UnitedHealthcare Insurance Company, Inc.

www.uhcfeds.com

Customer Service: 877-835-9861

UnitedHealthcare®

2024

Choice Plus Primary

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides, See page 8 for details. This plan is accredited. See page 13.

IMPORTANT
- Rates: Back Cover
- Changes for 2024: Page 16
- Summary of Benefits: Page 101

Enrollment in this plan is limited. You must live or work in our

Geographic service area to enroll.

Enrollment codes for this Plan:

AS1 -Self Only

AS3 -Self Plus One

AS2 - Self and Family

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

Alabama, Arkansas, District of Columbia, Florida, Georgia (Atlanta area), Illinois, Iowa, Kentucky, Louisiana, Maryland, Mississippi, Missouri (St. Louis), North Carolina, Pennsylvania, Tennessee, Texas and Virginia

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 UnitedHeathcare Insurance Company, Inc. About

Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the UnitedHealthcare Insurance Company Inc.'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 is 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% 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.

Potential Additional Premium for Medicare's High Income Members

Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your FEHB premium to enroll in and maintain Medicare prescription drug coverage. **This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return**. You do not make any IRMAA payments to your FEHB plan. Refer to the Part D-IRMAA section of the Medicare website: https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to this additional premium.

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 contract (CS-2964) between UnitedHealthcare Insurance Company Inc. and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer Service may be reached at 1-877-835-9861 or through our website: www.uhcfeds.com.

The address for administrative offices is:

UnitedHealthcare Insurance Company, Inc.
Federal Employees Health Benefit Plan
10175 Little Patuxent Parkway, 6th Floor
Columbia, MD 21044

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 Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2024, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates for each plan annually. Benefit changes are effective January 1, 2024, and changes are summarized on page 23. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easier to understand. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee and each covered 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 healthcare 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 phone or to people you do not know, except for your healthcare providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services that you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 1-877-835-9861 and explain the situation.
- If we do not resolve the issue

CALL - THE HEALTHCARE FRAUD HOTLINE 1-844-359-7736

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 they is disabled and incapable of self support).
- A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.
- 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 (TCC).
- 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

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. 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 and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and 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 medications you take.

- Bring the actual medications or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medications 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 medication is what the doctor ordered. Ask your pharmacist about the medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not 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 healthcare 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 reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
- www.bemedwise.org The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error. Participating providers may not bill or collect payment from UnitedHealthcare members for any amounts not paid due to the application of this reimbursement policy.

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. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

Minimum value standard

Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/healthcare-insurance for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies that 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, give you other plans' brochures 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 do not 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.

Once enrolled in your FEHB Program Plan, you should contact your carrier directly for address updates and questions about your benefit coverage

Enrollment types available for you and your family

Self Only coverage is for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include 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 Plus One or Self and Family 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 are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your employing or retirement office if you want to change from Self Only to Self Plus One or Self and Family. If you have a Self and Family enrollment, you may contact us to add a family member.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before age 26.

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in 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 your spouse by valid common-law marriage if you reside in a state that recognizes common-law marriages) and children as described below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: 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
Coverage: 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
Coverage: 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
Coverage: 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 implements 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 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 lowest-cost nationwide plan option as determined by OPM.
- 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, the lowest-cost nationwide plan option as determined by OPM.

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 does not 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 does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2024 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2023 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 an enrollee and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You **must** contact us to let us know the date of the divorce or annulment and have us remove your ex-spouse. We may ask for a copy of the divorce decree as proof. In order to change enrollment type, you must contact your employing or retirement office. A change will not automatically be made.

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member 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 website at https://www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

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, or if you are a covered child and you turn 26.

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 tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

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

Converting to individual coverage

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

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

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

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

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing 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 contact us in writing 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, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 1-866-546-0510 or visit our website at www.uhcfeds.com.

Health Insurance Marketplace

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

Section 1. How this Plan Works

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

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

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

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

OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Unitedhealthcare hold accreditation from the National Committee for Quality Assurance (NCCQA).

To learn more about this plan's accreditation(s), please visit the following websites: National Committee for Quality Assurance at:(www.ncqa.org);

General features of our High Option Plan

This plan is designed to make healthcare more affordable for you. Coverage for your visits to your in-network primary care physician and our contracted virtual visit physician groups will always be paid at 100% and they are not subject to deductible. This means that you have no out of pocket expense whenever you visit your primary care physician for wellness visits, for treatment for illness, for preventive services and virtual visits. These visits as well as in-network specialist visits all covered without you having to meet your deductible.

We have Open Access benefits

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

We have Point of Service (POS) benefits

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

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies).

Preventive care services

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

Annual deductible

The annual medical deductible must be met before Plan benefits are paid for many services other than preventive care services or services specifically designed as not requiring the deductible. Your deductible for this plan is $500 for Self only and $1,000 for Self Plus One or Self and Family for In-Network and $3,000 Self Only and $6,000 Self Plus One or Self and Family Out-of-network. Information on how this deducible works can be found in Section 4 *Your Cost for Covered Services.* This plan has services that are paid prior to meeting your deductible such as in-network primary care visits (paid at 100%) and in-network specialist visits.

Health education resources and accounts management tools:

myuhc.com gives you the the ability to:

- Review eligibility and look up benefits
- Check current and past claim status
- Find a doctor or hospital, including UnitedHealth Premium designated physicians.
- Print a temporary ID card or request a replacement card
- Compare hospitals in quality, efficiency, and cost – all at the procedure level
- "Chat" with a nurse in real-time
- Take a health assessment and participate in Health Coaching Programs
- Use the Personal Health Record to organize health data and receive condition specific information to better manage their health
- Learn about health conditions, symptoms and the latest treatment options

myHealthcare Cost Estimator

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

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 website (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 has been in existence since 1972
- Profit status – for profit

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, www.uhc.com. You can also contact us to request that we mail you a copy of that Notice.

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

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website www.uhc.com to obtain a Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

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

Service Area

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:

Entire states of : Alabama, Arkansas. Florida, Illinois, Iowa, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Pennsylvania, Tennessee, Texas and Virginia

District of Columbia

Georgia, Atlanta - including the counties of: (Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Forsyth, Fulton, Gwinnett, Haralson, Heard, Henry, Houston, Jasper, Morgan, Newton, Paulding, Putnam, Rockdale, Spalding and Walton)

Missouri, St Louis: (including the Missouri counties of : Bollinger, Butler, Cape Girardeau, Clark, Clinton, Crawford, Dent, Dunklin, Franklin, Gasconade, Greene, Howell, Iron, Jefferson, Lewis, Lincoln, Madison, Marion, Mississippi, Monroe, Montgomery, New Madrid, Oregon, Pemiscot, Perry, Phelps, Pike, Ralls, Randolph, Reynolds, Ripley, Scott, Shannon, St. Charles, St. Clair, St. Francois, St. Louis, St. Louis City, Ste. Genevieve, Stoddard, Texas, Warren, Washington and Wayne)

