeletal), Magnetic resonance angiogram (MRA), PET scans (non- cancer diagnosis) and Computed Tomography (CT) scans (brain, chest, heart)
- Therapeutic servcies: such as physical terapy, occupational therapy and speech therapy after the 8th visit
- Pulmonary rehabilitation
- Radiation therapy
- Reconstructive surgery
- Sclerotherapy
- Sleep apnea (surgery & appliance); wtith sleep studies,(polysommograms) attended
- Uvulopalatopharyngoplasty
- Vein Ablation
- Ventricular assist device

This list is subject to change upon notification to Plan providers. In addition, your admitting physician and facility must also preauthorize any elective inpatient stays.

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call us at 877-835-9861 before admission or services requiring prior authorization are rendered. Please note that members with Medicare as primary are also required to follow the precertification process.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;

- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay

- **Non-urgent care claims** For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

  If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims** If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

  If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

  We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

  You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 877-835-9861. You may also call OPM's Health Insurance 3 at (202) 606-0737 between 8 a. m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at (877) 835-9861. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims** A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

  If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim

• **Emergency inpatient admission**	If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
• **Maternity Care**	Your physician must obtain precertification for inpatient admission. Prior authorization is required if inpatient stay exceeds 48 hours following normal vaginal delivery or 96 hours following a cesarean section delivery.
• **If your treatment needs to be extended**	If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.
What happens when you do not follow the precertification rules when using non-network facilities	If you fail to obtain authorization/precertification when using non-network facilities you can be responsible for 100% of the charges.
Circumstances beyond our control	Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care
If you disagree with our pre-service claim decision	If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.
• **To reconsider a non-urgent claim**	Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure. In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to 1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or 2. Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision. 3. Write to you and maintain our denial.
• **To reconsider an urgent care claim**	In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure. Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM** — After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4 Your costs for covered services

This is what you will pay out-of-pocket for covered care.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: When you see your primary care physician you pay a copayment of $25 per office visit.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

- The calendar year deductible is $500 per person. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $500. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $1,000. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $1,000.
- All individual deductible amounts will count toward the family deductible but an individual will not have to pay more than the individual deductible. The full family deductible must be met for the plan benefits to apply for the entire family.
- This benefit plan contains a Per Occurrence Deductible that applies to certain Covered Health Services. This Per Occurrence Deductible must be met prior to and in addition to the Annual Deductible. Example: If you have services in network and the billed amount is $80 and the provider has agreed through his contract with us to accept $60 and you have not met your deductible you must pay $60. We will apply this $60 to your deductible. We will begin paying benefits once the remaining portion of your calendar year deductible has been satisfied.
- Note: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

Example: In our Plan, you pay 20% of our allowance for durable medical equipment when using in-network providers.

Differences between our Plan allowance and the bill

Network providers agree to accept our Plan allowance so if you use a network provider, you never have to worry about paying the difference between our Plan allowance and the billed amount for covered services.

Non-network Providers: If you use a non-network provider, you will have to pay the difference between our Plan allowance and the billed amount.

By using Premium Designated providers in the UnitedHealthcare network, you can take advantage of the significant discounts we have negotiated to help lower your out-of-pocket costs for medically necessary care. This can help you get the care you need at a lower price.

The example below is based on following the UnitedHealthcare benefits and insurance plan features and assumes that you have already met your deductible.

What your plan pays (plan coinsurance): 80% in network/50% out of network for benefits with coinsurance. There are in network benefits that require a copayment only. What you pay (coinsurance): 20% in network / 50% out of network .

Your out-of-pocket maximum is $3,000/$6,000 in network; $6,000/$12,000 out of network. Using the UnitedHealthcare cost estimator tool on myuhc.com allows you to compare procedures and the comparison of member costs when utilizing in network providers as compared to out of network providers. Even further savings can be achieved by using UnitedHealthcare premium designated in network providers.

Your catastrophic protection out-of-pocket maximum

After your in-network out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance total $3,000 for Self Only, or $6,000 for a Self Plus One or Self and Family enrollment in any calendar year, or out-of network $6,000 per Self Only or $12,000 for Self Plus One or Self and FAmily you do not have to pay any more for covered services. ***The maximum annual limitation on cost sharing listed under Self Only of in network $3,000 or out of network $6,000 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.***

Example Scenario: Your plan has an in-network $3,000 Self Only maximum out-of-pocket limit and a $6,000 Self Plus One or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has in-network out-of-pocket qualified medical expenses of $3,000 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment in-network out-of-pocket maximum of $6,000, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of $6,000 for the calendar year before their qualified medical expenses will begin to be covered in full.

However, copayments and coinsurance, if applicable for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services:

- Expenses for services and supplies that exceed the stated maximum dollar limit or day limit.

Be sure to keep accurate records and receipts of your copayments and coinsurance to ensure the plan's calculation of your out-of-pocket maximum is reflected accurately.

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

When Government Facilities Bill Us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Value Option Benefits

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Section 5. Value Options Benefit Overview

This Plan is a Value Option. The benefits are described in Section 5. Make sure that you review the benefits that are available. Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about benefits, contact us at (877) 835-9861 or on our website at www.uhcfeds.com.

You can save money when you make more informed decisions about the providers you choose. Select Premium designated physicians that have been recognized for deliverying quality, cost-efficient care as well as certain lower cost facilities. Since Choice Plus Advanced is an open-access product, you can seek care from many providers but may pay more out-of-pocket costs when you do not seek care from certain network providers and facilities.

You also have the opportunity earn incentives. Please refer to section 5 (h) Special Features of this plan.

Benefits	You pay
Medical Services provided by physicians:	
• Routine Preventive Care provided in network	Nothing
• Diagnostic and treatment services provided in the office	In-network: Office visit copay: $25 primary care physician Specialist: $50 copay for Tier 1 premium-designated specialist and $75 copay for a non-designated network provider; Out of network: 50% after deductible has been met
Services provided by a hospital	
• Inpatient	In-network: hospital 20% after deductible has been met. Out-of-network: 50% after deductible has been met.
• Outpatient Surgical	In-network: 20% copay,after deductible, when in an ambulatory surgical center or physician's office; 20% copay, after $250 per occurrence deductible and annual deductible has been met, when services are performed in an outpatient hospital based surgical center; Out-of-network: 50% copay, after the deductible has been met when services are performed in an ambulatory surgical center; Out-of-network: 50% after annual deductible is met, plus $250 per occurrence deductible, when services are performed in an outpatient hospital based surgical center.
Emergency benefits:	
• Emergency Room	$250 copay per visit in-network/out-of-network
• Ambulance - emergency services	20% copay, after deductible in-network/out-of-network.
Mental Health and substance Abuse treatment	Regular cost sharing
Prescription drugs:	In network benefits only; costs are as follows:

	30-day supply at Retail: Tier 1 $10; Tier 2 $35, Tier 3 $60, Tier 4 $100 Up to 90-day supply at Mail Order: Tier 1 $25; Tier 2 $87.50; Tier 3 $150; Tier 4 $250

Section 5(a) Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- A facility charge applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- The calendar year deductible is: $500 Self only, $1,000 Self Plus One and Self and Family in-network and $1,000 Self only $2,000, Self Plus One and Self and Family out-of-network. The calendar year deductible may apply to some benefits in this Section. We added "(After deductible has been met)" to show when the calendar year deductible does apply.

Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay	
Note: We say " after deductible has been met"when the deductible applies		
Diagnostic and treatment services	**In-Network**	**Out-of-Network**
Professional services of physicians • In physician's office • Office medical consultation • Second Surgical opinion	primary care physician (PCP) $25 copayment Tier 1 premium-designated specialist $50 copayment Non-designated specialist $75 copayment	50% of the Plan allowance and any difference between our allowance and the billed amount, (after deductible has been met)
Professional services of physicians • In an urgent care center • In an emergency room • During a hospital stay • In a skilled nursing facility	20% after deductible has been met	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
At home	primary care physician (PCP) $25 copayment Tier 1 premium-designated specialist $50 copayment Non-designated specialist $75 copayment	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Virtual Visits	**In-Network**	**Out-of-Network**
Log in to **myuhc.com®** and choose from provider sites where you can register for a virtual visit. You will pay your copayment. **Important note:** Coverage for virtual visits and prescription services may not be available in all states due to state regulations	$15 copayment	You pay 100%

Benefit Description	You pay	
Lab, X-ray and other diagnostic tests	**In-Network**	**Out-of-Network**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms	20% after deductible has been met	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Major Diagnostic tests • Computed Tomography (CT) scans • PET Scans • Magnetic resonance imaging (MRI) • Magnetic resonance angiogram (MRA) • Nuclear Medicine Pre-authorization is required	Outpatient for a free-standing diagnostic center or in a physician's office 20% after deductible has been met Outpatient hospital-based diagnostic center 20% after per occurrence deductible of $250 per service and annual deductible have been met	50% after per occurrence deductible of $250 per service and annual deductible have been met.
Preventive care, adult	**In-Network**	**Out-of-Network**
Routine physical every year which includes: Routine screenings, such as: • Total Blood Cholesterol • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 - Routine annual digital rectal exam (DRE) for men ages 40 and older	Nothing	100%
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing	100%
Annual preventive biometric screening in your physician's office to include: • Body Mass Index (BMI) • Blood pressure • Lipid/cholesterol levels • Glucose/hemoglobin AIC measurement Log onto myuhc.com to complete your Health Risk Assessment (HRA) and receive your incentive reward.	Nothing	100%

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**In-Network**	**Out-of-Network**
Services must be coded by your physician as preventive to be covered in full.	Nothing	100%
Well woman care; including, but not limited to: • Routine Pap test • Human papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections. • Annual counseling and screening for human immune-deficiency virus. • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence.	Nothing	100%
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	Nothing	100%
BRCA genetic counseling and evaluation is covered as preventive when a woman's family history is associated with an increased risk for deleterious mutations in BRCA1 and BRCA2 genes and medical necessity criteria has been met. Preauthorization required	Nothing	100%
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC):	Nothing	100%
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at https://www.healthcare.gov/preventive-care-benefits/		
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*	All charges

Benefit Description	You pay	
Preventive care, children	**In-Network**	**Out-of-Network**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing	100%
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction - Hearing exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22)	Nothing	100%
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at https://www.healthcare.gov/preventive-care-benefits/		
Not covered: Physical examinations and immunizations required for attending camp, school or travel	*All charges*	*All charges*
Maternity care	**In-Network**	**Out-of-Network**
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women between 24 to 28 weeks gestation or first prenatal visit for women at high risk • Delivery Postnatal care • Note: Here are some things to keep in mind: You do not need to precertify your normal delivery; see page 47 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary.	primary care physician (PCP) $25 copayment - initial visit only Tier 1 premium-designated specialist $50 copayment - initial visit only Non-designated specialist $75 copayment - initial visit only	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)

Maternity care - continued on next page

Benefit Description	You pay	
Maternity care (cont.)	**In-Network**	**Out-of-Network**
• We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Circumcisions are covered 100% during newborn stay. Note: Circumcisions following the newborn stay are covered under the surgical benefits at the applicable copayment or coinsurance.	primary care physician (PCP) $25 copayment - initial visit only Tier 1 premium-designated specialist $50 copayment - initial visit only Non-designated specialist $75 copayment - initial visit only	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Breastfeeding support, supplies and counseling for each birth	Nothing	100%
Not covered: *Routine sonograms to determine fetal age, size or sex*	*All charges.*	*All charges*
Family planning	**In-Network**	**Out-of-Network**
A range of voluntary family planning services, limited to: • Voluntary sterilization for women (See Surgical procedures Section 5(b) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Insertion and removal of Intrauterine devices (IUDs) • Diaphragms and fitting of diaphragms • Note: We cover oral contraceptives under the prescription drug benefit. • Contraceptive counseling on an annual basis	Nothing	100%
• Voluntary sterilization for men (See Surgical procedures Section 5(b)) • Genetic counseling Note: We cover oral and injectable contraceptives under the prescription drug benefit	primary care physician (PCP) $25 copayment Tier 1 premium-designated specialist $50 copayment Non-designated specialist $75 copayment	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges.*	

Family planning - continued on next page

Benefit Description	You pay	
Family planning (cont.)	**In-Network**	**Out-of-Network**
• *Interruption of pregnancy unless the life of the mother is at risk*	*All charges.*	
Infertility services	**In-Network**	**Out-of-Network**
COVERED: Diagnosis and treatment of infertility, **except** for the Reproductive services listed as **Not Covered:**	20% after deductible has been met	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Not Covered: *The services listed below are* ***not covered*** *as treatments for infertility or as alternatives to conventional conception:* • *Assisted reproductive technology (ART) and assisted insemination procedures, including but not limited to:* - *Artificial insemination (AI) ; In vitro fertilization (IVF)* - *Embryo transfer and Gamete Intrafallopian Transfer (GIFT); - Zygote Intrafallopian Transfer (ZIFT)* - *Intravaginal insemination (IVI) , - Intracervical insemination (ICI) , - Intracytoplasmic sperm injection (ICSI)* - *Intrauterine insemination (IUI)* • *Services, procedures, and/or supplies that are related to ART and/or assisted insemination procedures* • *Cryopreservation or storage of sperm (sperm banking), eggs, or embryos* • *Preimplantation diagnosis, testing, and/or screening, including the testing or screening of eggs, sperm, or embryos* • *Drugs used in conjunction with ART and assisted insemination procedures (see Prescription Drug section)* • *Services, supplies, or drugs provided to individuals not enrolled in this Plan*	*All charges.*	*All charges*
Allergy care	**In-Network**	**Out-of-Network**
• Testing and treatment • Allergy injections	primary care physician (PCP) $25 copayment Tier 1 premium-designated specialist $50 copayment Non-designated specialist $75 copayment	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Not covered:	*All charges*	*All charges*

Allergy care - continued on next page

Benefit Description	You pay	
Allergy care (cont.)	**In-Network**	**Out-of-Network**
• *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*	*All charges*
Treatment therapies	**In-Network**	**Out-of-Network**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants on page 40. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: – We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3. Preauthorization is required for certain services	20% after deductible has been met	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Autism Spectrum Disorder • assessments, evaluations, or tests by a licensed physician or licensed psychologist to diagnose whether an individual has an autism spectrum disorder; • Limited to age 6 and under	primary care physician (PCP) $25 copayment Tier 1 premium-designated specialist $50 copayment Non-designated specialist $75 copayment	50% of the Plan alloance and any difference between our allowance and the billed amount (after deductible has been met)

