UnitedHealthcare Insurance Company -Choice HMO

http://www.uhcfeds.com
Customer Service: 877-835-9861

UnitedHealthcare®

2017

Open Access HMO

The plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 9 for details.

IMPORTANT
- Rates: Back Cover
- Changes for 2017: Page 16
- Summary of benefits: Page 86

Serving :West (Colorado, Phoenix and Tucson Arizona) ; Southeast (Alabama, Arkansas, Louisiana, Mississippi and Knoxville, TN); Central (Des Moines, Iowa and Western Kentucky) and Northeast (District of Columbia, State of Maryland and Northern Virginia)

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 14 for requirements.

Enrollment codes in AL, MS, AK, LA and TN:

KK1 Self Only, KK3 Self Plus One, KK2 Self and Family

Enrollment codes in KY and IA:

LJ 1 Self Only, L3 Self Plus One, LJ2 Self and Family

Enrollment codes in MD, DC and Northern VA

LR1 Self Only, LR3 Self Plus One, LR2 Self and Family

Enrollment codes in CO and AZ

KT1 Self Only , KT3 Self Plus One, KT2 Self and Family

HEALTH PLAN NCQA ACCREDITATION ACCREDITED

This plan is Accredited by NCQA

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:
United States Office of Personnel Management
Healthcare and Insurance
http://www.opm.gov/insure

Important Notice from UnitedHealthcare Insurance Company About

Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the UnitedHealthcare Insurance Company'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 800-772-1213, (TTY 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 800-MEDICARE (800-633-4227), (TTY) 877-486-2048.

Table of Contents

Introduction

This brochure describes the benefits of UnitedHealthcare Insurance Company, Inc. under our contract (CS 2949) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 877-835-9861 or through our website www.uhcfeds.com. The address for our administrative offices is:

UnitedHealthcare Insurance Company, Inc.
Federal Employees Health Benefits (FEHB) Program
6220 Old Dobbin Lane, 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 are enrolled 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, 2017, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2017, and changes are summarized on page 15. 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 easy to understand. Here are some examples,

- 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, authorized 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) statements 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 age 26 or over (unless he/she is disabled and incapable of self-support prior to age 26)
- 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.

Discrimination is Against the Law

UnitedHealthCare Insurance Company complies with applicable Federal civil rights laws, to include both Title VII and Section 1557 of the ACA. Pursuant to Section 1557 UnitedHealthCare Insurance Company does notdiscriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex. (including pregnancy and gender identity).

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator. UnitedHealthCare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call **877-835-9861 (** toll-free member phone number listed on your health plan ID card), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. **Online** https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Phone: Toll-free **1-800-368-1019, 800-537-7697** (TDD)

Mail: U.S. Dept. of Health and Human Services ; 200 Independence Avenue, SW Room 509F, HHH Building

Washington, D.C. 20201

Nationally Aggregated languages

You have the right to get help and information in your language at no cost. To request an interpreter, call 877-835-9861, press 0. TTY 711. This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

1. Spanish

Tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para solicitar un intérprete,877-835-9861 llame aly presione el cero (0). TTY 711

2. Chinese

您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 877-835-9861 ，再按 0。聽力語言殘障服務專線711

3. Vietnamese

Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí.
Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi877-835-9861, bấm số 0. TTY 711

4. Korean

귀하는도움과정보를귀하의언어로비용부담없이얻을수있는권리가있습니다. 통역사를요청하기위해서는 877-835-9861로전화하여 0번을누르십시오. TTY 711

5. Tagalog

May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tumawag sa 877-835-9861, pindutin ang 0. TTY 711

6. Russian

Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по телефону877-835-9861 и нажмите 0. Линия TTY 711

7. Arabic

لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل بالرقم
877-835-9861، واضغط على 0. الهاتف النصي (TTY) 711

8. French Creole (Haitian Creole)

Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo 877-835-9861, peze 0. TTY 711

9. French

Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le 877-835-9861 et appuyez sur la touche 0. ATS 711.

10. Portuguese

Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para 877-835-9861, pressione 0. TTY 711

11. Polish

Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod numer 877-835-9861i wciśnij 0. TTY 711

12. German

Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die Nummer877-835-9861an und drücken Sie die 0. TTY 711

13. Japanese

ご希望の言語でサポートを受けたり、情報を入手したりすることができます。
料金はかかりません。通訳をご希望の場合は、877-835-9861までお電話
の上、0を押してください。TTY専用番号は 711です。

14. Persian (Farsi)

شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره 877-835-9861تماس حاصل نموده و 0 را فشار دهید. TTY

15. Italian

Hai ildiritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama 877-835-9861 e premi lo 0. Dispositivi per non udenti/TTY: 711

16. Navajo

T'áá jíík'eh doo bą́ą́h 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í ła yíníkeedgo, kohjį' 877-835-9861hodíilnih dóó 0 bił 'adidíílchił. TTY 711

Preventing Medical Mistakes

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. Medical mistakes continue to be a significant cause of preventabledeaths within the United States. Whiledeath is the most tragic outcome, medical mistakes cause other problems such aspermanent disabilities, extended hospital stays, longer recoveries, and evenadditional treatments. Medical mistakes and their consequences also add significantly to theoverall cost of healthcare. Hospitalsand healthcare providers are being held accountable for the quality of care andreduction in medical mistakes by their accrediting bodies. You can also improve the quality and safetyof your own health care and that of your family members by learning more aboutand understanding your risks.

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 take notes, 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 the pharmacist about your medicine 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.
- Understand both the generic and the brand names of your medication. This helps ensure you don't receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don’t assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

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

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic 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 or clinic.

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 reaction to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- http://www.jointcommission.org/speakup.aspx. The JointCommission’s Speak Up™ patient safety program.
- http://www.jointcommission.org/topics/patient_safety.aspx. The JointCommission helps health care organizations to improve the quality and safety ofthe care they deliver.

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

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem,you don't expect to leave with additional injuries, infections, or otherserious conditions that occur during the course of your stay. Although some ofthese complications may not be avoidable, patients do suffer from injuries orillnesses that could have been prevented if doctors or the hospital had takenproper precautions. Errors in medical care that are clearly identifiable,preventable and serious in their consequences for patients, can indicate asignificant problem in the safety and credibility of a health carefacility. These conditions and errorsare sometimes called "Never Events" or "Serious Reportable Events."

We have a benefit payment policy that encourages hospitals to reducethe likelihood of hospital-acquired conditions such as certain infections,severe bedsores, and fractures, and to reduce medical errors that should neverhappen. When such an event occurs,neither you nor your FEHB plan will incur costs 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 Insurance Company, Inc. 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 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 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 or 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 children as described in the chart below. A Self Plus One enrollment covers you and your spouse or one other eligible family member as described in the chart below.

Children	Coverage
Natural, 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.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

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 in Self Plus One or for 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 on 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 2017 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 2016 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 visit OPM's Web site, 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). 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.

- **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 Market Place**

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 a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory.

HMOs 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 and coinsurance described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO 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 High Option Plan

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your Primary Care Provider (PCP) or by another participating provider in the network. We have a wide service area of participating providers you must use to access care. You will not have to routinely file claims for medical services and we have Customer Service Department available at 877-835-9861.

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.