Section 2. How we Change for 2024

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 premium will increase for Self Only or increase for Self Plus One or increase for Self and Family. See rates page on the back of the brochure
- **Infertility services -** The plan will cover intravaginal insemination (IVI), intracervical insemination (ICI), and intrauterine insemination (IUI) at 50% coinsurance of the Plan allowance. This is new coverage for contract year 2024. See page 35
- **Infertility drugs** - The plan will now cover fertility drugs associated with artificial insemination procedures. The Plan will also provide three (3) cycles annually of fertility drugs associated with IVF. Preauthorization is required. The Plan will cover fertility drugs on all prescription drug tiers. See page 68
- **Gender Affirming Care and Services** - the Plan will expand coverage for medically necessary gender affirming care to include the following services for contract year 2024: breast enlargement including augmentation mammaplasty and breast implants, thyroid cartilage reduction/reduction thyroid chondroplasty, trachea shave (removal or reduction of the Adam's apple) and voice modification surgery (e.g., laryngoplasty, glottoplasty or shortening of vocal cords), facial gender affirming care surgery, and travel and lodging. The member cost share for these services is 20% coinsurance of the plan allowance. Preauthorization is required. There is a $2,000 maximum on travel and lodging. See page 48
- **COVID 19 Over The Counter (OTC) Test Kits** – The Plan will cover test kits (8 per member per month) at Tier 3 with a $12 cap cost share. See page 68
- **Revisional Bariatric surgery** - The Plan will now cover revisional bariatric surgery, a medical procedure used to correct problems with a previous weight loss operation. Members pay 20% coinsurance of the plan allowance. See page 46

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 1-877 835-9861 or write to us at UnitedHealthcare Insurance Company, Federal Health Benefits (FEHB) Program, at P.O. Box 30432, Salt Lake City, UT 84130-0432. You may also print temporary cards and request replacement cards through our website: www.myuhc.com.

Where you get covered care

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

- **Balance Billing Protection**

FEHB Carriers must have clauses in their in-network (participating) providers agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

- **Plan providers**

Plan providers are physicians and other healthcare professionals in our service area that we contract with to provide covered services to our members. Services by Plan Providers are covered when acting within the scope of their license or certification under applicable state law. We credential Plan providers according to national standards.

Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state's designation as a medically underserved area.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website.

This plan recognizes that transgender, non-binary, and other gender diverse members require health care delivered by healthcare providers experienced in gender affirming health. Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex or gender.

This plan provides Care Coordinators for complex conditions and can be reached 877-835-9861 for assistance.

- **Plan facilities**

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

	A freestanding facility is an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims as a freestanding entity and not as a hospital. You will have a lower out of pocket expenses when you use a freestanding facility instead of a hospital for outpatient services. Outpatient services are health services or treatments that do not require an overnight hospital stay. Outpatient care received in a hospital will typically cost you more. Talk to your doctor about the options available to you for these services.
• **Non-network providers and facilities**	You can access care from any licensed provider or facility. Providers and facilities not in the UnitedHealthcare Choice Plus network are considered non-network providers and facilities.
What you must do to get covered care	It depends on the type of care you need. You can go to any provider you choose to but it will cost you less to get care from our Premium designated providers and in-network providers. We must approve some care in advance.
• **Primary Care**	Your visits to your primary care provider (PCP) are paid at 100% for all ages and all visits whether they are for preventive care or treatment for an illness. Your primary care provider may be a family practitioner, an internist, or pediatrician. Your primary care provider will provide most of your healthcare.
• **Specialty care**	Here are some other things you should know about specialty care: • If your current specialist does not participate with us, you may want to consider treatment from a specialist who does to avoid additional costs. If you have a chronic and disabling condition and lose access to your specialist because we: - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or 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. • Terminate our contract with your specialist for other than cause; • You may receive services from your current specialist until we can make arrangements for you to see someone else.
• **Hospital care**	Your Network primary care provider or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.
If you are hospitalized when your enrollment begins	We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 877-835-9861. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage. If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until: • you are discharged, not merely moved to an alternative care center; • the day your benefits from your former plan run out; or • the 92nd day after you become a member of this Plan, whichever happens first.

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

You need prior Plan approval for certain services

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

- **Your hospital stay**

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

- **Inpatient hospital admission**

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

- **Other services**

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

- Angioma/Hemangioma (with pictures)
- Applied Behavioral Analysis
- Ambulance (Air and non-emergency)
- Blepharoplasty (with pictures)
- Breast implant removal, breast reconstruction for non-cancer diagnosis, breast reduction
- Certain out of network services
- Dental procedures in a facility
- Certain Durable Medical Equipment supplies over $1000
- Clinical trials
- Coronary artery bypass graft
- Congenital anomaly repair
- Computed Tomography (CT) scans (brain, chest, heart
- Dialysis
- Discectomy/fusion
- Gender Affirming Surgical Procedures
- Genetic testing
- Gynecomastia surgery
- Human Growth hormone
- Hysterectomy
- Iatrogenic infertility services
- Infertility Services
- Implanted spinal cord stimulators
- Inpatient hospitalization
- Intensive Outpatient Treatment
- Joint replacement
- Morbid obesity surgery
- Magnetic resonance imaging (MRI) (brain, chest, heart, musculoskeletal)

- Magnetic resonance angiogram (MRA)
- Partial Hospitalization
- PET scans (non- cancer diagnosis)
- Pulmonary rehabilitation
- Radiation therapy
- Reconstructive surgery
- Sclerotherapy
- Sleep apnea (surgery & appliance) with sleep studies,(polysomnography) attended
- Tempromandibular Joint Dysfunction surgery
- Transplants
- Therapeutic services: such as physical therapy, occupational therapy and speech therapy after the 8th visit
- Uvulopalatopharyngoplasty
- Vein Ablation
- Ventricular assist device

Call 1-877-835-9861 and they will assist you in determining if your service requires preauthorization. In addition, your admitting physician and facility must also preauthorize any elective inpatient stays.

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

First, your physician, your hospital, you, or your representative, must call us at 1-877-835-9861 before admission or services requiring prior authorization are rendered. Please note that members with Medicare as primary are also required to follow the precertification process.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay

- **Non-urgent care claims**

For non-urgent care claims, we will 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 or not it is an urgent care claim by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

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

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

  You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 1-877-835-9861. You may also call OPM's FEHB 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 1-877-835-9861. 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, 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 phone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity Care**

  You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, your physician or the hospital must contact us for precertification of additional days for your baby.

  Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

• **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, we will make a decision within 24 hours after we receive the claim.
What happens when you do not follow the precertification rules when using non-network facilities	If you fail to obtain authorization/precertification when using non-network facilities you can be responsible for up to 100% of the charges.
Circumstances beyond our control	Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care
If you disagree with our pre-service claim decision	If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call 877-835-9861 If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.
• **To reconsider a non-urgent claim**	Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure. In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to 1. Precertify your hospital stay or, if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply; or 2. Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision. 3. Write to you and maintain our denial.
• **To reconsider an urgent care claim**	In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure. Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by phone, 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 provider you pay a copayment of $25 per office visit.

Deductible

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

- The calendar year deductible is $500 Self Only and $1,000 Self Plus One or Self and Family. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $500. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $1,000. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $1,000. The Out-of-network deductible is $3,000 Self Only and $6,000 Self Plus One or Self and Family.
- We also have separate deductibles for:
  - Pharmacy - Tier 3 and 4 prescriptions only. Prescription paid under the pharmacy benefit are not subject to the medical deductible. There is however, a pharmacy deductible which only applies to Tier 3 and Tier 4 prescription drugs. That deductible is $250 Self Only, $500 Self Plus One or Self and Family.
- There are in-network benefits that are paid prior to your deductible being satisfied, such as Primary Care visits, Specialist Visits, Virtual/Telemedicine visits - please refer to the benefits section of this brochure.
- Note: If you change plans during open season, you do not have to start a new deductible under your prior plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

Coinsurance

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

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

Differences between our Plan allowance and the bill

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

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

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

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

What your plan pays (plan coinsurance): 80% in network or 50% of the Plan allowance for out of network for benefits with coinsurance . There are in-network benefits that require a copayment only. What you pay (coinsurance): 20% in network 50% out of network (plus the difference between the Plan allowance and the billed amount).