Benefit Description	You pay	
Habilitative/Rehabilitative Therapies	**In-Network**	**Out-of-Network**
Habilitative/ Rehabilitative Services Outpatient Therapy when performed by qualified physicial therapists and occupational therapists: • Physical Therapy - up to 20 visits per year • Occupational Therapy - up to 20 visits per year • Cardiac rehabilitation is provided for up to 36 visits per year per condition • Pulmonary Rehabilitation -up to 20 visits per year • Cognitive Rehabilitation up to 20 visits per year • Post cochlear implant rehabilitation and aural therapy up to 30 visits per year Note: We only cover therapy when a provider orders the care.	$25 copay per visit	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*	*All charges*
Speech therapy	**In-Network**	**Out-of-Network**
Up to 20 visits per year per condition for speech therapy	$25 copayment per visit	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Not covered: • *Exercise programs, gyms or pool memberships* • *Work hardeing/functional capacity programs or evaluations* • *Voice therapy*	*All charges*	*All charges*
Hearing services (testing, treatment, and supplies)	**In-Network**	**Out-of-Network**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	20% after deductible has been met	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)

Hearing services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay	
Hearing services (testing, treatment, and supplies) (cont.)	**In-Network**	**Out-of-Network**
External Hearing Aids - A single purchase (including repair/replacement) per hearing impaired ear every three (3) years for enrolled dependent children up to age 18. $2,500 per ear and are limited to a single purchase (including repair/replacement) per hearing impaired ear every three (3) years for all other members.	20% after deductible has been met	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Implanted hearing related devices, such as bone anchored hearing aids (BAHA) and coclear implants For therapy associated with coclear implants please refer to the outpatient therapy section of this brochure	20% after deductible has been met	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Not covered: • *All other hearing testing*	*All charges.*	*All charges*
Vision services (testing, treatment, and supplies)	**In-Network**	**Out-of-Network**
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	20% after deductible has been met	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Diagnosis and treatment of diseases of the eye	$25 per PCP visit $50 copay for premium-designated specialist $75 copay for non-designated in-network specialist;	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Routine Eye Examination - Eye refraction every two years examination to provide a written lens prescription Note: See *Preventive care, children* for eye exams for children.	$25 copayment	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*	*All charges*

Benefit Description	You pay	
Foot care	**In-Network**	**Out-of-Network**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	primary care physician (PCP) $25 copayment Tier 1 premium-designated specialist $50 copayment Non-designated specialist $75 copayment	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**In-Network**	**Out-of-Network**
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Enteral equipment and supplies • Internal prosthetic devices , such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. • see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device. • Ostomy supplies • Orthotic braces and splints not available over the counter that straighten or change the shape of a body part • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome and/or Myofacial Pain Dysfunction (MDP). • Bone anchored hearing aids (BAHA) limited to one per member per lifetime, when the member has either of the following - Craniofacial anomalies in which abnormal or absent ear canals preclude the use of a wearable hearing aid	20% after deductible has been met	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
Orthopedic and prosthetic devices (cont.)	**In-Network**	**Out-of-Network**
- Hearing loss of sufficient severity that it cannot be adequeately remedied by a wearable hearing aid Note: Most orthopedic and prosthetic devices must be preauthorized. Call us at 877-835-9861 (TTY:301-360-8111) if your plan physician prescribes this and you need assistance locating a health care physician or health care practitioner to sell or rent you orthopedic or prosthetic equipment. You may also call us to determine if certain devices are covered. Single purchase of each type of prosthetic device every three (3) years (in-network). Prior authorization is required for prosthetic devices in excess of $1,000. Internal prosthetic devices are paid as hospital benefits. For information on the professional charges for the surgery to insert an implant please refer to Section 5(b) surgical procedures. For information on the hospital and/or ambulatory surgical center benefits see Section 5(c) Services provided by a hospital or other facility.	20% after deductible has been met	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, suppor t hose, and other supportive devices* • *Prosthetic replacements provided less than 5 years after the last one (except as needed to accommodate growth in children or socket replacement for members with significant residual limb volume or weight changes)* • *External penile devices* • *Speech prosthetics (except electrolarynx)* • *Carpal tunnel splints* • *Deodorants, filters, lubricants, tape, appliance cleansers, adhesive and adhesive removers related to ostomy supplies*	*All charges*	*All charges*

Benefit Description	You pay	
Durable medical equipment (DME)	**In-Network**	**Out-of-Network**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: A single purchase of a type of durable medical equipment (including repair and replacement) every three (3) years. This limit does not apply to wound vacuums. Prior authorization is required for durable medical equipment in excess of $1,000. • Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks); • Dialysis equipment; • Standard hospital beds; • Wheelchairs; • Crutches; • Walkers; • Blood glucose monitors • Insulin pumps. and insulin pump supplies • Surgical dressings not available over-the-counter • Burn garments • Braces, including necessary adjustments to shoes to accommodate braces, which are used for the purpose of supporting a weak or deformed body part • Braces restricting or eliminating motion in a diseased or injured part of the body Note: Many DME items must be preauthorized. Call us at 877-835-9861 (TTY:301-360-8111) if your plan physician prescribes this and you need assistance locating a health care physician or health care practitioner to sell or rent you equipment. You may also call us to determine if certain devices are covered.	20% after deductible has been met	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Not covered: • *Power operated vehicles unless medically necessary based upon diagnosis* • *Duplicate or back up equipment* • *Parts and labor costs for supplies and accessories replaced due to wear and tear such as tires and tubes* • *Educational, vocational or environmental equipment*	*All charges.*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	**In-Network**	**Out-of-Network**
• *Deluxe or upgraded equipment or supplies* • *Home or vehical modifications; seat lifts* • *Over-the-counter medical supplies* • *Activities of daily living aids (such as grab bars and utensil holders)* • *Personal hygiene equipment* • *Paraffin baths, whirlpools and cold therapy* • *Augmentative communication devices* • *Physical fitness equipment* • *Continuous pulse oximetry unless skilled nursing is involved in home care and it is part of their medically necessary equipment*	*All charges.*	*All charges*
Home health services	**In-Network**	**Out-of-Network**
Services include: oxygen therapy, intravenous therapy and medications. Limited to 60 visits per year Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required	20% after deductible has been met	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.* • *Private duty nursing* • *Foods that can be obtained over the counter (without a prescription) even if prescribed by your physician*	*All charges.*	*All charges*
Chiropractic	**In-Network**	**Out-of-Network**
• Manipulation of the spine and extremities up to 20 visits per year • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	$25 copayment per visit	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)

Benefit Description	You pay	
Alternative treatments	**In-Network**	**Out-of-Network**
Acupuncture - Up to 12 visits per year • Anesthesia • Pain relief • Nausea that is related to surgery, pregnancy or chemotherapy • Acupuncture services must be performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body: - Doctor of Medicine - Doctor of Osteopathy - Chiropractor - Acupuncturist	20% after deductible has been met	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Massage Therapy* • *Herbal medicine* • *Rolfing* • *Ayurveda* • *Homeopathy* • *Other alternative treatments unless specifically listed as covered*	*All charges.*	*All charges*
Educational classes and programs	**In-Network**	**Out-of-Network**
Outpatient self-management training for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin using diabetes. Diabetes outpatient self-management training, education and medical nutrition therapy services must be prescribed by a licensed health care professional who has appropriate state licensing authority. Outpatient self-management training includes, but is not limited to, education and medical nutrition therapy. The training must be given by a certified registered or licensed health care professional trained in the care and management of diabetes. Coverage includes:	primary care physician (PCP) $25 copayment Tier 1 premium-designated specialist $50 copayment Non-designated specialist $75 copayment	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)