United Healthcare Insurance Company, Inc. is a health maintenance organization. You do not need to select a Primary Care Physician (PCP) and you do not need to get written referrals to see a participating specialist for medical service. The provider must be participating for services to be covered. You must call United Behavioral Health at 877-835-9861 to obtain information regarding authorization for some services to use Mental Health/Substance Abuse benefits. Women may see a plan gynecologist for their routine examinations.

The Plan's provider directory lists primary care doctors with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. The directory is updated on a regular basis and is available at the time of enrollment or upon calling the Customer Service Department at 877-835-9861. When you enroll in this Plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or participation of any one doctor, hospital, or other provider, cannot be guaranteed.

The Plan will provide benefits for covered services only when the services are medically necessary to prevent, diagnose or treat your illness or condition. Payment of claims for prosthetic devices or durable medical equipment, when the item cost is more than $1000 requires prior notification.

Your rights and responsibilities

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 Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- UnitedHealthcare Insurance Company, Inc.has been in existence since 1972
- UnitedHealthcare Insurance Company, Inc.is a for-profit organization

You are also entitled to a widerange of consumerprotections and have specific responsibilities as a member of this Plan. You can view the complete list of theserights and responsibilities by visiting our website at www.myuhc.com. You can also contact us to request that wemail a copy to you.

If you want more information about us, call 877-835-9861. You may also visit our Web site at www.uhcfeds.com.

By law, you have the right toaccess your personal health information (PHI). For more information regarding access to PHI, visit our website at www.myuhc.com. You can also contact us to request that we maila copy regarding access to PHI.

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.

Catastrophic protection

We protect you against catastrophic out-of-pocketexpenses for covered services. Yourannual out-of-pocket expenses for covered services, including deductibles andcopayments, cannot exceed $7,150 for Self Onlyenrollment, and $14,300 for a Self Plus One or Selfand Family.

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area is:

South East - Plan code KK :

Alabama, Louisiana, Mississippi, Arkansas as well as the following counties in **Tennessee**: Anderson, Blount, Campbell, Claiborne, Cocke, Cumberland, Fentress, Grainger, Hamblen, Jefferson, Knox, Loudon, Monroe, Morgan, Roane, Scott, Sevier and Union**.**

North East - Plan code LR:

District of Columbia, State of Maryland and the following counties in **Virginia:** Frederick, Shenandoah, Arlington, Rockingham, Page, Warren, Madison, Orange, Spottsylvania, King George, Stafford, Culpepper, Rappahancock, Fauquier, Loudoun, Clarke, Prince William, Alexandria, Greene and, Fairfax

West - Plan code KT:

Colorado (entire state), Tucson, Arizona (Including the counties of: Santa Cruz, and portion of Pima county including the following zip codes : 85321,85341,85601,85602,85611,85614,85619, 85622, 85629, 85633, 85634, 85637,85639,85641,85646,85652,85653,85654,85658, 85701,85702,85703,85704,85705, 85706, 85707,85708,85709,85710,85711,85712,85713,85714,85715,85716,85717,85718,85719,85720,85721,85722,85723,85724,8572-5,85726,85728,85730,85731,85732,85733,85734,85735.85736,85737,85738,85739,85740,85741,85742,85743,85744,85745,857-46,85747,85748,85749,85750,85751,85752,85754,85755,85756,85757,85775

Phoenix, Arizona – *Including the counties of:* Maricopa and Pinal

Central - Plan code LJ:

Des Moines, Iowa (***Including the counties of:*** Adair, Appanoose, Audubon, Boone, Buena Vista, Calhoun, Carroll, Cerrogordo, Chicksaw, Clarke, Clay, Dallas, Davis, Decatur, Dickinson, Emmet, Floyd, Franklin, Greene, Guthrie, Hamilton, Hancock, Hardin, Howard, Humboldt, Jasper, Kissuth, Lucas, Madison, Mahaska, Marion, Marshall, Mitchell, Monroe, Palo Alto, Pocahontas, Polk, Ringgold, SAC, Story, Tama, Union, Warren, Wayne, Webster, Winnebago, Worth, and Wright.

Western Kentucky ***Including the following counties***: Allen, Ballard, Barren, Breckenridge, Bullitt, Butler, Caldwell, Calloway, Carlisle, Carroll, Christian, Crittenden, Cumberland, Edmonson, Fulton, Graves, Grayson, Hancock, Hardin, Hart, Henry, Hickman, Hopkins, Jefferson, Larue, Livingston, Logan, Lyon, Marshall, McCracken, McLean, Meade, Metcalf, Monroe, Muhlenberg, Nelson, Ohio, Oldham, Shelby, Simpson, Spencer, Todd, Trimble, Warren and Webster.

Section 2. Changes for 2017

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5. Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Changes to this plan:

- Your share of the non-Postal premium will increase for Self Only or increase for Self plus one or Self and Family.
- We have removed the exclusion in reconstructive surgery for all gender reassignment surgery as some procedures are now covered. Please refer to section 5(b) for details.
- Copayments for prescription drugs have changed for Tier 3 and Tier 4: 50% coinsurance will no longer apply. Tier 3 drugs will now have a copayment of $85 for 30-day supply and $212.50 for a 90-Day supply at mail order. Tier 4 will have a copayment of $175 for 30-day supply and a copayment of $437.50 for a 90-day supply at mail order .
- The health and wellness gift card incentives has been discontinued.

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, or write to us at United Healthcare Insurance Company Inc., Federal Employees 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 web site www.myuhc.com.

Where you get covered care

You get care from "Plan providers" and "Plan facilities". You will only pay copayments, and/or coinsurance. If you use our Open Access program you can receive covered services from a participating provider without a required referral from your 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.

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web sites at www.myuhc.com and www.uhcfeds.com.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web sites www.myuhc.com and www.uhcfeds.com

What you must do to get covered care

You do not need to select a primary care physician and you do not need to get written referrals to see a contracted specialist for medical services. The provider must be participating for services to be covered. You need to call Customer Service at 877-835-9861 to obtain authorization for some services. Prior authorization for Prosthetic devices or durable medical equipment is required when the item costs more than $1,000 or for Growth Hormone Therapy (GHT). Please refer to prior approval in this section for more information. The Plan will provide benefits for covered services only when the services are medically necessary to prevent, diagnose or treat your illness or condition.

- **Primary care**

Your primary care physician (PCP) can be a family practitioner, internist, or pediatrician. Your primary care physician (PCP) will provide most of your health care

- **Specialty care**

You do not need to have a referral to see a participating specialist. If you need the care of a specialist, you may select a specialist from our provider directory, or call your PCP who will assist you in locating an appropriate participating provider. If your current specialist is a Plan provider, you may continue to see that doctor without a written referral unless the provider is a mental health/ substance abuse specialist and some of those services need prior authorization. You should call Customer Service at 877-835-9861 to obtain authorization for services to use mental health/ substance abuse benefits.

Here are some other things you should know about specialty care:

- If you are seeing a specialist when you enroll in our Plan, check with the specialist to verify that the specialist is participating with the Plan. If the specialist is contracted with the Plan, you may continue to see the provider. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

If you have a chronic and disabling condition and lose access to your specialist because we:

- terminate our contract with your specialist for other than cause;
- drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or
- reduce our service area and you enroll in another FEHB plan,

you may be able to continue seeing your specialist 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 until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Plan 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

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services*.