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

You should also see section Important Notice About Surprise Billing – Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.

Your catastrophic protection out-of-pocket maximum

After your in-network out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance total $7,350 for Self Only, or $14,700 for a Self Plus One or Self and Family enrollment in any calendar year, or out-of network $15,000 per Self Only or $30,000 for Self Plus One or Self and Family you do not have to pay any more for covered services.

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

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

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

Carryover

If you changed to this Plan during Open Season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your prior 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 prior 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 Prior 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 prior 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.

Important Notice About Surprise Billing - Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services.

A surprise bill is an unexpected bill you receive for:

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from surprise bills.

Plan: Use language in following sentence that is applicable to your coverage. In addition, your health plan adopts and complies with the surprise billing laws of the District of Columbia.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to uhcfeds.com or contact the health plan at 877-835-9861.

- **The Federal Flexible Spending Account Program – *FSAFEDS***

Healthcare FSA (HCFSA) – Reimburses you for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, physician prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you, your tax dependents, and your 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.

Section 5. High Option Benefits

On page 92 is a benefits summary for this plan.

Section 5. High Options Benefit Overview

This Plan is a High Option. The benefits are described in Section 5. Make sure that you review the benefits that are available. Section 5. is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about benefits, contact us at 1-877-835-9861 or on our website at www.uhcfeds.com.

Medical Services Provided by Physicians: Routine Preventive Care provided in-network	Nothing
Medical Services Provided by Physicians: Diagnostic and treatment services provided in office	Primary care physician - zero copayment in-network all ages (deductible does not apply) Specialist: $60 copayment in network (deductible does not apply); Out-of-network: 40% after deductible has been met and any difference between our allowance and the billed amount
Medical Services Provided by Physicians: Virtual visits - through UHC Designated Virtual Visit Network Provider Group. Call customer service at 1-877-835-9861 for network listing.	In-network: You pay nothing - not subject to deductible. Out-of-network: You pay all charges
Urgent Care	In-network: $50 copayment (deductible does not apply) Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Services provided by a hospital: Inpatient	In-network 20% coinsurance Out-of-network 40% of the Plan allowance and any difference between our allowance and the billed amount
Services provided by a hospital: Outpatient Surgical	In-network 20% coinsurance Out of Network: 40% of the plan allowance and any difference between our allowance and the billed amount
Emergency Benefits: Emergency room	In-network: 20% coinsurance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Mental Health and Substance Use Disorder Treatment	Regular cost sharing
Prescription Drugs:	Retail 30-day supply Note: In-network only Tier 1-$5, Tier 2-$50, Tier 3-$100, Tier 4-$150 Mail Order - 90-day supply Tier 1-$12.50, Tier 2-$125, Tier 3-$250, Tier 4-$375 Note: Tier 3 and Tier 4 drugs are subject to a pharmacy deductible of $250 Self Only /$500 Self Plus One or Self and Family Out-of-network:you pay all charges

Pharmacy - Specialty Medications (30-day supply)	Tier 1 - $5 Tier 2 - $150 Tier 3 - $350 Tier 4 - $500 Available through in-network designated Specialty Pharmacy Only

UnitedHealthcare Retiree Advantage Health Plan

Medical Benefit: Deductible
Member Pays: No deductible; Brochure Section: 9

Medical Benefit: Primary Care Visit
Member Pays: Nothing; Brochure Section: 9

Medical Benefit: Preventive Care
Member Pays: Nothing; Brochure Section: 9

Medical Benefit: Specialist Visit
Member Pays: Nothing; Brochure Section: 9

Medical Benefit: Virtual Visit
Member Pays: Nothing; Brochure Section: 9

Medical Benefit: Urgent Care
Member Pays: Nothing; Brochure Section: 9

Medical Benefit: Emergency Room
Member Pays: Nothing; Brochure Section: 9

Medical Benefit: Pharmacy (30-day supply)
Member Pays: Tier 1 - $6, Tier 2 - $25, Tier 3 - $60, Tier 4 - $90; Brochure Section: 9

*Note: You must have Medicare Part A and Part B, and Medicare must be primary for you to enroll in the UnitedHealthcare Retiree Advantage Plan. This plan reduces your costs by eliminating your cost sharing for covered medical services. Please see Section 9 in this brochure for additional information on how to enroll in this plan and for details on a reimbursement of $150.00 of your Medicare Part B premium.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- A facility charge applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- The calendar year deductible is: $500 Self only, $1,000 Self Plus One and Self and Family in-network and $3,000 Self only $6,000, Self Plus One and Self and Family out-of-network. The calendar year deductible may apply to some benefits in this Section. We added -"Not subject to Deductible" to show when the calendar year deductible does not apply.
- If you enroll in UnitedHealthcare Choice Plus Primary Plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a $150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.)
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with other coverage*, including with Medicare.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description		
Diagnostic and treatment services	**In Network You pay**	**Out of Network You pay**
Professional services of physicians: • In Provider's office / telehealth visit • Primary care / Optum Primary care • Office Medical consultations • Second surgical opinion • Advanced care planning	Primary care Provider (PCP) visit you pay nothing - Not subject to deductible Specialist per visit $60 copayment - Not subject to deductible	Primary care Provider (PCP) visit - 40% of the Plan allowance and any difference between our allowance and the billed amount
2nd MD - Second opinion program You now have access to to personalized second opinions by video or by phone through the Second Opinion Program. Second Opinion is powered by 2nd MD, a third-party-vendor, to assist you with more informed decision making. This is an in-network only option. It does not change the costs for your second opinion benefit when utilized through other providers.	$0 when the 2nd MD is the provider.	*All charges*
Professional services of physicians • In an urgent care center • In an emergency room • During a hospital stay • In a skilled nursing facility	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Diagnostic and treatment services - continued on next page

Benefit Description		
Diagnostic and treatment services (cont.)	**In Network You pay**	**Out of Network You pay**
At home	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Telehealth services	**In Network You pay**	**Out of Network You pay**
Use virtual visits through our designated virtual visit network provider groups 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 are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at 1-877-835-9861. Access to Virtual Visits and prescription services may not be available in all states due to state regulations. You can pre-register with a group. After registering and requesting a visit you will pay your portion of service costs and then you enter a virtual waiting room.	$0 Not subject to deductible	*All charges*
Lab, X-ray and other diagnostic tests	**In Network You pay**	**Out of Network You pay**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG	20% coinsurance of plan allowance	*All charges*
Major Diagnostic tests • CT scans/MRI • PET Scans • Nuclear Medicine Pre-authorization is required	20% coinsurance of plan allowance	*All charges*