Educational classes and programs - continued on next page

Benefit Description	You pay	
Educational classes and programs (cont.)	**In-Network**	**Out-of-Network**
• Initial training visit, up to 10 hours, after you are diagnosed with diabetes, for the care and management of diabetes, including but not limited to: Counseling in nutrition , the use of equipment and supplies, training and education, up to four hours, as a result of a subsequent diagnosis by a Physician of a significant change in your symptoms or condition which require modification of your program of self-management of diabetes. Also included is training and education, up to four hours, because of the development of new techniques and treatments.	primary care physician (PCP) $25 copayment Tier 1 premium-designated specialist $50 copayment Non-designated specialist $75 copayment	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Coverage is provided for: Tobacco Cessation programs, including individual group/telephonic counseling and for over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. Over -the-counter drugs must be purchased with a physician written prescription.	Nothing for counseling for up to two quit attempts per year with up to four counseling sessions per attempt. Nothing for OTC (with written prescription) and prescription drugs approved by the FDA to treat tobacco dependence.	100%
Childhood obesity education	Nothing	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)

Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Physicians must provide or arrange your care.
- The calendar year deductible is: $500 Self Only, $1,000 Self Plus One and Self and Family in-network and $1,000 Self Only, $2,000 Self Plus One and Self and Family out-of-network. The calendar year deductible applies to almost all benefits in this Section. We indicate " after deductible " to show when the calendar year deductible applies.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about *coordinating benefits with other coverage*, including with Medicare.
- **The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).**

YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification or call us at 877-835-9861 and we will assist you.

Benefit Description	You pay	
Surgical procedures	**In-Network**	**Out-of-Network**
A comprehensive range of services, such as: • Operative procedures • surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy. • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Insertion of internal prosthetic devices . See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	20% after deductible has been met	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Surgical treatment of morbid obesity (Bariatric surgery) when the following criteria has been met:	20% after deductible has been met	All charges

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**In-Network**	**Out-of-Network**
• Eligible members must be 18 or over (coverage for members under 18 is limited to individuals who meet guidelines established by the National Heart, Lung and Blood Institute (NHLBH) and • Individuals must have a Body Mass Index (BMI) of 40 or 35 with at least one documented comorbidity, and • Must complete a pre-surgical psychological evaluation, and • The member's PCP must submit clinical records documenting completion of a 6 month PCP supervised structured weight loss program. • This benefit must be coordinated by UnitedHealthhcare Bariatric Surgery program and in a Bariatric Centers of Excellence Facility	20% after deductible has been met	All charges
Physician charges for Scopic Procedures such as: • Endoscopy • Colonoscopy (Diagnostic) • Sigmoidscopy Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery.* Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.	20% after deductible has been met	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*	*All charges*
Reconstructive surgery	**In-Network**	**Out-of-Network**
Physician charges for : • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birthmarks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: • Surgery to produce a symmetrical appearance of breasts;	20% after deductible has been met	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)

Reconstructive surgery - continued on next page

Benefit Description	You pay	
Reconstructive surgery (cont.)	**In-Network**	**Out-of-Network**
• Treatment of any physical complications, such as lymphedemas; • Breast prostheses and surgical bras and replacements (see *Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	20% after deductible has been met	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*	*All charges*
Oral and maxillofacial surgery	**In-Network**	**Out-of-Network**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	20% after deductible has been met	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges.*	*All charges*
Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants)	**In-Network**	**Out-of-Network**
These **solid organ transplants** are covered. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas	20% after deductible has been met	All charges

Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants) - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants) (cont.)	**In-Network**	**Out-of-Network**
• Kidney • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	20% after deductible has been met	All charges
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	20% after deductible has been met	All charges
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy)	20% after deductible has been met	All charges

Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants) - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants) (cont.)	**In-Network**	**Out-of-Network**
- Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	20% after deductible has been met	All charges
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed)	20% after deductible has been met	All charges

Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants) - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants) (cont.)	**In-Network**	**Out-of-Network**
- Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	20% after deductible has been met	All charges
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP)	20% after deductible has been met	All charges

Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants) - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants) (cont.)	**In-Network**	**Out-of-Network**
- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MDDs) - Myelodysplasia/Myelodysplastic Syndromes - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for: - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyosarcoma - Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)	20% after deductible has been met	All charges

Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants) - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants) (cont.)	**In-Network**	**Out-of-Network**
- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis National Transplant Program (NTP) - OptumHealth Care Solutions (URN) used for organ tissue transplants **Limited Benefits** – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. **Note:** We cover related medical and hospital expenses of the donor when we cover the recipient. **Transplants must be provided in a Plan designated Center for Transplants. These centers do a large volume of these procedures each year and have a comprehensive program of care.**	20% after deductible has been met	All charges
Donor testing for bone marrow/stem cell transplants for up to 4 potential donors whether family or non-family	20% after deductible has been met	All charges
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered* • *All services related to non-covered transplants* • *All services associated with complications resulting from the removal of an organ from a non-member*	*All charges*	*All charges*
Anesthesia	**In-Network**	**Out-of-Network**
Professional services provided in : • Hospital (inpatient) • Hospital outpatient • Surgical center • Skilled nursing center • Office	20% after deductible has been met	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)

Section 5(c) Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In this Section when the deductible applies we have added " after deductible has been met" The calendar year deductible is: $500 Self Only, $1,000 Self Plus One and Self and Family in-network and $1,000 Self Only, $2,000 Self Plus One and Self and Family out-of-network.
- Some benefits in this section are subject to a **"per occurrence" deductible**. When this applies we will state " per occurrence deductible." When utilizing free-standing facilities you can reduce your out of pocket expenses.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about *coordinating benefits with other coverage*, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge such as physician charges are in Sections 5(a) or (b).

YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS. Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay	
Note: When the calendar year deductible applies we say below: "(when deductible has been met')		
Inpatient hospital	**In-Network**	**Out-of-Network**
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	20% after annual deductible has been met	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen	20% after deductible has been met	50% of the Plan allowance and any difference between our allowance and the billed amount (after deductible has been met)
• Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products.	20% after deductible has been met	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**In-Network**	**Out-of-Network**
• Blood products, derivatives and components, artificial blood products and biological serum. Blood products include any product created from a component of blood such as, but not limited to, plasma, packed red blood cells, platelets, albumin, Factor VIII, immunoglobulin, and prolastin • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthesia services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	20% after deductible has been met	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • Private nursing care	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**In-Network**	**Out-of-Network**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	20% after deductible has been met for services in ambulatory surgical center or physician's office; 20% after $250 per occurrence deductible and annual deductible has been met for services in outpatient hospital based surgical center	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met) in ambulatory surgical center or physician's office 50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met) plus $250 per occurrence deductible for services in outpatient hospital based surgical center
Not covered: Blood and blood derivatives not replaced by the member	*All charges*	*All charges*

Benefit Description	You pay	
Extended care benefits/Skilled nursing care facility benefits	**In-Network**	**Out-of-Network**
Services and supplies provided during Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for up to 60 days per year when full-time nursing care is medically necessary as determined by the Plan. Services include: • Room and board in a Semi-private Room (a room with two or more beds), and general nursing care • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a physician.	20% after deductible has been met	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Not covered: • *Custodial care* • *Rest cures, domicillary or convalescent care* • *Personal comfort items, such as telephone, barber services, guest meals and beds*	*All charges*	*All charges*
Hospice care	**In-Network**	**Out-of-Network**
Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes: physical, psychological, social,spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.	20% after deductible has been met	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Not covered: Independent and private duty nursing, homemaker services	*All charges*	*All charges*
Ambulance	**In-Network**	**Out-of-Network**
Medically Necessary emergency ground or air ambulance.	20% after deductible has been met	20% after deductible has been met

Section 5(d) Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $500 Self Only, $1,000 Self Plus One and Self and family in-network and $1,000 Self Only, $2,000 Self Plus One and Self and Family out-of-network. The calendar year deductible applies to almost all benefits in this Section. We state "after deductible has been met "for those services subject to the deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about *coordinating benefits with other coverage*, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Emergencies within or outside our service area

If you are in an emergency situation, please call your Primary Care Physician. In extreme emergencies, if you are unable to contact your physician, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan or Primary Care Physician within 48 hours, unless it was not reasonably possible to notify us within that time. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify us within that time.