- **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**

You do not need to have a referral to see a participating specialist. For certain services, however, you or your physician must obtain prior approval from us. We call this review and approval process prior notification. You or your physician must obtain prior notification for some services such as, but not limited to the following:

- Applied Behavioral Analysis (ABA)
- Orthopedic and prosthetic devices over $1,000
- Capsule endoscopy
- Congenital anomaly repair
- Dialysis
- Discectomy/fusion

- Durable medical equipment over $1,000.
- Electro-convulsive therapy
- Hysterectomy
- Inpatient Hospitalization
- Intensive Outpatient treatments
- Growth hormone therapy (GHT).
- Joint replacement
- Magnetic resonance imaging (MRI) and/or Magnetic resonance angiogram (MRA)
- Morbid obesity surgery
- Partial hospitalization
- Psychological, neurophysiological and extended developmental testing
- Pet scans and/or Computed tomography (CT) scans.
- Nuclear medicine studies including nuclear cardiology.
- Reconstructive surgery
- Rhinoplasty/septo-rhinoplasty
- Substance Abuse Treatments
- Sleep apnea - surgery and appliance (with sleep studies); sleep studies (polysomnograms) - attended
- Clinical trials. See page 60
- Vein Ablation.
- Virtual Colonoscopy
- Transplants.

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.

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 planned days of confinement.

- **Non-urgent care claims**

For non-urgent care claims, we will 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) to 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, your hospital, you or your representative, must call us at 877-835-9861 prior to admission.
• **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	This plan is an HMO and does not offer coverage for non-network facilities. If you use non-network faciltiies without written authorization from the plan, you will be responsible for 100% of 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 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.

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.

Subject to a request for 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 and when you go in the hospital, you pay $150 per day up to a maximum of $750 per admission.
Deductible	We do not have a deductible.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Example: In our Plan, you pay 50% of our allowance for durable medical equipment
Your catastrophic protection out-of-pocket maximum	After your out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance total $5,000 for Self Only, or $10,000 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. ***The maximum annual limitation on cost sharing listed under Self Only of $5,000 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 a $5,000 Self Only maximum out-of-pocket limit and a $10,000 Self Plus One or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of $5,000 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 out-of-pocket maximum of $10,000, 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 $10,000 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: • Copayments or coinsurance for chiropractic services • Expenses for services and supplies that exceed the stated maximum dollar or day limit • Expenses from utilizing out-of-network providers 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.

High Option Benefits

See Section 2 for how our benefits changed this year. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5. High Option Benefits Overview

This Plan offers a High Option. Our benefit package is described in Section 5. Make sure that you review the benefits carefully.

The High Option 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 High Option benefits, contact us at 877-835-9861 or at our Web site at www.uhcfeds.com.

Our benefit package offers the following unique features:

High Option Benefits	You pay
Medical services provided by physicians:	
• Preventive Care Services	No copayments for preventive care services. This includes items such as, but not limited to, immunizations, physical examinations and screenings as appropriate and recommended by U.S. Preventive Services Task Force. Please refer to Section 5 of the brochure for more detail.
• Diagnostic and treatment services provided in the office	$25 per visit to your Primary Care Physician $15 per visit virtual visit $35 per Tier 1 premium-designated specialist / $50 per non-premium-designated specialist
Services provided by a hospital:	
• Inpatient	$150 per day up to $750 per admission
• Outpatient Surgical	$150 copayment per visit at approved free standing surgical facility $300 copayment per visit outpatient surgical facility charge at hospital
Emergency benefits:	
• In or out-of-area	$150 per visit
Mental health and substance abuse treatment:	Regular cost sharing
Prescription drugs:	
• Plan retail pharmacy and Specialty Pharmaceuticals	Tier 1: $10; Tier 2: $40; Tier 3: $85; Tier 4: $175
• Plan mail order for up to a 90-day fill	Tier 1: $25; Tier 2: $100; Tier 3: $212.50; Tier 4: $437.50
Vision care:	$35 specialist copayment for eye refraction exam with Tier 1 specialist every other year

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.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in a hospital, an ambulatory surgical center or the outpatient department of a hospital. See *Section 5(c) Services provided by a hospital or other facility, and ambulance services* for more information.
- We have no 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.
- **YOUR PHYSICIAN MUST GETPREAUTHORIZATION FOR SOME SERVICES AND/OR PROCEDURES.** Please refer to the preauthorization information shown in Section3 or call customer service to be sure which services require preauthorization.

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office • Office medical consultations • Second surgical opinion • Advanced care planning	$25 copayment per primary care physician (PCP) visit $35 copayment per Tier 1 premium-designated specialist $50 copayment per non-premium-designated specialist
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • At home	Nothing
Telehealth services	
Use virtual visits when: • Your doctor is not available • You become ill while traveling • Conditions such as: cold, flu, bladder infection, bronchitis, diarrhea, fever, pink eye, rash, sinus problem, sore throat, stomach ache Network Benefits areavailable only when services are delivered through a Designated Virtual VisitNetwork Provider.	$15 copayment per visit

Telehealth services - continued on next page

Benefit Description	You pay
Telehealth services (cont.)	
Find a DesignatedVirtual Visit Network Provider Group at myuhc.com or by calling Customer Careat 877-835-9861. Access to Virtual Visits and prescription services may not beavailable in all states due to state regulations. You canpre-register with a group. After registering and requesting a visit you willpay your portion of service costs and then you enter a virtual waitingroom.	$15 copayment per visit
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG	$50 copayment per visit
• Cat Scans • MRI • Pet Scans	$150 per visit
Preventive care, adult	

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
  • Colonoscopy screening – every ten years starting at age 50, (Virtual colonscopy requires medical preauthorization)
  • Routine annual digital rectal exam (DRE) for men age 40 and older
	Nothing

One annual biometric screening to include: • Body Mass Index (BMI) • Blood pressure • Lipid/cholesterol levels • Glucose/hemoglobin A1c measurement	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	
Note: Office visit and lab services must be rendered on the same day and coded by your doctor as preventive to be covered in-full Members can complete their HRA (Health Risk Assessment) on www.myuhc.com	Nothing
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing
Well woman care; including but not limited to: • Routine pap test • Human pappillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections • Annual counseling and screening for human immuno-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence	Nothing
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
BRCA genetic counseling and evaluation are covered as preventive services when a woman's family history is associated with an increased risk for deleterious mutations in *BRCA1* or *BRCA2* genes and medical necessity criteria has been met	Nothing
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	Nothing
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/ **Women's preventiveservices:** https://www.healthcare.gov/preventive-care-women/	
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*

Benefit Description	You pay
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Childhood immunizations recommended by the American Academy of Pediatrics (birth to age 5)	Nothing
• 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) - Examinations for amblyopia and strabismus - limited to one screening examination (age 3 through 5)	Nothing
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/ .	
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for woman at high risk • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your vaginal delivery; see page 44 for other circumstances, such as extended stays for you or your baby. • Routine care includes office visits, one office sonogram (as part of prenatal care) and laboratory work. Copays will continue to apply to specialized scanning, any specialist not the member's current OB/GYN, durable medical equipment, prescription drugs, chiropractic and acupuncture services, emergency room visits, urgent care visits, or inpatient hospital copayments as these services are not considered routine.	Nothing for routine prenatal care or the first postpartum care visit, $25 copayment per primary care physician (PCP) initial visit. $35 copayment per Tier 1 premium-designated specialist; $50 copayment per non-premium-designated specialist.