Benefit Description		
Preventive care, adult	**In Network You pay**	**Out of Network You pay**
Routine physical every year The **following** preventive services are covered at the time interval recommended at each of the links below. • Immunizations such as Pneumococcal, influenza, shingles, tetanus/Tdap, and human papillomavirus (HPV). For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ • Screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer screening. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b- recommendations • Individual counseling on prevention and reducing health risks • Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women please visit the Health and Human Services (HHS) website at https://www.healthcare.gov/preventive-care-women/ • To build your personalized list of preventive services go to https://health.gov/myhealthfinder	$0	*All charges*
Annual preventive biometric screening in your physician's office to include: • Body mass index (BMI) • Blood pressure • Lipid/cholesterol levels • Glucose/hemoglobin AIC measurement Services must be coded by your physician as preventive to be covered in full.	$0	40% of the Plan allowance and any difference between our allowance and the billed amount
Routine mammogram - covered	$0	40% of the Plan allowance and any difference between our allowance and the billed amount
BRCA genetic counseling and evaluation is covered as preventive when a woman's family history is associated with an increased risk for deleterious mutations in BRCA1 and BRCA2 genes and medical necessity criteria has been met. Preauthorization required	$0	40% of the Plan allowance and any difference between our allowance and the billed amount

Preventive care, adult - continued on next page

Benefit Description		
Preventive care, adult (cont.)	**In Network You pay**	**Out of Network You pay**
Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC) based on the Advisory Committee on Immunization Practices (ACIP) schedule. Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	$0	40% of the Plan allowance and any difference between our allowance and the billed amount
• Medical Nutrition Therapy and Intensive Behavioral Therapy for the prevention of obesity related comorbidities as recommended under the U.S. Preventive Services Task Force (USPSTF) A and B recommendations.	$0	*All charges*
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*	*All charges*
Preventive care, children	**In Network You pay**	**Out of Network You pay**
• Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org • Immunizations such as DTap/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/index.html • You can also find a complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) online at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b- recommendations Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	$0	*All charges*
Not covered: Physical examinations and immunizations required for attending camp, school or travel	*All charges*	*All charges*

Benefit Description		
Maternity care	**In Network You pay**	**Out of Network You pay**
Complete maternity (obstetrical) care, such as: • Prenatal and Postpartum care • Screening for gestational diabetes • Screening for bacteriuria • Delivery • Breastfeeding support, supplies and counseling for each birth • Screening and counseling for prenatal and postpartum depression Postnatal care • Note: Here are some things to keep in mind: You do not need to pre-certify your vaginal delivery; see page 53 for other circumstances, such as extended stays for you or your baby. • 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. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Circumcisions are covered 100% during newborn stay. Note: Circumcisions following the newborn stay are covered under the surgical benefits at the applicable copayment or coinsurance. • Hospital services are covered under Section 5(c) and Surgical benefits section 5(b).	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: *Routine sonograms to determine fetal age, size or sex*	*All charges*	*All charges*
Family planning	**In Network You pay**	**Out of Network You pay**
A range of voluntary family planning services, limited to: • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragms • Tubal ligation Note: We cover oral contraceptives under the prescription drug benefit.	$0	40% of the Plan allowance and any difference between our allowance and the billed amount

Family planning - continued on next page

Benefit Description		
Family planning (cont.)	**In Network You pay**	**Out of Network You pay**
• Voluntary sterilization for men (See Surgical procedures Section 5(b))	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Genetic testing is covered when medically necessary for certain conditions such as pregnancy testing for cystic fibrosis, coverage of certain cancer drugs, certain autosomal recessive conditions autosomal dominant less penetrant conditions, x-linked conditions and certain chromosome abnormalities. Prior authorization is required	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling unless medically necessary.Interruption of pregnancy unless the life of the mother is at risk*	*All charges*	*All charges*
Infertility services	**In Network You pay**	**Out of Network You pay**
Diagnosis and treatment of infertility	20% coinsurance of the plan allowance	
Infertility: A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. It is defined by the failure to achieve a successful pregnancy after 12 months or more of unprotected intercourse or artificial insemination for individuals under age 35. Earlier evaluation and treatment for those individuals actively looking to achieve a conception may be justified based on medical history and diagnostic testing and is warranted after six (6) months for individuals aged 35 years or older. Diagnosis and treatment of infertility specific to: • Artificial insemination: • Intravaginal insemination (IVI) • Intracervical insemination (ICI) • Intrauterine insemination (IUI) Fertility drugs (see section 5f) • Oral and injectable drugs associated with artificial insemination and IVF (3 cycles annually) procedures Note: Prior Authorization required	50% coinsurance of plan allowance	50% of the Plan allowance and any difference between our allowance and the billed amount

Benefit Description		
Allergy care	**In Network You pay**	**Out of Network You pay**
• Testing and treatment • Allergy injections - including serum	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*	*All charges*
Treatment therapies	**In Network You pay**	**Out of Network You pay**
• 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 47. • Respiratory and inhalation therapy (pulmonary rehabilitation) is provided for up to 20 sessions • Cardiac rehabilitation following qualifying event/ condition is provided for up to 36 sessions • Intravenous (IV)/Infusion Therapy - Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See Services requiring our prior approval in Section 3.	20% coinsurance of the plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Habilitative/Rehabilitative Therapies	**In Network You pay**	**Out of Network You pay**
Habilitative/Rehabilitative Services Outpatient Therapy when performed by qualified physical therapists and occupational therapists: • Physical Therapy/ Occupational therapy - up to 60 visits per year combined • Cognitive Rehabilitation up to 20 visits per year • Post cochlear implant rehabilitation and aural therapy up to 30 visits per year Note: We only cover therapy when a physician: • Orders the care • Identifies the specific professional skills the patient requires and the medical necessity for skilled services; and	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Habilitative/Rehabilitative Therapies - continued on next page

Benefit Description		
Habilitative/Rehabilitative Therapies (cont.)	**In Network You pay**	**Out of Network You pay**
• indicates the length of time the services are needed.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*	*All charges*
Speech therapy	**In Network You pay**	**Out of Network You pay**
Up to 20 visits per year for speech therapy	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Exercise programs, gyms or pool memberships* • *Work hardening/functional capacity programs or evaluations* • *Voice therapy*	*All charges*	*All charges*
Hearing services (testing, treatment, and supplies)	**In Network You pay**	**Out of Network You pay**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Routine hearing for children is covered as preventive services with no copayment	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
External Hearing Aids - • Limit of $2,500 per ear and limited to a single purchase (including repair/replacement) per hearing impaired ear every three (3) years . Repair and replacement of a hearing aid would apply to this limit in the same manner as a purchase.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Implanted hearing related devices, such as bone anchored hearing aids (BAHA) and coclear implants For therapy associated with cochlear implants please refer to the rehabilitative treatment therapy section of this brochure	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *All other hearing testing*	*All charges*	*All charges*

Benefit Description		
Vision services (testing, treatment, and supplies)	**In Network You pay**	**Out of Network You pay**
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Diagnosis and treatment of diseases of the eye	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Routine Eye Examination - Eye refraction every two years examination to provide a written lens prescription Note: Eye examinations for children follow the Bright Futures Guidelines (American Academy of Pediatrics) at no charge	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*	*All charges*
Foot care	**In Network You pay**	**Out of Network You pay**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**In Network You pay**	**Out of Network You pay**
• Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Enteral equipment and supplies • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. • See Section 5(c) for payment information. Insertion of the device is paid as surgery • Ostomy supplies and urinary catheters • Orthotic braces and splints not available over the counter that straighten or change the shape of a body part	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Orthopedic and prosthetic devices - continued on next page