Benefit Description	You pay	
Emergency Care	**In-Network**	**Out-of-Network**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital , including doctors' services	primary care physician (PCP) $25 copayment; Tier 1 premium-designated specialist $50 copayment, Non-designated specialist $75 copayment $100 copayment at Urgent Care center $250 copayment per visit at Hospital emergency room	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met) 50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met) $250 copay per visit at Hospital emergency room.
Not covered: Elective care or non-emergency care at Hospital emergency room	*All charges*	*All charges*

Benefit Description	You pay	
Ambulance	**In-Network**	**Out-of-Network**
Professional emergency ambulance service when medically appropriate.	20% when deductible has been met	20% when deductible has been met

Section 5(e) Mental health and substance abuse benefits

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible applies to almost all benefits in this Section. We added "after deductible has been met " to show when a deductible applies.
- The calendar year deductible is: $500 Self Only, $1,000 Self Plus One and Self and Family in-network and $1,000 Self Only, $2,000 Self Plus One and Self and family out-of-network. Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

YOU MUST GET PREAUTHORIZATION FOR SOME OF THESE SERVICES. Please contact our customer service department at 877-835-9861 if you need assistance.

Benefit Description	You pay	
Note: The calendar year deductible applies to almost all benefits in this Section. We state "(after deductible has been met)" when it applies.		
Professional Services	**In-Network**	**Out-of-Network**
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$75 copay per visit	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)

Professional Services - continued on next page

Benefit Description	You pay	
Professional Services (cont.)	**In-Network**	**Out-of-Network**
Autism Spectrum Disorder children through age 6- • Assessments, evaluations, or tests by a licensed physician or licensed psychologist to diagnose whether an individual has an autism spectrum disorder; • Treatment of autism spectrum disorders when it is determined by a licensed physician or licensed psychologist that **the treatment is medically necessary health care**. A licensed physician or licensed psychologist may be required to **demonstrate ongoing medical necessity**	$75 copayment for specialist	50% of the Plan allowance and any difference between our allowance and the billed amount (after deductible has been met)
Inpatient Hospital or other covered facility	**In-Network**	**Out-of-Network**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semi-private or intensive accommodations, general nursing care, meals and special diets, and other hospital services. Prior authorization is required • Partial day treatment • Residental Treatment	20% after deductible has been met	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Diagnostics	**In-Network**	**Out-of-Network**
Diagnostic tests • Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	20% after deductible has been met	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Outpatient hospital	**In-Network**	**Out-of-Network**
Outpatient services provided by and billed by a covered facility such as: • Facility based intensive outpatient treatment programs	20% after deductible has been met	50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Not covered	**In-Network**	**Out-of-Network**
• *Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by the Plan physician to be necessary and appropriate* • *Methadone Maintenance* • *Services and supplies when paid for directly or indirectly by a local state or Federal Government agency* • *Room and board at a therapeutic boarding school* • *Services rendered or billed by schools* • *Services that are not medically necessary*	*All charges*	*All Charges*

Not covered - continued on next page

Benefit Description	You pay	
Not covered (cont.)	**In-Network**	**Out-of-Network**
• *Not covered: Services requiring approval that we have not approved.Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*	*All Charges*

Preauthorization	To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:
Limitation	We may limit your benefits if you do not obtain a treatment plan.

Section 5(f) Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page. Some injectable medications may be covered under your medical benefit.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare. sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about *coordinating benefits with other coverage*, including with Medicare.
- There are no out of network benefits for prescription drugs.
- Federal law prevents the pharmacy from accepting unused medications.
- Prescription drugs are not subject to deductible.

There are important features you should be aware of. These include:

• **Who can write your prescription**. A health care provider licensed to write the prescription.

• **Where you can obtain them**. You may fill the prescription at a Plan pharmacy. Retail or mail order Specialty Pharmacydrugs ae only filled at our Specialty Pharmacy. Some drugs are only available at the retail pharmacy for safety or other reasons. To locate the name of a Plan pharmacy near you, refer to your Directory of Health Care Professionals, call our Customer Service Department 1-877-835-9861 (TTY 301-360-8111) or visit our website, www.uhcfeds.com.

• **We use a Prescription Drug List (PDL).**Our PDL Management Committee creates this list that includes FDA approved prescription medications, products, or devices. Our Plan covers all prescription medications written in accordance with FDA guidelines for a particular therapeutic indication except for prescription medications or classes of medications listed under "Not Covered" in this section of the brochure. The PDL Management Commitee decides the tier placement based upon clinical information from the UnitedHealthcare Pharmacy and Therapeutics (P&T) Committee as well economic and financial considerations. You will find important information about our PDL as well as other Plan information on our web site, www.uhcfeds.com.

• **The PDL consists of Tiers 1, 2, 3 and 4.**

- **Tier 1** is your **lowest** copayment option (**$10** for up to a 30-day supply or $25.00 for up to a 90-day supply through mail order), and includes all generic medications, as well as select preferred brand medications. Brand medications in Tier 1 include select insulin products, select inhalers for asthma, and select medications for migraine headaches for which no generic alternative(s) are available. For the lowest out-of-pocket expense, you should always consider Tier 1 medications if you and your provider decide they are appropriate for your treatment.
- **Tier 2** is your **middle** copayment option ($**35** for up to a 30-day supply or $87.50 for up to a 90-day supply through mail order), and contains all preferred brand medications not included in Tier 1. Preferred medications placed in Tiers 1 and 2 are those the PDL Management Committee has determined to provide better overall value than those in Tier 3. If you are currently taking a medication in Tier 2, ask your provider whether there are Tier 1 alternatives that may be appropriate for your treatment.
- **Tier 3** is your **higher** copayment option ($6**0** for up to a 30-day supply or $150 for up to a 90-day supply through mail order), and consists of only non-preferred brand medications. Sometimes there are alternatives available in Tier 1 or Tier 2. If you are currently taking a medication in Tier 3, ask your provider whether there are Tier 1 or Tier 2 alternatives that may be appropriate for your treatment.

- **Tier 4** is your **highest** priced ($100 for up to a 30-day supply or $250 for up to a 90-day supply through mail order) non-preferred brand name medications that do not add clinical value over their covered Tier1, Tier 2, or Tier 3 alternatives. Some medications on Tier 4 may also have an over-the-counter alternative which can be purchased without a prescription.

Changes to Tier level for all covered medications and supplies may occur January 1 and July 1 of each year. Throughout the year, if new generic medications come to market throughout the Plan year they will be placed on Tier 1and the brand could move to a higher tier. Newly marketed brand medications will be evaluated by our PDL Management Committee and they will be placed in the appropriate Tier. A prescription medication may be moved to the 4th tier of PDL at anytime if the medication changes to over-the-counter status, or removed from the PDL due to safety concerns declared by the Food and Drug Administration (FDA).