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	
• You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • 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. Surgical benefits, not maternity benefits, apply to a circumcision. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	Nothing for routine prenatal care or the first postpartum care visit, $25 copayment per primary care physician (PCP) initial visit. $35 copayment per Tier 1 premium-designated specialist; $50 copayment per non-premium-designated specialist.
Breastfeeding support, supplies and counseling for each birth	Nothing
Not covered: Routine sonograms to determine fetal age, size or sex after the first sonogram.	*All charges*
Family planning	
A range of voluntary family planning services, such as: • Voluntary sterilization for women (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Administration of injectable contraceptive drugs (such as Depo provera) • Insertion and removal of intrauterine devices (IUDs) • Diaphragms and fitting for diaphragms • Contraceptive counseling on an annual basis Note: We cover oral contraceptives under the prescription drug benefit	Nothing
• Voluntary sterilization for men (See Surgical procedures Section 5 (b)) • Genetic counseling Note: We cover oral and injectable contraceptives under the prescription drug benefit	$25 per primary care physician (PCP) visit. $35 copayment per Tier 1 premium-designated specialist visit; $50 copayment per non-premium-designated specialist visit
Not covered: • *Reversal of voluntary surgical sterilization*	*All charges*

Benefit Description	You pay
Infertility services	
COVERED: Diagnosis and treatment of the cause of infertility, **except** for the Reproductive services listed as **Not Covered:**	$25 copayment per primary care (PCP) visit $35 copayment per Tier 1 premium designated specialist; $50 copayment per non-premium designated specialist
*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*
Allergy care	
• Testing and treatment • Allergy injections	$25 copayment per primary care physician (PCP) visit $35 copayment per Tier 1 premium-designated specialist; $50 copayment per non-premium-designated specialist
Allergy serum	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*

Benefit Description	You pay
Treatment therapies	
• 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 38. • 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. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services* on page 16. • Applied Behavior Analysis (ABA) - Children with autism spectrum disorder	$25 copayment per primary care physician (PCP) visit $35 copayment per Tier 1 premium-designated specialist; $50 copayment per non-premium-designated specialist $50 per outpatient facility visit
Physical and occupational therapies	
Up to two consecutive months per condition per year for rehabilitative/habilitative in any combination of the following: • Qualified physical therapists • Occupational therapists • Physician • Licensed therapy provider Services must be performed by a physician or by a licensed therapy provider. Note: We only cover therapy when a provider orders the care; Benefits can be denied or shortened for covered persons who are not progressing in goal-directed rehabilitative services or if rehabilitation goals have been met.	$25 copayment per primary care physician (PCP) visit $35 copayment per Tier 1 premium-designated specialist; $50 copayment per non-premium-designated specialist

Physical and occupational therapies - continued on next page

Benefit Description	You pay
Physical and occupational therapies (cont.)	
We will pay benefits for cognitive rehabilitation therapy only when Medically Necessary following sudden External injuries such as car accidents or falls; or sudden internal injuries such as stroke (cerebral vascular accident), aneurysm, anoxia, encephalitis or brain tumors. Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 36 sessions per calendar year. Pulmonary rehabilitation is provided for up to 20 visits per calendar year. All Therapies subject to medical necessity.	$25 copayment per primary care physician (PCP) visit $35 copayment per Tier 1 premium-designated specialist; $50 copayment per non-premium-designated specialist
Habilitative Services - for children under age 19 with congenital or genetic birth defects. Treatment is provided to enhance the child's ability to function. Services include: • Speech therapy • Occupational therapy; and • Physical therapy Includes medically necessary habilitative services coverage for children with Autism, an Autism Spectrum disorder, or Cerebral Palsy Note: No day or visits apply to these services. A congenital disorder means a significant structural or functional abnormality that was present from birth	$25 copayment per primary care physician (PCP) visit $35 copayment per Tier 1 premium-designated specialist; $50 copayment per non-premium-designated specialist
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*
Speech therapy	
Up to two consecutive months per condition per calendar year for rehabilitative/habilitative speech therapy.	$35 copayment per Tier 1 premium-designated specialist; $50 copayment per non-premium-designated specialist
Not covered: • *Exercise programs* • *Voice therapy*	*All charges*

Benefit Description	You pay
Hearing services (testing, treatment, and supplies)	
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist. • First hearing aid and testing only when necessitated by accidental injury Note: for routine hearing screening performed during a child's preventive care visit, see Section 5(a) Preventive care children • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: for benefits for the devices, see Section (a) *Orthopedic and prosthetic devices.*	$25 copayment per primary care physician (PCP) visit $35 copayment per Tier 1 premium-designated specialist; $50 copayment per non-premium-designated specialist
Not covered: • *All other hearing aids and testing for them* • *Hearing services that are not shown as covered*	*All charges*
Vision services (testing, treatment, and supplies)	
• Initial pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Annual eye refraction exams **Note:** See *Preventive care, children* for eye exams for children. *Replacement glasses or contact lenses are not covered after the initial pair.*	$25 copayment per primary care physician (PCP) visit $35 copayment per Tier 1 premium-designated specialist; $50 copayment per non-premium-designated specialist
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$35 copayment per Tier 1 premium-designated specialist; $50 copayment per non-premium-designated specialist
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*	*All charges*

Foot care - continued on next page

Benefit Description	You pay
Foot care (cont.)	
• *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*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes • Stump hose • Orthopedic devices such as braces, medical supplies including colostomy supplies, dressings, catheters and related supplies • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy • Bone-anchored hearing aids (BAHA) are covered only 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; - Hearing loss of sufficient severity that it cannot be adequately remedied by a wearable hearing aid - Benefits limited to one bone anchored hearing aid per member, who meets the above coverage criteria, during the entire period of time the member is enrolled in the health plan. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services. Note**:** Plan prior authorization required for items that cost $1,000 or more.	50% of charges
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	
• *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Speech prosthetics (except electrolarynx)* • *Prosthetic replacements provided less than 3 years after the last one we covered*	*All charges*
Durable medical equipment (DME)	
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Blood glucose monitors • Insulin pumps. **Note:** Plan prior authorization is required for items that cost $1,000 or more. Repairs and replacements are covered if needed due to a change in the member's medical condition. Call us at 877-835-9861 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	50% of charges
Not covered: Motorized wheelchairs. audible prescription reading devices; hearing aids, speech generating devices, talkers, story boards, scooters	*All charges*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true: - It must be delivered or supervised by a licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for safety of the patient - It is ordered by a physician	$25 per visit

Home health services - continued on next page

Benefit Description	You pay
Home health services (cont.)	
- It is not delivered for the purpose of assisting with activities of daily living including dressing, feeding, bathing or transferring from a bed to a chair - It requires clinical training in order to be delivered safely and effectively - It is not custodial care • We will determine if benefits are available by reviewing both the skill nature of the service and the need for Physician directed medical management. A service will not be determined to be skilled simply because there is not an available caregiver. • Services include oxygen therapy, intravenous therapy and medications. • Limit of 60 visits per year	$25 per visit
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 a physician*	*All charges*
Chiropractic	
• Diagnosis and related services for the manipulation of the spine and extremities to remove nerve interference or its effects. Limited to one treatment per day up to 20 visits per calendar year **Note:** The interference must be the result of, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column.	50% of charges
Alternative treatments	
Acupuncture – by a doctor of medicine or osteopathy for up to 12 visits per year : • Anesthesia • Pain relief	$35 copayment per Tier 1 premium-designated specialist; $50 copayment per non-premium-designated specialist