Benefit Description **Orthopedic and prosthetic devices (cont.)**	**In Network You pay**	**Out of Network You pay**
• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome and/or Myofascial Pain Dysfunction (MDP). See section 5(b) for limitations • Bone anchored hearing aids (BAHA) limited to one per member per lifetime, when the member has either of the following - Craniofacial anomalies in which abnormal or absent ear canals preclude the use of a wearable hearing aid - Hearing loss of sufficient severity that it cannot be adequately remedied by a wearable hearing aid • Single purchase of each type of prosthetic device every three (3) years (in-network). Prior authorization is required for prosthetic devices in excess of $1,000. Note: Most orthopedic and prosthetic devices must be preauthorized. Call us at 1-877-835-9861 if your plan physician prescribes this and you need assistance locating a health care physician or health care practitioner to sell or rent you orthopedic or prosthetic equipment. You may also call us to determine if certain devices are covered. Internal prosthetic devices are paid as hospital benefits. For information on the professional charges for the surgery to insert an implant please refer to Section 5(b) surgical procedures. For information on the hospital and/or ambulatory surgical center benefits see Section 5(c) Services provided by a hospital or other facility.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than 5 years after the last one (except as needed to accommodate growth in children or socket replacement for members with significant residual limb volume or weight changes)* • *External penile devices* • *Speech prosthetics (except electrolarynx)* • *Carpal tunnel splints* • *Deodorants, filters, lubricants, tape, appliance cleansers, adhesive and adhesive removers related to ostomy supplies*	*All charges*	*All charges*

Benefit Description **Durable medical equipment (DME)**	**In Network You pay**	**Out of Network You pay**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: A single purchase of a type of durable medical equipment (including repair and replacement) every three (3) years. This limit does not apply to wound vacuums. Prior authorization is required for durable medical equipment in excess of $1,000. • Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks) • Dialysis equipment • Standard hospital beds • Wheelchairs • Crutches • CPAP • Walkers • Blood glucose monitors/continuous glucose monitors • Insulin pumps. and insulin pump supplies • Surgical dressings not available over-the-counter • Burn garments • Braces, including necessary adjustments to shoes to accommodate braces, which are used for the purpose of supporting a weak or deformed body part • Braces restricting or eliminating motion in a diseased or injured part of the body • Hair prosthesis (wigs for hair loss due to cancer treatment) - limited to $350 per year Note: Many DME items must be preauthorized. Call us at 1-877-835-9861 if your plan physician prescribes this and you need assistance locating a healthcare physician or health care practitioner to sell or rent you equipment. You may also call us to determine if certain devices are covered.	20% coinsurance of plan allowance	*All charges*
Not covered: • *Power operated vehicles unless medically necessary based upon diagnosis* • *Duplicate or back up equipment* • *Parts and labor costs for supplies and accessories replaced due to wear and tear such as tires and tubes* • *Educational, vocational or environmental equipment* • *Deluxe or upgraded equipment or supplies* • *Home or vehicle modifications; seat lifts* • *Over-the-counter medical supplies* • *Activities of daily living aids (such as grab bars and utensil holders)* • *Personal hygiene equipment*	*All charges.*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description		
Durable medical equipment (DME) (cont.)	**In Network You pay**	**Out of Network You pay**
• *Paraffin baths, whirlpools and cold therapy* • *Augmentative communication devices* • *Physical fitness equipment* • *Continuous pulse oximetry unless skilled nursing is involved in home care and it is part of their medically necessary equipment* • *Out-of-network purchases*	*All charges.*	*All charges*
Home health services	**In Network You pay**	**Out of Network You pay**
• Medically necessary Home healthcare 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 - It is not delivered for the purpose of assisting with the 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 the Physician directed medical management. A service will not be determined to be skilled simply because there is not an available caregiver. - Services include the administration of: oxygen therapy, intravenous therapy and medications. - Limited to 60 visits per year • Prescription foods covered when the following criteria have been met: - Amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases which are prescribed for the therapeutic treatment of inherited metabolic diseases and are administered under the direction of a physician. - Specialized formulas for the treatment of a disease or condition and are administered under the direction of a Physician	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Home health services - continued on next page

Benefit Description		
Home health services (cont.)	**In Network You pay**	**Out of Network You pay**
- Medical foods which are determined to be the sole source of nutrition and cannot be obtained without a physician's prescription Note: medications delivered will be subject to pharmacy charges.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Private duty nursing* • *Foods that can be obtained over the counter (without a prescription) even if prescribed by your physician*	*All charges*	*All charges*
Chiropractic	**In Network You pay**	**Out of Network You pay**
• Manipulation of the spine and extremities up to 20 visits per year • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Alternative treatments	**In Network You pay**	**Out of Network You pay**
Acupuncture - by a doctor of medicine or osteopathy, or licensed or certified acupuncture practitioner Up to 12 visits per year Dry Needling – by a licensed or certified practitioner	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Massage Therapy* • *Herbal medicine* • *Rolfing* • *Ayurveda* • *Homeopathy* • *Other alternative treatments unless specifically listed as covered*	*All charges*	*All charges*

Benefit Description		
Educational classes and programs	**In Network You pay**	**Out of Network You pay**
Outpatient self-management training for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin using diabetes and designated chronic conditions. Diabetes outpatient self-management training, education and medical nutrition therapy services must be prescribed by a licensed health care professional who has appropriate state licensing authority. Outpatient self-management training includes, but is not limited to, education and medical nutrition therapy. The training must be given by a certified registered or licensed health care professional trained in the care and management of diabetes. Coverage includes: • Initial training visit, up to 10 hours, after you are diagnosed with diabetes, for the care and management of diabetes, including but not limited to: Counseling in nutrition , the use of equipment and supplies, training and education, up to four hours, as a result of a subsequent diagnosis by a Physician of a significant change in your symptoms or condition which require modification of your program of self-management of diabetes. Also included is training and education, up to four hours, because of the development of new techniques and treatments.	20% coinsurance	40% of the Plan allowance and any difference between our allowance and the billed amount
Coverage is provided for: Tobacco Cessation program including online learning, Nicotine Replacement Therapy and over-the-counter and prescription drugs approved by the FDA (subject to age and treatment therapy recommendations) to treat tobacco dependence. Learn more about this program in Section 5(h) Wellness and other Special Features.	$0	$0
Multicomponent, family centered programs focused on childhood obesity that are part of intensive behavioral interventions (behavior change counseling for healthy diet and physical activity)	$0	$0

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare 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.
- The calendar year deductible is: $500 Self Only, $1,000 Self Plus One and Self and Family in-network and $3,000 Self Only, $6,000 Self Plus One and Self and Family out-of-network. The calendar year deductible applies to most benefits in this Section. We indicate "Not subject to deductible" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost sharing works. Also read Section 9, C*oordinating benefits with other coverage*, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other healthcare professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET 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.
- If you enroll in UnitedHealthcare Choice Plus Primary Plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a $150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.)