In rare cases, you will pay the full copayment amount for a medication when the actual cost of that medication is less than the discounted ingredient cost of the drug. This means if the medication you have filled costs $6, you may have to pay the full copayment of $10 if it is a Tier 1 medication. This is our network contracting policy, however, only a few retail pharmacies apply this policy. You will never pay more than the appropriate copayment for a medication. Contact our Customer Service Department at 877-835-9861 (TTY 301-360-8111) with questions.

These are the dispensing limitations: These are the dispensing limitations. Some drugs may only be available at a retail pharmacy or through the designated Specialty Pharmacy. See the bottom of this page for details on Specialty Pharmacy drugs.

Contraceptives - You pay one copay for up to a 90-day supply of contraceptive medications, subject to QLL and QD limitations. Note: Tier 1 hormonal contraceptives are offered with no copayment.

Step Therapy -step-therapy is a tool used to control costs for certain drug types as well as ensure quality and safety. If you have a new prescription for certain kinds of medications, you must first try the most cost-effective (first-line) drug in that category before another one is covered. In most cases, the cost-effective drug will work for you, but if it doesn't, your physician will need to request preauthorization for another (second-line) drug in the same category.

Quantity Duration (QD) - Some medications have a limited amount that can be covered for a specific period of time.

Quantity Level Limits (QLL) - Some medications have a limited amount that can be covered at one time.

Day Supply - “Day supply” means consecutive days within the period of prescription. Where a prescription regimen includes “on and off days” when the medication is taken, the off days are included in the count of the day supply.

Injectable medications - Medications typically covered under the pharmacy benefit and received through a retail or mail order pharmacy are those that are self-administered by you or a non-skilled caregiver. However, injectable medications that are typically administered by a health care professional are covered under your medical benefit and need to be accessed through your provider or Specialty pharmacy. Contact the Health Plan at 877-835-9861 (TTY 301-360-8111) for more information on these medications.

Special dispensing circumstances - UnitedHealthcare will give special consideration to filling prescription medications for members covered under the FEHB if:

- You are called to active duty, or
- You are officially called off-site as a result of a national or other emergency, or
- You are going to be on vacation for an extended period of time

Your physician may need to request prior authorization from us in order to fill a prescription for the reasons listed above. Please contact us on 1-877-835-9861 (TTY: 301-360-8111) for additional information

Changes to quantity duration and quantity level limits may occur on January 1 and July 1 of each year. We base these processes upon the manufacturer's package size, FDA-approved dosing guidelines as defined in the product package insert and/or the medical literature or guidelines that support the use of doses other than the FDA-recommended dosage. If your prescription written by your provider exceeds the allowed quantity, please refer to Section 7, to file an appeal with the Plan.

Refill Frequency - A process that allows you to receive a refill once when you have used 75 percent of the medications. For example, a prescription that was filled for a 30-day supply can be refilled after 23 days. While this process provides advancement on your next prescription refill, we cannot dispense more than the total quantity your prescription allows.

Mandatory Specialty Pharmacy Program - Our Specialty Pharmacy Program includes medications for rare, unusual or complex diseases. Members must obtain these medications through our designated specialty pharmacy. You will pay the applicable Tier copay for your specialty medications and receive up to a maximum of a consecutive 30-day supply of your prescription medication. Our specialty pharmacy providers will give you superior assistance and support during your treatment.This Program offers the following benefits to members:

- Expertise in storing, handling and distributing these unique medications
- Access to products and services that are not available through a traditional retail pharmacy
- Access to nurses and pharmacists with expertise in complex and high cost diseases
- Free supplies such as syringes and needles
- Educational materials as well as support and development of a necessary care plan

Why use Tier 1 drugs? Medications in Tier 1 offer the best health care value and are available at the lowest copayment. Tier 2 and Tier 3 medications are available at a progressively higher copayment and Tier 4 medications are available at the highest copayment level. This approach helps to assure access to a wide range of medications and control health care costs for you.

Benefit Description	You pay	
Covered medications and supplies	**In-Network**	**Out-of-Network**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin with a copayment charge applied every 2 vials • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction are limited. Contact the plan for dosage limits. • Oral and injectable contraceptive drugs	Non-maintenance medications at a retail pharmacy: • Up to a 30-day supply - Tier 1: $10 copayment - Tier 2: $35 copayment - Tier 3: $60 copayment - Tier 4: $100 copayment Maintenance medications from the Plan mail order pharmacy for up to a a maximum of a 90-day supply • Tier 1: $25 copayment • Tier 2: $87.50 copayment • Tier 3: $150 copayment • Tier 4: $250 copayment	All charges
Women's Tier 1 Contraceptive drugs and devices Woman's contraceptive drugs and devices: • Tier 1 hormonal contraceptives • The "morning after pill" (tier 1) is provided at no cost if prescribed by a physician and purchased at the network pharmacy Please contact customer service at 877-835-9861 if you have any questions regarding contraceptive coverage	Nothing - covered at 100%. Not subject to deductible	All charges

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**In-Network**	**Out-of-Network**
Smoking cessation medications are covered as follows: • Prescription medications for smoking cessation • Over-the-counter smoking cessation medications with a prescription from physician	Nothing - covered at 100%. Not subject to deductible	All charges
Not covered: • *Medications, drugs and supplies used for cosmetic purposes* • *Medical Marijuana* • *Any product dispensed for the purpose of appetite suppression and other weight loss products* • *Drugs to enhance athletic performance* • *Medical supplies such as dressings and antiseptics* • *Artifical insemination fertility drugs* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed* • *Vitamins,nutrients and food supplements (except pre-natal vitamins for pregnant women and prescription strength vitamin D (for members 65 and older) that can be purchased without a prescription* • *Nonprescription medicines* • *Drugs available over-the-counter that do not require a prescription order by federal or state law before being dispensed* • *Alcohol swabs and bio-hazard disposable containers* • *Compound drugs that do not contain at least one covered ingredient that requires a prescription order to fill*	*All Charges.*	*All charges*

Section 5(g) Special features

Feature	
Feature	**High Option**
Care 24 / 24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call (1-888-887-4114) and talk with a registered nurse who will discuss treatment options and answer your health questions. Members will learn self-care for minor illnesses and injuries, understand diagnosed conditions, manage chronic diseases, discover and evaluate possible benefits and risks of various treatment options, learn about specific medications and connect with community support groups.
Health Rewards Program- Get Rewarded for Healthy Action	Earn gift card rewards up to $75 per Self Only enrollment, $75 each for Subscriber and Spouse in Self plus One or Self and Family enrollment ($150 total). $50 reward for completion of online Health Risk Assessment and $25 reward for completion of three Rally missions.
Healthy Pregnancy Program	With our Healthy Pregnancy Program, UnitedHealthcare members receive personal support through all stages of pregnancy and delivery. Some features of the program include a pregnancy assessment to identify special needs, identification of pregnancy risk factors, a 24-hour toll-free phone number to experienced nurses and customized maternity educational materials. To enroll in the Healthly Pregnancy Program, simply call toll-free to 1-800-411-7984, or visit www.healthy-pregnancy.com
UnitedHealth Premium	The UnitedHealth Premium® program was created to help people make more informed choices about their health care. The Premium program recognizes doctors who meet standards for quality and cost efficiency. We use evidence-based medicine and national industry guidelines to evaluate quality. The cost efficiency standards rely on local market benchmarks for the efficient use of resources in providing care. A doctor's Premium designation is shown on myuhc.com® and in provider directories
Specialty Pharmacy	Specialty medications are designed to address the most complex and life threatening diseases. These drugs require an approach that looks beyond the drug to the whole disease. All of the pharmacies in the specialty network provide personalized care, monitoring and medication counseling. Members have access to pharmacists 24 hours a day to answer any questions regarding medications.
Blue Button	**Blue Button** allows you to access and download your information from your UnitedHealthcare Personal Health Record (PHR) into a very simple text file or PDF that can be read, printed, or saved on any computer. It gives you complete control of this information – without any special software – and enables you to share this data with your health care providers, caregivers, or people you trust. UnitedHealthcare is an advocate for empowering patients to best utilize the important information and data in their PHR. Blue Button makes this easier and more secure.
UHC.TV℠ for Health and Happiness	UHC.TV is an online television network that presents educational and entertaining video programs about good health and living well. Get inspired by watching short motivational talks by well-known speakers, including authors Dan Buettner and Gail Sheehy, futurist Jack Uldrich, former U.S. Surgeon General Dr. Jocelyn Elders and Olympic Gold Medalist Scott Hamilton. Get advice from health experts, including the Centers for Disease Control (CDC), Dr. Oz® and other health professionals, on a variety of topics. Simply go to www.uhc.tv and tune into one of our great channels. You can also subscribe to UHC.TV and be the first to know about new programs, content and features as they are added to the site. Like us on Facebook® or follow us on Twitter.·®
Cancer Clinical Trials	To be a qualifying clinical trial, a trial must meet all of the following criteria:

Feature - continued on next page

Feature	
Feature (cont.)	**High Option**
	• Be sponsored and provided by a cancer center that has been designated by the *National Cancer Institute (NCI)* as a *Clinical Cancer Center* or *Comprehensive Cancer Center* or be sponsored by any of the following: • *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI)*) • *Centers for Disease Control and Prevention (CDC)* • *Agency for Healthcare Research and Quality (AHRQ)* • *Centers for Medicare and Medicaid Services (CMS)* • *Department of Defense (DOD)* • *Veterans Administration (VA)* • The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals. Benefits are not available for preventive clinical trials. • The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

Section 5(h) Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- The calendar year deductible is: $500 Self Only, $1,000 Self Plus One and Self and Family in-network and $1,000 Self Only, $2,000 Self Plus One and Self and Family out-of-network. The calendar year deductible applies to some benefits in this Section. We state "after deductible has been met " to show when the calendar year deductible applies.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.

Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Desription	You Pay	
Accidental injury benefit	**High Option**	**Basic Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. • Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry • The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period provided you do so within 60 days of the injury and if extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wire from fracture care.) • Benefits for treatment of accidental injury arelimited to the following: - Emergency examination - Necessary x-rays - Endodontic (root canal) treatment - Temporary splinting of teeth - Prefabricated post and core - Simple minimal restorative procedures (fillings) - Extractions - Placement of a crown if such treatment is the only clinical treatment and in cases of an injury as described above in this section - Replacement of lost teeth due to injury	20% after deductible has been met	Out-of-network provider: 50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Not covered:	*All charges*	*All charges*

Accidental injury benefit - continued on next page

Benefit Desription	You Pay	
Accidental injury benefit (cont.)	**High Option**	**Basic Option**
• *Oral implants and related procedures, including bone grafts to support implants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva and alveolar bone)*	*All charges*	*All charges*

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. For additional information about any of these programs contact the Plan at 1-877-835-9861 or visit www.myuhc.com.

Preventive PPO Dental Plan: There is no additional premium for this benefit and enrollment is automatic when you enroll in this plan. Cleanings for all eligible family members at no charge when in-network dentists are utilized. Visit www.uhcfeds.com for additional information**.**

Discounts on Wellness Proucts and Services: Enjoy a healthy lifestyle for less with our discounted products and services. You can get discounts on fitness club memberships, weight loss programs, teeth whitening and more. Access our health discount program online at www.uhcfeds.com.

Online Health Coach: Exercise Program -This program provides personalized exercise routines to help you meet the challenges of getting in shape. This staged approach to getting fit walks you through five program levels. Plus, you'll receive tips on nutrition, fitness articles and access to interactive tools to help you keep your exercise routine for life. To access this program, log on to www.myuhc.com, click 'Health & Wellness', then 'Your Personal Health Center' on the right side of the screen.

Online Personal Health Manager -Available on www.myuhc.com, the online Personal Health Manager helps you manage your health information all in one place.You can securely record your current health status or conditions, document your medical contacts, create an emergency medical wallet card and store information from doctors and print reports.

Online Health Assessment, and Personalized Report -Available through www.myuhc.com, the Health Assessment is an online confidential survey that helps assess your overall current state of health. After taking the 20-minute Health Assessment, you immediately receive a Personalized Report with your results. You then can begin taking steps to achieve a healthier lifestyle through using the online Health Improvement Programs, based on your Personalized Report's suggested improvement areas. You also have the option to speak with a consultative nurse about your results.

Health and Wellness Library - Get the latest information on a variety of health and wellness topics. Log on to www.myuhc.com and click 'Health&Wellness', then 'Conditions AtoZ'. **Health Improvement Programs -**Through myOptumHealth, UnitedHealthcare medical members have access to tools that can help contribute to your overall health and well-being. It offers premier motivational and interactive tools that allow you to make better health and lifestyle management choices. Find out ways to improve your emotional well-being and create a plan to help motivate your children. Inspire yourself; understand what motivates you to say "I'll do it"! Continue, or expand your plan of prevention, or educate yourself on your health vulnerabilities. Share tips, tell your story, and find mutual support from people walking the same road as you.

The educational, yet entertaining content covers a wide range of topics/ programs including nutrition, diabetes, exercise and fitness, women's & men's health, weight management, heart health, and so much more. First register on the link from the member page, then use the wide range of self care tools & tips, news and trends,, videos, slide shows, quizzes and other effective ways to **engage, plan, learn and take action** to maximize your health and that of your loved one

Source4Women - Learn more about health and wellness for you and your family, and find new ways to stay healthy. Source4Women offers complimentary online tools, resources, seminars and events focused on keeping you and your family healthy. Visit **www.source4women**and register to attend any of the complimentary one-hour seminars. The interactive seminars feature health and wellness experts, as well as time for questions with the speakers.

Section 6 General exclusions – things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures or unproven treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.
- Extra care costs related to taking part in a clinical trial such as additional tests that a patient may need as a part of the trial but not as part of the patient's routine care
- Research costs related to conducting a clinical trial such as research physician and nurse-time, analysis of results, and clinical tests performed only for research purposes.

Section 7 Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider.

If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at (877) 835-9861, (TTY): 301-360-8111.

When you must file a claim – such as for services you received outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the physician or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit domestic medical claims to:

UnitedHealthcare, P.O. Box 740817, Atlanta, GA 30374-0817.

Submit international medical claims to:

UnitedHealthcare, PO Box, 740817, Atlanta GA 30374-0817.

Prescription drugs

Submit your claims to:

Usually, there are no claim forms to fill out when you fill a prescription at a Plan pharmacy. In some cases, however you may pay out-of-pocket, in an emergency medical situation. If this happens, send the following information:

- Your receipt
- The drug NDC number
- The pharmacy's NABP number
- The prescribing physician's or dentist's DEA number

Submit your claims to: OptumRx at PO Box 29044, Hot Springs, AR 71903.

Other supplies or services

Submit your claims to: UnitedHealthcare, P.O. Box 740825, Atlanta, GA 30374-0825.

Deadline for filing your claim	Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.
When we need more information	Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond.
Post-service claims procedures	We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected. If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information. If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.
Authorized Representative	You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.
Notice Requirements	If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language. Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes

Section 8. The disputed claims process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.uhcfeds.com.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing UnitedHeathcare, Federal Employees Health Benefits Program at P.O. Box 30432, Salt Lake City, UT 84130-0432 or by calling 877-835-9861, TTY:(301-360-8111).