Alternative treatments - continued on next page

Benefit Description	You pay
Alternative treatments (cont.)	
• 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	$35 copayment per Tier 1 premium-designated specialist; $50 copayment per non-premium-designated specialist
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback* • *Massage Therapy* • *Herbal medicine* • *Rolfing* • *Ayurveda* • *Homeopathy* • *Other alternative treatments unless specifically listed as covered*	*All charges*
Educational classes and programs	
Coverage is provided for : • Tobacco Cessation program, including individual / group/ telephonic counseling and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence.	No copayment for counseling for up to two quit attempts per year with up to four counseling sessions per attempt See prescription drug benefit
Childhood Obesity education	Nothing
• Outpatient self-management training for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insuling using diabetes. • Must be prescribed by a licensed healthcare 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 provided by a certified registered or licensed healthcare professional trained in the care and management of diabetes.	$25 copayment per primary care physician (PCP) visit $35 copayment per Tier 1 premium-designated specialist, $50 copayment for non- premium-designated specialist

Educational classes and programs - continued on next page

Benefit Description	You pay
Educational classes and programs (cont.)	
• Initial training visit; up to 10 hours, after you are diagnosed with diabetes for the care and management of diabetes	$25 copayment per primary care physician (PCP) visit $35 copayment per Tier 1 premium-designated specialist, $50 copayment for non- premium-designated specialist

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.
- Plan physicians must provide or arrange your care.
- We have no 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.
- 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(a) for charges associated with an office visit and Section 5 (c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GETPREAUTHORIZATION FOR SOME SERVICES AND/OR PROCEDURES.** Please refer to the preauthorization information shown in Section3 or call customer service to be sure which services require preauthorization.

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of morbid obesity (bariatric surgery) - Eligible members must be age 22 or over; - have a minimum Body Mass Index (BMI) of 40, or 35 with at least 2 co-morbid conditions present) and - must have completed a 6-month Plan physician supervised weight loss program; and - must complete a pre-surgical psychological evaluation; and - Individuals must weigh 100 pounds or 100% over his or her normal weight according to current underwriting standards. • Insertion of internal prosthetic devices. See 5(a) *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization men (vasectomy) • Treatment of burns	$25 copayment per primary care physician (PCP) visit $35 copayment per Tier 1 premium-designated specialist; $50 copayment per non-premium-designated specialist

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	
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.	$25 copayment per primary care physician (PCP) visit $35 copayment per Tier 1 premium-designated specialist; $50 copayment per non-premium-designated specialist
Voluntary sterilization women (tubal ligation)	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*
Reconstructive surgery	
• 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; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see *Prosthetic devices*) • Gender reassignment surgery is limited to the following procedures: - Mastectomy - Hysterectomy - Oophorectomy - Gonadectomy - Orchiectomy **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.	$25 copayment per primary care physician (PCP) visit $35 copayment per Tier 1 premium-designated specialist; $50 copayment per non-premium-designated specialist
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*	*All charges*

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	
• *Gender Reassignment surgeries not listed above*	*All charges*
Oral and maxillofacial surgery	
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; • Dental care necessary to release pain in treatment of temporomandibular joint pain dysfunction; • 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.	$25 copayment per primary care physician (PCP) visit $35 copayment per Tier 1 premium-designated specialist; $50 copayment per non-premium-designated specialist
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*
Organ/tissue transplants	
These **solid organ transplants** are covered. These solid organ transplants are subject to medical necessity and experimental/ investigational review by the Plan. Refer to *Other* Services in Section 3 for prior authorization procedures. • Cornea • Heart • Heart/lung • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach and pancreas • Kidney • Kidney-Pancreas • Liver • Lung single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectormy) only for patients with chronic pancreatitis	$25 copayment per primary care physician (PCP) visit $35 copayment per Tier 1 premium-designated specialist; $50 copayment per non-premium-designated specialist

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
These **tandem blood** or **marrow stem cell transplants for covered transplants** are subject to medical review by the Plan. Refer to *Other services* in Section 3 for your authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent gem cell tumors (including testicular cancer)	$25 copayment per primary care physician (PCP) visit $35 copayment per Tier 1 premium-designated specialist; $50 copayment per non-premium-designated specialist
Blood or marrow stem cell transplants The plan extends coverage for the diagnoses as indicated below:. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - 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) - 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	$25 copayment per primary care physician (PCP) visit $35 copayment per Tier 1 premium-designated specialist; $50 copayment per non-premium-designated specialist
• Autologous transplants for	$25 copayment per primary care physician (PCP) visit

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reccurrence (relapsed) - Amyloidosis - Breast Cancer - Epithelial ovarian cancer - Ewing's sarcoma - Multiple myeloma - Medulloblastoma (clinical trial only) - Pineoblastoma (clinical trial only) - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	$25 copayment per primary care physician (PCP) visit $35 copayment per Tier 1 premium-designated specialist; $50 copayment per non-premium-designated specialist
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 reccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reccurrence (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	$25 copayment per primary care physician (PCP) visit $35 copayment per Tier 1 premium-designated specialist; $50 copayment per non-premium-designated specialist

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Advanced Hodgkin's lymphoma with reccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reccurrence (relapsed) - Amyloidosis - Neuroblastoma	$25 copayment per primary care physician (PCP) visit $35 copayment per Tier 1 premium-designated specialist; $50 copayment per non-premium-designated specialist
These blood or marrow stem cell transplants 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) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Sickle Cell Anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning 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 - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myeloproliferative disorders (MPDs) - Myelodysplasia/Myelodysplactic Syndromes - Sarcomas	$25 copayment per primary care physician (PCP) visit $35 copayment per Tier 1 premium-designated specialist; $50 copayment per non-premium-designated specialist

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Sickle Cell anemia • Autulogous Transplants for - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin's lymphoma - Breast Cancer - Childhood rhabdomyosarcoma - Epithelial ovarian cancer - Mantle Cell (Non- Hodgkin lymphoma) - Multiple sclerosis - Systemic sclerosis	$25 copayment per primary care physician (PCP) visit $35 copayment per Tier 1 premium-designated specialist; $50 copayment per non-premium-designated specialist
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. We cover donor testing for the actual solid organ donor. 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. A listing of these centers can be found in the Plan Directory of Health Care Providers, at our member web site www.myuhc.com or call our Customer Service Department at 877-835-9861 to request an up-to-date listing.	
Note: We cover donor screening tests for up to 4 potential bone marrow/stem cell transplant donors.	You pay 50%
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *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*

Benefit Description	You pay
Anesthesia	
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	$25 copayment per primary care physician (PCP) visit $35 copayment per Tier 1 premium-designated specialist; $50 copayment per non-premium-designated specialist

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.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no 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.
- 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 (i. e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GETPREAUTHORIZATION FOR SOME SERVICES AND/OR PROCEDURES.** Please refer to the preauthorization information shown in Section3 or call customer service to be sure which services require preauthorization.