Benefit Description		
Surgical procedures	**In-Network You pay**	**Out-of-Network You pay**
A comprehensive range of services, such as: • Operative procedures • surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Insertion of internal prosthetic devices . See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (vasectomy) • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description **Surgical procedures (cont.)**	**In-Network You pay**	**Out-of-Network You pay**
Physician charges for Scopic Procedures such as: • Endoscopy • Colonoscopy (Diagnostic) • Sigmoidscopy Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery.* Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*	*All charges*
Bariatric Surgery	**In-Network You pay**	**Out-of-Network You pay**
Surgical treatment of severe obesity (Bariatric surgery) when the following criteria has been met: Eligible members must be age 18 or older or for adolescents, have achieved greater than 95% of estimated adult height AND a minimum Tanner Stage of 4 • A Body Mass Index (BMI) above 40 kg/m2 without co-morbidity; or • A BMI of 35 kg/m2 or greater with obesity-related co-morbid medical conditions including: - Hypertension - Cardiopulmonary condition - Sleep apnea - Diabetes - Any life threatening or serious medical condition that is weight induced • must enroll in the Bariatric Resource Services Program (BRS) • must use a designated Bariatric Resource Services (BRS) provider and facility • Documentation that dietary attempts at weight control have been ineffective through completion of a structured diet program, such as Weight Watchers or Jenny Craig. Either of the following in the two-year period that immediately precedes the request for the surgical treatment of morbid obesity meets the indication: 1. One structured diet program for six consecutive months; or 2. Two structured diet programs for three consecutive months	20% coinsurance of plan allowance	*All charges*

Bariatric Surgery - continued on next page

Benefit Description **Bariatric Surgery (cont.)**	**In-Network You pay**	**Out-of-Network You pay**
• A carrier or a private review agent acting on behalf of a carrier shall use flexibility with regard to defining a structured diet program • Completion of a psychological examination of the member's readiness and fitness for surgery and the necessary postoperative lifestyle changes Revisional Bariatric Surgery using one of the following procedures Type 2 diabetes; or • Cardiovascular disease [e.g., history of stroke and/or myocardial infarction, poorly controlled hypertension (systolic blood pressure greater than 140 mm Hg or diastolic blood pressure 90 mm Hg or greater, despite pharmacotherapy)]; or • History of coronary artery disease with a surgical intervention such as coronary artery bypass or percutaneous transluminal coronary angioplasty; or • History of cardiomyopathy; or • Obstructive Sleep Apnea (OSA) confirmed on polysomnography with an AHI or RDI of ≥ 30 **and** • The individual must also meet the following criteria: Both of the following: • Completion of a preoperative evaluation that includes a detailed weight history along with dietary and physical activity patterns; and • Psychosocial-behavioral evaluation by an individual who is professionally recognized as part of a behavioral health discipline to provide screening and identification of risk factors or potential postoperative challenges that may contribute to a poor postoperative outcome	20% coinsurance of plan allowance	*All charges*
Iatrogenic Infertility Services	**In-Network You pay**	**Out-of-Network You pay**
Coverage is available for fertility preservation for medical reasons that cause irreversible infertility such as surgery, including surgical treatment of gender dysphoria, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes. **Covered benefits include the following procedures:** • Collection of sperm • Cryo-preservation of sperm • Oocyte cryo-preservation • Embryo cryo-preservation • Ovarian stimulation, retrieval of eggs and fertilization	20% coinsurance of plan allowance; $60 per specialist visit	40% of the Plan allowance and any difference between our allowance and the billed amount

Iatrogenic Infertility Services - continued on next page

Benefit Description		
Iatrogenic Infertility Services (cont.)	**In-Network You pay**	**Out-of-Network You pay**
Benefits are not available for: • Embryo transfer • Long-term storage costs (greater than 1 year) • Elective fertility preservation. **Benefits are further limited to one cycle of fertility preservation for iatrogenic infertility per covered person during the period of time he or she is enrolled for coverage under the policy.** There is a benefit limit of $20,000 for medical services and $5,000 for pharmacy benefits. The preimplantation genetic testing and fertility preservations are one combined maximum. Prior authorization is required.	20% coinsurance of plan allowance; $60 per specialist visit	40% of the Plan allowance and any difference between our allowance and the billed amount
Reconstructive surgery	**In-Network You pay**	**Out-of-Network You pay**
Physician charges for : • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birthmarks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts; - Treatment of any physical complications, such as lymphedemas; - Breast prostheses and surgical bras and replacements (see *Prosthetic devices)* Surgical treatment for Gender Dysphoria may be indicated for individuals who meet the medical criteria and persistent, well-documented diagnostic criteria A disorder characterized by the following diagnostic criteria (Diagnostic and Statistical Manual of Mental Disorders, 5th edition [DSM-5]).	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Reconstructive surgery - continued on next page

Benefit Description Reconstructive surgery (cont.)	In-Network You pay	Out-of-Network You pay
Requirements: • Must be 18 years of age or older • Must have documented evidence of persistent gender dysphoria • Favorable psychosocial-behavioral evaluation to provide screening and identification of risk factors or potential postoperative challenges • Persistent, well-documented Gender Dysphoria • Capacity to make a fully informed decision and to consent for treatment • Complete at least 12 months of successful continuous full-time real-life experience in the desired gender • Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated) • Treatment plan that includes ongoing follow-up and care by a Qualified Behavioral Health Provider experienced in treating Gender Dysphoria* Gender reconstructive surgeries for (male to female) include: • Laser or electrolysis hair removal in advance of genital reconstruction • Orchiectomy: removal of testicles • Penectomy: removal of penis • Vaginoplasty: creation of vagina • Clitoroplasty: creation of clitoris • Labiaplasty: creation of labia • Prostatectomy: removal of prostate • Urethroplasty: creation of urethra Gender reconstructive surgeries for (female to male) include: • Laser or electrolysis hair removal in advance of genital reconstruction • Salpingo-oophorectomy: removal of fallopian tubes and ovaries • Vaginectomy: removal of vagina • Vulvectomy: removal of vulva • Metoidioplasty: creation of micro-penis using the clitoris • Phalloplasty: creation of penis, with or without urethra • Hysterectomy: removal of uterus • Urethroplasty: creation of urethra within penis • Scrotoplasty: creation of scrotum • Testicular prosthesis: implantation of artificial testes • Mastectomy: removal of the breast • Penile prosthesis • Tracheal shave • Voice modification surgery	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Reconstructive surgery - continued on next page

Benefit Description		
Reconstructive surgery (cont.)	**In-Network You pay**	**Out-of-Network You pay**
• Voice modification lessons and therapy • Chest and breast surgery including bilateral mastectomy • Breast reduction and Breast augmentation • Gender Affirming Facial Surgeries • Travel and Lodging ($2000 maximum) Note: Prior Authorization is required	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Oral and maxillofacial surgery	**In-Network You pay**	**Out-of-Network You pay**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*	*All charges*
Temporomandibular Joint Dysfunction (TMJ)	**In-Network You pay**	**Out-of-Network You pay**
Services for the evaluation and treatment of TMJ and associated muscles • Diagnosis: Exam, radiographs and applicable imaging studies and consultation. • Non-surgical treatment including: Clinical exams, Oral appliances (orthotic splints), Arthrocentesis, Trigger-point injections Benefits are provided for surgical treatment if the following criteria are met: • There is radiographic evidence of joint abnormality. • Non-surgical treatment has not resolved the symptoms. • Pain or dysfunction is moderate or severe. Benefits for surgical services include: • Arthrocentesis • Arthroscopy • Arthroplasty	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Temporomandibular Joint Dysfunction (TMJ) - continued on next page