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

1 Ask us in writing to reconsider our initial decision. You must:

a) Write to us within 6 months from the date of our decision; and

b) Send your request to us at: UnitedHealthcare, Federal Employees Health Benefit Program (FEHB) Appeals, P.O. Box 30573, Salt Lake City, Utah 84130-0573; and

c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and

d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

2 In the case of a post-service claim, we have 30 days from the date we receive your request to:

a) Pay the claim or

b) Write to you and maintain our denial or.

c) Ask you or your provider for more information

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

If you do not agree with our decision, you may ask OPM to review it.

3

You must write to OPM within:
• 90 days after the date of our letter upholding our initial decision; or
• 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or
• 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3630.
Send OPM the following information:
• A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
• Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
• Copies of all letters you sent to us about the claim;
• Copies of all letters we sent to you about the claim; and
• Your daytime phone number and the best time to call.
• Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4

OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at (877) 835-9861. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at (202) 606-0737 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9 Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC website at www.NAIC.org.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

- **TRICARE and CHAMPUS**

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

When others are responsible for injuries

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone 1-877-888-3337 (TTY 1-877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare?

- **What is Medicare**

Medicare is a health insurance program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY: 1-877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY:1-800-325-0778).

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213, (TTY: 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage.

It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10 % increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at (877) 835-9861 9TTY: 301-360-8111) or see our member website at www.myuhc.com.

We do not waive any costs if the Original Medicare Plan is your primary payor.

Please review the following table it illustrates your cost share if you are enrolled in Medicare Part B. Medicare will be primary for all Medicare eligible services. Members must use providers who accept Medicare's assignment.

Benefit Description	Member Cost without Medicare	Member Cost with Medicare Part B
Deductible	$500 Self Only; $1,000 Self Plus One or Self and Family	$500 Self only; $1,000 Self Plus One or Self and Family
Out of Pocket Maximum	$5,000 self only/$10,000 Self Plus One or Self and Family	$5,000 self only/$10,000 Self Plus One or Self and Family
Primary Care Physician	$25 PCP copayment	$25 PCP copayment
Specialist	$50 copayment Tier 1 Premium Designated	$50 copayment Tier 1 Premium Designated
Inpatient Hospital	20% after annual deductible premium designated hospital	20% after annual deductible Premium designated hospital
Outpatient Hospital	20% after annual deductible	20% after deductible
Rx	Tier 1 -$10 Tier 2 -$35 Tier 3 - $60 Tier 4 – $100	Tier 1 -$10 Tier 2 -$35 Tier 3 - $60 Tier 4 – $100
Rx – Mail Order (90 day supply)	2.5 x retail copay	2.5 x retail copay

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country.

To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY: 1-877-486-2048) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Medicare Advantage plan:

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers). However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

• **Medicare prescription drug coverage (Part D)**	When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10 Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical trials cost categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 20.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 20.

Cost Sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Covered services

Care we provide benefits for, as described in this brochure.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 20.

Experimental or investigational service

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that , at the time we make a determination regarding coverage in a particular case are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA*) to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States American Hospital Pharmacopoeia Dispensing Information* as appropriate for the proposed use
- Not recognized, in accordance with generally accepted medical standards, as being safe and effective for your condition;
- Subject to review and approval by any institution review board for the proposed use. (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be
  Experimental or Investigational.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Medical necessity

Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, Substance Use Disorder disease or its symptoms, that are all of the following as determined by us or our designee, within our discretion.

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, Substance Use Disorder, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider
- Not more costly than an alternate drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community , relying primarily on controlled clinical trials, or if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. The fact that a Physician may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered by this Plan.

If no credible scientific evidence is available then standards are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary.

Plan allowance

Allowable expense(plan allowance) is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid.

Post-service claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims

Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Reimbursement

A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Subrogation

A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

Unproven Service(s)

Unproven services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com .

Please note: If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent care claims

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at ***877-835-9861 (TTY:301-360-8111)***. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We

Us and We refer to UnitedHealthcare

You

You refers to the enrollee and each covered family member.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program

The Federal Flexible Spending Account Program - FSAFEDS

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,550 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to out-of-pocket dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26).
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1, you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?	Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS, (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program - FEDVIP

Important Information	The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment. FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.
Dental Insurance	All dental plans provide a comprehensive range of services, including: • Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays. • Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments. • Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures. • Class D (Orthodontic) services with up to a 12-month waiting period. **Most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.**
Vision Insurance	All vision plans provide comprehensive eye examinations and coverage for your choice of either lenses and frames or for contact lenses. Other benefits such as discounts on LASIK surgery may also be available.
Additional Information	You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/dental and www.opm.gov/vision . These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.
How do I enroll?	You enroll on the Internet at www.BENEFEDS.com . For those without access to a computer, call 1-877-888-3337, (TTY:1-877- 889-5680).

The Federal Long Term Care Insurance Program - FLTCIP

It's important protection	The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337), (TTY:1-800-843-3557), or visit www.ltcfeds.com

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Summary of Benefits for the Value Option of UnitedHealthcare Insurance Company - 2016

- Do not rely on this chart alone. All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- Below, an asterisk (*) means the item is subject to the deductible. The calendar year deductible is: $500 self only $1,000 self and family in-network and $1,000 self only $2,000 self and family out-of-network.

Standard Option Benefits	You Pay
Medical services provided by physicians:	
Diagnostic and treatment services provided in the office	In-network: primary care physician (PCP) $25 copayment Tier 1 premium-designated specialist $50 copayment, Non-designated specialist $75 copayment Out-of-network: Out -of-network provider: 50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible hasbeen met).
Services provided by a hospital:	
• Inpatient	In-network: Tier 1 Premium Designated network hospital: 20% after annual deductible has been met; Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount and annual deductible has been met
• Outpatient (Non-surgical)	In-network: 20% after deductible has been met Out-of-network: 50% of the plan allowance and any difference between our allowance and the billed amount (after deductible has been met)
Emergency benefits:	
• Emergency Room of Hospital	$250 copayment per visit in-network or out-of-network
• Urgent Care Facility	In-network: $100 copayment per visit Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Mental health and substance abuse treatment:	Regular cost sharing
Prescription drugs:	In-network benefits only
• Retail pharmacy	Up to 30-day supply at retail (in-network only) Tier 1: $10 copayment

	Tier 2: $35 copayment Tier 3: $60 copayment Tier 4: $100 copayment
• Mail order	Up to 90-days at Mail Order (in-network only) Tier 1: $25 copayment Tier 2: $87.50 copayment Tier 3: $150 copayment Tier 4: $250 copayment
Vision care:	Routine Eye Examination In-network $25 copayment Out-of-Network::50% of the Plan allowance and any difference between our allowance and the billed amount. (after deductible has been met)
Annual Deductible	In-network $500 Self only, $1,000 Self Plus One and Self and Family Out-of-network: $1,000 Self only, $2,000 Self Plus One and Self and Family
Protection against catastrophic costs (out-of-pocket maximum)**:**	You pay nothing after: In-network: $3,000 Self only ; $6,000 Self plus One and Self and Family Out-of-Network: $6,000 Self only; $12,000 Self Plus One and Self and Family

2016 Rate Information for - UnitedHealthcare Insurance Company, Inc.

For 2016 health premium information, please see: http://www.opm.gov/healthcare-insurance/indian-tribes/health-insurance/#url=Premiums or contact your tribe's Human Resources department.