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • 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.	$150 per day up to $750 per admission
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 • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	
• *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care unless medically necessary*	*All charges*
Outpatient hospital or ambulatory surgical center	
• 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 • 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.	$150 per outpatient surgical charge at approved free standing surgical facility $300 per outpatient surgical charge at hospital
Not covered: Blood and blood derivatives not replaced by the member	*All charges*
Extended care benefits/Skilled nursing care facility benefits	
• Room and board in a semi-private room • General nursing • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor • Benefits up to 60 days when full time skilled nursing care is necessary and confinement is medically appropriate.	Nothing when transferred directly from inpatient $150 per day for up to $750 per admission if not transferring from inpatient
Not covered: Custodial care	*All charges*
Hospice care	
• Inpatient care • Outpatient care • Family counseling • Supportive and palliative care for a terminally ill member is covered in the home or hospice	Nothing
Not covered: Independent nursing, homemaker services	*All charges*

Benefit Description	You pay
Ambulance	
Non-emergency local professional ambulance service when medically appropriate with a network provider and when ordered or authorized by a Plan doctor.	Nothing

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.
- We have no 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. If you are hospitalized in a non-Plan facility and Plan physicians believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full, unless the Plan physician or health care practitioner believes this would result in death, disability or significant jeopardy to your condition. To be covered by this Plan, any follow-up care recommended by non-Plan physicians or health care practitioners must be approved by the Plan or provided by Plan physicians or health care practitioners.

Benefit Description	You pay
Emergency within or outside our service area	
• Emergency care at a doctor's office	$25 copayment per primary care physician (PCP) visit $35 copayment per Tier 1 premium-designated specialist; $50 copayment per non-premium-designated specialist
• Emergency care at an urgent care center	$35 copayment per visit
• Emergency care as an outpatient at a hospital, including doctors' services **Note:** We waive the ER copay if you are admitted to the hospital.	$150 copayment per visit
Not covered:	*All charges*

Emergency within or outside our service area - continued on next page

Benefit Description	You pay
Emergency within or outside our service area (cont.)	
• *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	
• Professional ambulance service when medically appropriate. • Air ambulance service when medically appropriate. **Note:** See Section 5(c) for non-emergency service.	Nothing

Section 5(e). Mental health and substance abuse benefits

You need to get Plan approval (preauthorization) for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are 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.
- 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.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required
- 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.
- **YOUR PHYSICIAN MUST GETPREAUTHORIZATION FOR SOME SERVICES AND/OR PROCEDURES.** Please refer to the preauthorization information shown in Section3 or call customer service to be sure which services require preauthorization.

Benefit Description	You pay
Professional Services	
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for any 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	$25 copayment per visit $150 per day up to 5 days per inpatient admission

Professional Services - continued on next page

Benefit Description	You pay
Professional Services (cont.)	
• Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$25 copayment per visit $150 per day up to 5 days per inpatient admission
Diagnostics	
• 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	Your cost-sharing responsibilities are no greater than for other illness or condition. See diagnostic tests section 5(a)
Inpatient Hospital or other covered facility	
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nusring care, meals and special diets, and other hospital services • Services in approved half-way house, residential treatment, full-day hospitalization, partial hospitalization	$150 per day up to 5 days per admission
Outpatient hospital or other covered facility	
Outpatient services provided and billed by a hospital or other covered facility • Services in facility-based intensive outpatient treatment	$50 copayment per visit
Not covered	
• *Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determed by a Plan physician to be necessary and appropriate* • *Services and supplies when paid for directly or indirectly by a local, State, or Federal Government agency.* • *Room and board at therapeutic boarding schools* • *Services rendered or billed by schools* • *Services that are not medically necessary* • *Methodone maintenance unless it is a part of an approved treatment program*	All charges

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescription medications, as described in the chart beginning on the next page. Some injectable medications are provided by your medical benefit. Please see below for more information.
- 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. Some prescription medications have Quantity Level Limits (QLL) and Quantity per Duration Limits (QD). Please see below for more information.
- We have no deductible.
- Federal law prevents the pharmacy from accepting unused medications.
- Certain medications require your health care provider to request approval from us in order for these to be payable under the Pharmacy Plan. Drugs requiring prior approval may be limited to quantites prescribed in accordance to acceptable practice standards in the United States. If your pharmacist tells you that your prescription medication requires prior approval, ask your pharmacist or physician to contact the Plan at the number on your Member ID card for further instructions.
- ***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.***

. **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 Pharmacy drugs are 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 877-835-9861 or visit our website, www.uhcfeds.com. The PDL consists of Tiers 1, 2, 3 and 4.
- **We use a Prescription Drug List (PDL). Called the Advantage 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 as economic and financial considerations. You will find important information about our PDL as well as other Plan information on our member web site www.myuhc.com or our premember webiste at www.uhcfeds.com. Please familiarize yourself with the Advantage PDL as it offers both generic and brand drug on all of its tiers.
- **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 a number of 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 (**$40** for up to a 30-day supply or $100 for up to a 90-day supply through mail order), and contains a 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 (**$85** for up to a 30-day supply or $212.50 for up to a 90-day supply through mail order), and consists of non-preferred 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** copayment option (**$175** for up to a 30-day supply or $437.50 for up to a 90-day supply through mail order) non-preferred medications that do not add clinical value over their covered Tier 1, 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 1 and 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 with questions.

These are the dispensing limitations.

- Some drugs may only be available at a retail pharmacy or through the designated Specialty Pharmcy. See the next page for details on Specialty Pharmacy drugs.
- Subject to your prescription's instructions, you may purchase up to a 90-day supply for most covered medications and supplies at a retail pharmacy for the applicable tier copayment for each 30-day supply. Durgs available through mail order require the applicable tier copayment.
- **Contraceptives** - You pay one copay for up to maximum of a 90-day supply of contraceptive medications, subject to QLL and QD limitations.
- **Quantity Duration (QD)** Some medications have a limited amouont 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 for more information on these medications.
- **Special dispensing circumstances**. The Plan 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 at 877-835-9861 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 8, 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 most drugs. For example, a prescription that was filled for a 30-day supply can be refilled after 24 days. While this process provides advancement on your next prescription refill, we cannot dispense more than the total quantity your prescription allows.
- **Half Tablet Program**. With certain medications, you may elect to join the voluntary Half Tablet Program. This Program allows you to save money in copayments by electing a double strength medication, receiving half the quantity, and splitting the tablet in half. If you take advantage of this Program, you will pay half a copayment at a retail pharmacy or through mail order. Your provider must write the prescription for the increased dosage, with the instructions to "take a half tablet". A free tablet splitter is provided. For more information on this Program please contact customer service.
- **Specialty Pharmacy Program**. Our Specialty Pharmacy Program is designed to address the rare, complex and life threatening diseases. We want to make these medications accessible and cost effective for our members. That's why we offer the Specialty Pharmacy Program. This program supports the health care provider/patient relationship and provides focused support to help better manage rare and complex conditions by offering: **Members who have been prescribed specialty medications must obtain these medications from one of the designated specialty pharmacies.** You will continue to pay the applicable Tier copay for your specialty medications. Prescriptions for specialty medications must be filled for a maximum of a 30-day supply. To locate a specialty pharmacy for your particular needs members can log onto: http://www.uhcspecialtyrx.com/, enter the prescription name and available specialty pharmacies will be provided.
  Members can also contact customer service at 877-835-9861. Your new specialty pharmacy will be able to help you transfer your active prescriptions from your current pharmacy. If you're out of refills, the specialty pharmacy will contact your doctor to get a new prescription.
  - **Better use of benefits** — Members can make the most of their health benefits by getting the right specialty medications from our network providers when they need them.
  - **Specialty pharmacies and home health care providers** — Our network providers have the resources and expertise needed to store and dispense specialty medications and ancillary supplies
  - **Expert support** — Members get 24/7 telephone access to specially trained pharmacists who can provide answers, patient education materials, proactive refill monitoring, counseling on side effects and more.
  - **Individualized services** — experienced nurses and pharmacists trained in specialty medications and rare and complex conditions offer personalized therapy support that can lead to better health outcomes.
  - **Supplies, such as sharps containers, needles, syringes** and tubing necessary to administer an injectable specialty drug are provided at **no cost** to you by the specialty pharmacy. Talk with your specialty pharmacy to learn more
- **Why use Tier 1 drugs?** Medications in Tier 1 offer the best health care value and are available at the lowest copayment. Tier 2 medications are available at a higher copayment and Tier 3 and Tier 4 medications are available at the highest copayment levels. This approach helps to assure access to a wide range of medications and control health care costs for you.