Benefit Description		
Temporomandibular Joint Dysfunction (TMJ) (cont.)	**In-Network You pay**	**Out-of-Network You pay**
• Arthrotomy • Open or closed reduction of dislocations. $3,000 limit for all services pertaining to TMJ	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants)	**In-Network You pay**	**Out-of-Network You pay**
These **solid organ transplants** are covered. Solid organ transplants are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung: single/bilateral/lobar • Pancreas	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Blood or marrow stem cell transplants The plan extends coverage for the diagnoses as indicatedbelow. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed)	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

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

Benefit Description		
Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants) (cont.)	**In-Network You pay**	**Out-of-Network You pay**
- Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hematopoietic stem cell - 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 • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Hematopoietic stem cell - Multiple myeloma - Medulloblastoma	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

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

Benefit Description Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants) (cont.)	In-Network You pay	Out-of-Network You pay
- Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
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 - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MDPs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

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

Benefit Description		
Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants) (cont.)	**In-Network You pay**	**Out-of-Network You pay**
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.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
• 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 - Multiple sclerosis - Sickle Cell anemia		
• Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MDDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia		
• Autologous Transplants for:		

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

Benefit Description		
Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants) (cont.)	**In-Network You pay**	**Out-of-Network You pay**
- Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis National Transplant Program (NTP) - OptumHealth Care Solutions (URN) used for organ tissue transplants **Limited Benefits** – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. **Note:** We cover related medical and hospital expenses of the donor when we cover the recipient. **Transplants must be provided in a Plan designated Center of Excellence for Transplants. These centers do a large volume of these procedures each year and have a comprehensive program of care.**	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Donor testing for bone marrow/stem cell transplants for up to 4 potential donors whether family or non-family	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor - except as listed above* • *Implants of artificial organs* • *Transplants not listed as covered* • *All services related to non-covered transplants*	*All charges*	*All charges*

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

Benefit Description		
Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants) (cont.)	**In-Network You pay**	**Out-of-Network You pay**
• *All services associated with complications resulting from the removal of an organ from a non-member*	*All charges*	*All charges*
Anesthesia	**In-Network You pay**	**Out-of-Network You pay**
Professional services provided in : • Hospital (inpatient) • Hospital (outpatient) • Surgical center • Skilled nursing center • Office	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

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.
- The calendar year deductible is: $500 Self Only, $1,000 Self Plus One and Self and Family in-network and $3,000 Self Only, $6,000 Self Plus One and Self and Family out-of-network. The calendar year deductible applies to almost all benefits in this Section. We indicate "Not subject to deductible" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your Costs for Covered Services* for valuable information about how cost sharing works. Also read Section 9, C*oordinating benefits with other coverage*, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge such as physician charges are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET 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.
- If you enroll in UnitedHealthcare Choice Plus Primary Plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a $150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.)

Benefit Description		
Note: When the calendar year deductible does not apply we indicate - "Deductible does not apply"		
Inpatient hospital	**In-Network You pay**	**Out-of-Network You pay**
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.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
• Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Inpatient hospital - continued on next page

Benefit Description		
Inpatient hospital (cont.)	**In-Network You pay**	**Out-of-Network You pay**
• Administration of blood and blood products • Blood products, derivatives and components, artificial blood products and biological serum. Blood products include any product created from a component of blood such as, but not limited to, plasma, packed red blood cells, platelets, albumin, Factor VIII, immunoglobulin, and prolastin • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthesia services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as phone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**In-Network You pay**	**Out-of-Network You pay**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, x-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: Blood and blood derivatives not replaced by the member	*All charges*	*All charges*

Benefit Description		
Extended care benefits/Skilled nursing care facility benefits	**In-Network You pay**	**Out-of-Network You pay**
Services and supplies provided during Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for up to 60 days per year when full-time nursing care is medically necessary as determined by the Plan. Services include: • Room and board in a Semi-private Room (a room with two or more beds), and general nursing care • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a physician.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Custodial care* • *Rest cures, domiciliary or convalescent care* • *Personal comfort items, such as phone, barber services, guest meals and beds*	*All charges*	*All charges*
Hospice care	**In-Network You pay**	**Out-of-Network You pay**
Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes: • Physical • Psychological • Social • Spiritual • Respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care • Benefits are available when hospice care is received from a licensed hospice agency.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: Independent and private duty nursing, homemaker services	*All charges*	*All charges*
Ambulance	**In-Network You pay**	**Out-of-Network You pay**
Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities only when the transport meets one of the following: • From an Out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required.	20% coinsurance of plan allowance	40% coinsurance of the Plan allowance and any difference between our allowance and the billed amount

Ambulance - continued on next page

Benefit Description Ambulance (cont.)	In-Network You pay	Out-of-Network You pay
• To the closest Network Hospital that provides the required Covered Health Care Services that were not available at the original Hospital, including transportation costs of a newborn to the nearest appropriate facility to treat the newborn's condition. The Physician must certify that such transportation is necessary to protect the health and safety of the newborn. • From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility where the required Covered Health Care Services can be delivered. • **Prior Authorization Requirement** In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you **must** obtain authorization as soon as possible before transport. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid. For the purpose of this Benefit the following terms have the following meanings: • "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting. • "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness. • "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.	20% coinsurance of plan allowance	40% coinsurance of the Plan allowance and any difference between our allowance and the billed amount

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $500 Self Only, $1,000 Self Plus One and Self and Family in-network and $3,000 Self Only, $6,000 Self Plus One and Self and Family out-of-network. The calendar year deductible applies to almost all benefits in this Section. We indicate "Not subject to deductible" to show when the calendar year deductible does not apply..
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost sharing works. Also read Section 9, C*oordinating benefits with other coverage*, including with Medicare.
- If you enroll in UnitedHealthcare Choice Plus Primary Plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a $150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.)

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 phone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan or Primary Care Physician within 48 hours, unless it was not reasonably possible to notify us within that time. It is your responsibility to ensure that the Plan has been timely notified.

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

Benefit Description		
Emergency Care	**In-Network You pay**	**Out-of-Network You pay**
• Emergency care at a Provider's office **(PCP)**	Primary care Provider (PCP) $0 Not subject to deductible	Primary care physician (PCP) $0 Not subject to deductible
• Emergency care at a doctor’s office - **Specialist**	$60 copayment specialist visit Not subject to deductible	40% of the Plan allowance and any difference between our allowance and the billed amount
• Emergency care at an urgent care center	$50 copayment Not subject to deductible	40% of the Plan allowance and any difference between our allowance and the billed amount

Emergency Care - continued on next page

Benefit Description		
Emergency Care (cont.)	**In-Network You pay**	**Out-of-Network You pay**
• Emergency care as an outpatient at a hospital, including providers' services	20% coinsurance of plan allowance (waived if admitted)	40% of the Plan allowance and any difference between our allowance and the billed amount (waived if admitted)
Not covered: Elective care or non-emergency care at hospital emergency room	*All charges*	*All charges*
Ambulance	**In-Network You pay**	**Out-of-Network You pay**
Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance or water vehicle) to the nearest Hospital where the required Emergency Health Care Services can be performed.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between allowance and the billed amount

Section 5(e). Mental Health and Substance Use Disorder Benefits

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- The calendar year deductible is: $500 Self Only, $1,000 Self Plus One and Self and Family in-network and $3,000 Self Only, $6,000 Self Plus One and Self and Family out-of-network. The calendar year deductible applies to almost all benefits in this Section. We indicate "Not subject to deductible" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost sharing works. Also read Section 9 *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.
- If you enroll in UnitedHealthcare Choice Plus Primary Plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a $150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.)