Benefit Description	You pay
Preventive care medications	
Medications topromote better health as recommended by ACA. The following drugsand supplements are covered without cost-share, even if over-the-counter, areprescribed by a health care professional and filled at a network pharmacy. • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 & 800 mcg • Liquid iron supplements for children age 0-1 year • Vitamin D supplements (prescription strength) (400 & 1000 units)for members 65 or older • Pre-natal vitamins for pregnant women	Nothing

Preventive care medications - continued on next page

Benefit Description	You pay
Preventive care medications (cont.)	
• Fluoride tablets, solution (not toothpaste, rinses) for childrenage 0-6 Note: To receive this benefit aprescription from a doctor must be presented to pharmacy. Benefits available at in-network pharmacy only.	Nothing
Covered medications and supplies	
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 **Note:** Intravenous fluids and medications for home use, implantable drugs, and some injectable drugs are covered under *Medical services and supplies Section (5a)* or *Surgical and anesthesia services Section (5b).*	Plan retail pharmacy up to a maximum of a 30-day supply: Tier 1- $10 Tier 2- $40 Tier 3- $85 Tier 4 -$175 Plan mail order pharmacy for up to a maximum of up to a 90-day supply: Tier 1- $25 Tier 2- $100 Tier 3- $212.50 Tier 4- $437.50
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	Nothing
• Diabetic supplies limited to insulin syringes, needles, glucose test tape, Benedict's solution or equivalents and acetone test tablets. • Implanted contraceptive drugs and devices such as Norplant	50% of charges
Prescription tobacco cessation drugs and FDA approved over the counter tobacco cessation drugs, obtained with a prescription from a plan provider, are covered with no member responsiblity.	Nothing.
Not covered: • *Medications, drugs and supplies used for cosmetic purposes* • *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 except Clomid (clomiphene)* • *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*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	
• *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them* • *Nonprescription medicines* • *Drugs available over-the-counter that do not require a prescription order by federal or state law before being dispensed, and any drug that is therapeutically equivalent to an over- the-counter* • *Compound drugs that do not contain at least one covered ingredient that requires a Prescription Order or Refill* • *Alcohol swabs and bio-hazard disposable containers* • *Medical Marijuana* • *Drugs for sexual performance for patients that have undergone genital reconstruction* **Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered as described above.**	*All charges*

Section 5(g). 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.
- Plan dentists must provide or arrange your care.
- We have no deductible.
- 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.
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SERVICES AND/OR PROCEDURES.** Please refer to the preauthorization information shown in Section 3 or call customer service to be sure which services require preauthorization

Benefit Desription	You Pay
Accidental injury benefit	
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 are limited 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 Note: A sound natural tooth is a tooth that has no active decay, has at least 50% bony support, has no filling on more than two surfaces, has no root canal treatment, is not an implant and is not in need of treatment except as a result of the accident and functions normally in chewing and speech. (Crowns, bridges and dentures are not considered sound, natural teeth.)	Nothing
	All charges

Accidental injury benefit - continued on next page

Benefit Desription	You Pay
Accidental injury benefit (cont.)	
Not covered: • *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, gingival and aveolar bone)*	*All charges*

Section 5(h). Special features

Feature	Description
Healthy Pregnancy Program	With our Healthy Pregnancy Program, UnitedHealthcare enrollees 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, and a 24-hour toll-free phone number to experienced nurses and customized maternity educational materials. To enroll in the Healthy Pregnancy Program, simply call toll-free at 800-411-7984 or visit www.healthy-pregnancy.com.
Health4Me™	Your family's health care resources, in your hands. UnitedHealthcare Health4Me™ provides instant access to your family's critical health information – anytime and anywhere. Whether you want to find a physician near you, check the status of a claim or speak directly with a health car professional, Health4Me is a your go-to resource. Key features include: • Search for physicians or facilities by location or specialty • Store favorite physicians and facilities • Have a representative contact you to answer any questions • View and share health plan ID card information • Contact an experienced registered nurse 24/7 • Access and update your Personal Health Record • Check health-related financial account balanced • Locate nearby convenience clinics urgent care facilities and ER's • Check status of deductible and out-of-pocket spending • Complete confidentiality Available on the App Store; Android available in Google play
Rally℠ – It's time for an easy digital resource for managing health.	Rally is an innovative consumer engagementplatform. It is a fun, interactivehealth and wellness enhancement to our **member portal.** With the online Rally Health Survey, personalized Missions, rewards and connections to wearables like Fitbit®, Jawbone® and more, we make it easier for you to get motivated to be healthier. When you sign up for Rally, the first thing you'll learn is your Rally Health Age, which tells you how your body is feeling right now. Then you canstart exploring all the great digital tools that may help you make healthier choices based on your life, schedule and needs. With Rally, you canalso join an online challenge, share your accomplishments with others throughmoderated health communities, choose an Avatar, connect with a personalwellness coach or join a competition to increase the fun. Once you havecompleted the Health Survey, we have the data we need to suggest action stepsor "Missions." "Move,""Eat,""Feel," and "Care" Missions are interactive andprovide choices that may help improve or maintain your health. They're alsolinked to reminders and trackingaccomplishments, giving you just the push you need to keep going. Visit www.myuhc.com now.
UHC.TV for Health and Happiness	**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 personalities, such as Laila Ali, Today Show nutritionist Joy Bauer, and Olympic Gold Medalist Scott Hamilton, who share their stories of physical, social, emotional, mental or spiritual health. Get information from health experts, including Dr. Mehmet Oz and other health professionals, on a variety of topics.

	Simply type **UHC.TV** into your Internet browser to start watching for your health and happiness. 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.
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. For example: • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claims process (see Section 8).
Specialty Pharmacy Program	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.
Cancer Clinical Trials	To be a qualifying clinical trial, a trial must meet the following criteria: 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 thatdescribes a scientifically sound study and have been approved by all relevantinstitutional review boards (IRBs) before participants are enrolled in thetrial. We may, at any time, request documentation about the trial to confirmthat the clinical trial meets current standards for scientific merit and hasthe relevant IRB approvals. Benefits are not available for preventive clinicaltrials. • 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.
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.
Condition Management Programs	Members with conditions such as Asthma, Coronary Artery Disease and Diabetes (among other diseases) may participate in UnitedHealthcare's condition management programs. These programs incorporate a number of steps to work with the member to determine the 1) right care, 2) right medication, 3) right provider and 4) right lifestyle. Members work with a nurse manager who provides support in education, supplying clinical content on the specific disease and assists the member in working with their physician for treatment.
Care24	For any of your health concerns, 24 hours a day, 7 days a week, you may call 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.

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. These programs and materials are the responsibility of the Plan and all appeals must follow their guidelines. For additional information contact the Plan at 877-835-9861 or visit our website at www.uhcfeds.com.

PPO Dental - Preventive benefits for each family member covered under your policy. Eligible members receive $500 per member per year in preventive dental services . Your dental benefit COC s available on www.uhcfeds.com for more information.

UnitedHealth Wellness^{SM} As a comprehensive portfolio of wellness programs and services offered through UnitedHealthcare, UnitedHealth Wellness can help improve your total health and well-being. UnitedHealth Wellness is not insurance. Instead, it is our commitment to bring you more ways than ever to stay healthy. For more information also visit us on the web at www.uhc.com We are pleased to offer you the following portfolio of wellness programs and services:

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. Program features include: Trackers to monitor your weight and exercise programs; exercise recommendations; calculators for body mass index, healthy weight, calorie burn and heart rate; strength exercise demonstrations, quizzes to help you advance through the program; motivational support and much, much more! To access the program, log on to www.myuhc.com , click "Health and Wellness", then "Your Personal Health Center" on the right side of the screen.

Discounts on wellness products and services : You can get discounts on wellness products and health care services not covered by your medical, dental or vision plans. From nutrition supplements and fitness gear, to LASIK procedures and teeth whitening, this is the place to go before you buy anything. Log on to www.myuhc.com and click "Health&Wellness". A discount link is located on the bottom left side of the screen.

Online Health Assessment, and Personalized Report is available through www.myuhc.com and Rally. The Health Assessment is an online confidential survey that helps assess your overall current state of health. After taking the very short Health Assessment, you immediately receive a Personalized Report with your results. You then can begin taking steps to achieve a healthier lifestyle 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, including: content personalized based upon your condition, life stage or life style; clinical information on a wide range of diseases, conditions, tests, procedures, treatments, therapies and drugs; exclusive articles to help you make sense of the latest health news and trends and daily articles on consumer health news. Log onto www.myuhc.com and click "Health&Wellness", then "ConditionsAtoZ"

***Healthy Mind Healthy Body*® monthly newsletter** *Healthy Mind Healthy Body*® is an award-winning newsletter, providing health and wellness news in a monthly e-mail format as well as several print editions throughout the year. You will receive brief updates on relevant and timely health topics, links to additional health resources, as well as an Ask the Doctor segment. Go to **www.uhc.com/myhealthnews** and follow the instructions to sign up.

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, held the second Tuesday of each month at 12:30 p.m. (ET). The interactive seminars feature health and wellness experts, as well as time for questions with the speakers.

Section 6. General exclusions – services, drugs and supplies we do not cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3 *When you need prior Plan approval for certain services.***

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergencyservices/accidents*);
- 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, investigational or unproven procedures, treatments, drugs or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, fetal reduction or non-surgical or drug induced pregnancy terminations 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;
- Surrogate parenting
- Reversal of voluntary sterilization
- 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 or research 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.

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, call us at 877-835-9861.

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 your claims to: UnitedHealthcare, P.O. Box 30555, Salt Lake City, UT 84130-0555.

Prescription drugs

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

International Claims

In the event that emergency services were required while traveling, **submit international claims to**: UnitedHealthcare, PO Box 30555, Salt Lake City, UT 84130-0555.

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.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive the claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review as long as we 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, a health care professional with knowledge of your medical condition will be permitted 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 be able to 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 calling 877-835-9861.

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 original 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.

Step	Description
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 Benefits (FEHB) Program 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) Your email address, if you would like to receive our decision via email. Please note that by providing your email address, you may receive 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 sue, 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 sue 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 hasten 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 202-606-0755 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 program if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and 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 coordination of benefits, visit our website at myuhc.com.

When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

TRICARE and CHAMPVA

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 dental/vision 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 at 877-888-3337, (TTY 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, and the related care is not covered within the clinical trial, this plan will provide coverage for related costs based on the criteria listed below.

- 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. These costs are covered by the plan.
- 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. This plan does not cover these costs.
- 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 are considered research costs. 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 800-MEDICARE (800-633-4227), (TTY 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. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778). 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. The notice will give you guidance on enrolling in Medicare Part D.

- **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 800-772-1213, (TTY 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 can also 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.

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.

- **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. You will not need to do anything. To find out if you need to do something to file your claim, call us at 877-835-9861 or see our Web site at www.uhcfeds.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	$0	$0
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	$25
Specialist	Tier 1 $35	Tier 1 $35
Inpatient Hospital	$150 per day up to $750 per admission	$150 per day up to $750 per admission
Outpatient Hospital	$150 free standing; $300 hospital based	$150 free standing; $300 hospital based
Rx	Tier 1 -$10 Tier 2 -$40 Tier 3 -$85 Tier 4 -$175	Tier 1 -$10 Tier 2 -$40 Tier 3 - $85 Tier 4 – $175
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 800-MEDICARE (800-633-4227), (TTY 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: You may enroll in our Medicare Advantage plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments or coinsurance for your FEHB plan. For more information on our Medicare Advantage plan, please contact 800-504-4848 to see if this program is available in your area.

  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), but we will not waive any of our copayments or coinsurance. 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.

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.

Custodial care

Services that are non-health related, such as daily living activities, or services which are health related but do not seek to cure, or services which do not require a trained medical professional. Custodial care that lasts 90 days or more is sometimes known as long term care.

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. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense

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

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. 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 Insurance Company, Inc.

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

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, **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 877-FSAFEDS (877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY:866-353-8058.

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 877-888-3337 (TTY 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 800-LTC-FEDS (800-582-3337), (TTY 800-843-3557), or visit www.ltcfeds.com

Index

Summary of benefits for the High Option of the UnitedHealthcare Insurance Company - 2017

- **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.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
• Preventive Care	No copayments for preventive care services. This includes items such as, but not limited to, immunizations, physical examinations and screenings as appropriate and recommended by U.S. Preventive Services Task Force. Please refer to Section 5.	26
• Diagnostic and treatment services provided in the office	$25 copayment per primary care physician (PCP) visit $35 copayment per Tier 1 premium-designated specialist; $50 copayment per non-premium-designated specialist	25
Services provided by a hospital:		
• **Inpatient**	$150 per day up to 5 days per admission	44
• Outpatient Services • Outpatient Surgical	$50 per outpatient non-surgical visit $150 per outpatient surgical visit for services performed at approved free standing surgical facility $300 per outpatient hospital surgical visit	45
Emergency benefits:		
• In or out-of-area	$150 per emergency room visit $35 per urgent care visit	47
Mental health and substance abuse treatment:	Regular cost-sharing	49
Prescription drugs:		52
• Plan Retail pharmacy and Specialty Pharmaceuticals	Tier 1: $10 Tier 2: $40 Tier 3: $85 Tier 4: $175	54
• Plan mail order for up to a 90-day fill	Tier 1: $25 Tier 2: $100	54

	Tier 3: $212.50 Tier 4: $437.50	
Vision care:	$35 specialist copayment for eye refraction exam every other year	31
Special features:	Advocate4me, Rally Health, Flexible Benefits Option, Care 24, Healthy Pregnancy Program and Health and Wellness Programs.	59
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $5,000 for Self Only enrollment or $10,000 for Self PlusOne and Self and Family enrollment per year. Some costs do not count toward this protection	19

Notes

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To compare your FEHB health plan options please go to www.opm.gov/fehbcompare.

For 2017 health premium information, please see: https://www.opm.gov/healthcare-insurance/tribal-employers/benefits-premiums/ or contact your tribe's Human Resources department.