Benefit Description		
Professional services	**In-Network You pay**	**Out-of-network You pay**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and medication 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 substance use disorders, including detoxification, treatment and counseling	$60 copayment per specialist visit - Not subject to deductible	40% of the Plan allowance and any difference between our allowance and the billed amount

Professional services - continued on next page

Benefit Description		
Professional services (cont.)	**In-Network You pay**	**Out-of-network You pay**
• Professional charges for outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$60 copayment per specialist visit - Not subject to deductible	40% of the Plan allowance and any difference between our allowance and the billed amount
Autism Spectrum Disorder for children with autism spectrum disorder • Assessments, evaluations, or tests by a licensed physician or licensed psychologist to diagnose whether an individual has an autism spectrum disorder; • Treatment of autism spectrum disorders when it is determined by a licensed physician or licensed psychologist that the treatment is medically necessary health care. A licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity	$60 copayment per specialist visit - Not subject to deductible	40% of the Plan allowance and any difference between our allowance and the billed amount
Diagnostics	**In-Network You pay**	**Out-of-network You pay**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	20% coinsurance of plan allowance	*All charges*
Inpatient Hospital or other covered facility	**In-Network You pay**	**Out-of-network You pay**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semi-private or intensive accommodations, general nursing care, meals and special diets, and other hospital services. Prior authorization is required • Partial day treatment • Residental Treatment	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Diagnostics	**In-Network You pay**	**Out-of-network You pay**
Diagnostic tests • Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	20% coinsurance of plan allowance	*All charges*

Benefit Description		
Outpatient hospital	**In-Network You pay**	**Out-of-network You pay**
Outpatient services provided by and billed by a covered facility such as: • Facility based intensive outpatient treatment programs	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount.
Not covered	**In-Network You pay**	**Out-of-network You pay**
• *Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by the Plan physician to be necessary and appropriate* • *Methadone Maintenance for substance use unless it is part of an approved treatment program* • *Services and supplies when paid for directly or indirectly by a local state or Federal Government agency* • *Room and board at a therapeutic boarding school* • *Services rendered or billed by schools* • *Services that are not medically necessary* • *Out-of-network lab or X-ray* *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page. Some injectable medications may be covered under your medical benefit.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare. sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9, C*oordinating benefits with other coverage*, including with Medicare.
- Your Medical deductible for Self only is $500; Your deductible for Self Plus One or Self and Family is $1,000. Your pharmacy deductible which is applicable only for Tier 3 and Tier 4 drugs for Self Only is $250 and for Self Plus One or Self and Family is $500. This deductible does not apply to any Tier 1 or Tier 2 drugs or to medications on the specialty pharmacy tiers.
- Federal law prevents the pharmacy from accepting unused medications.
- Prescription drugs paid under the pharmacy benefit are not subject to the medical deductible.
- If you enroll in UnitedHealthcare Choice Plus Primary Plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a $150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.)

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

• **Who can write your prescription**. A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice, must prescribe your medication.

• **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 1-877-835-9861 or visit our website, www.uhcfeds.com.

• **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 economic and financial considerations. You will find important information about our PDL as well as other Plan information on our web site, www.uhcfeds.com.

- **Tier 1** is your **lowest** copayment option (**$5** for up to a 30-day supply or $12.50 for up to a 90-day supply through mail order), and includes select generic medications, as well as select preferred 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 ($50 for up to a 30-day supply or $125 for up to a 90-day supply through mail order), and contains most 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 ($10**0** for up to a 30-day supply or $250 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. **This tier is subject to the pharmacy deductible described above.**
- **Tier 4** is your **highest** priced (**$150** for up to a 30-day supply or $375 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. **This tier is subject to the pharmacy deductible described above.**

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).

Specific Drug Exclusions - The plan will exclude higher cost medications that have therapeutic alternatives available without any additional clinical value over other options in their class. These drugs cost significantly more than those alternatives.

These are the dispensing limitations: Some drugs may only be available at a retail pharmacy or through a designated Specialty Pharmacy.

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

- Tier 1 $5; Tier 2 $150; Tier 3 $350, Tier 4 $500 (there is no additional pharmacy deductible for specialty medications)
- Expertise in storing, handling and distributing these unique medications
- Access to products and services that are not available through a traditional retail pharmacy
- Access to nurses and pharmacists with expertise in complex and high cost diseases
- Free supplies such as syringes and needles
- Educational materials as well as support and development of a necessary care plan

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

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

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

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

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

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

Injectable medications - Some injectable medications may be covered under the medical policy. 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 1-877-835-9861 for more information on these medications.

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

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

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

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

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

Benefit Description		
Preventive care medications	**In-network You pay**	**Out-of-Network You pay**
Medications to promote better health as recommended by ACA. Note: Preventive Medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a health care professional and filled by a network pharmacy. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations The following drugs and supplements are covered without cost-share, even if over-the-counter, are prescribed 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 • Pre-natal vitamins for pregnant women • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6	$0	*All charges*

Preventive care medications - continued on next page

Benefit Description		
Preventive care medications (cont.)	**In-network You pay**	**Out-of-Network You pay**
• Certain statins to treat cardiovascular disease for adults age 40 to 75 will be covered without a copayment as recommended by the United States Preventive Services Task force (USPSTF) when the following criteria is met: - one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); - and a calculated 10-year risk of a cardiovascular event of 10% or greater	$0	*All charges*
Covered medications and supplies	**In-network You pay**	**Out-of-Network You pay**
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 medications 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 • Drugs to treat gender dysphoria • Oral and injectable drugs associated with artificial insemination and IVF (3 cycles annually) procedures • Some drugs may require prior authorization Prior Authorization is required 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).	Non-maintenance medications at a retail pharmacy: Up to a 30-day supply • Tier 1: $5 copayment • Tier 2: $50 copayment • Tier 3: $100 copayment • Tier 4: $150 copayment Maintenance medications from the Plan mail order pharmacy for up to a a maximum of a 90-day supply • Tier 1: $12.50 copayment • Tier 2: $125 copayment • Tier 3: $250 copayment • Tier 4: $375 copayment	*All charges*
Specialty Medications (per 30-day supply)	Tier 1 $5 Tier 2 $150 Tier 3 $350 Tier 4 $500	*All charges*
COVID-19 Over The Counter (OTC) Test Kits • 8 Tests per member per month	Tier 3 -$12 Capped	*All charges*
Contraceptive drugs and devices as listed in the ACA/HRSA site.	$0	*All charges*

Covered medications and supplies - continued on next page

Benefit Description Covered medications and supplies (cont.)	In-network You pay	Out-of-Network You pay
Contraceptive coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in all methods of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. • Members have a clinical review for contraceptives that are excluded. They should reach out to their prescribing provider. Contraceptive products that are not already available at $0 cost-share can be provided at $0 member cost-share if the provider determines that a particular contraceptive is medically necessary for that member. The cost-share waiver process requires that providers attest the product is needed for contraceptive purposes and this can be submitted electronically by the provider. • Reimbursement for over-the-counter contraceptives can be submitted by completing a prescription drug claim form and submitting it with the required documentation to: OptumRx at PO Box 29044, Hot Springs, AR 71903. • The "morning after pill" (tier 1) is provided at no cost if prescribed by a physician and purchased at the network pharmacy	$0	*All charges*
Smoking cessation medications are covered as follows: • Prescription medications for smoking cessation • Over-the-counter smoking cessation medications with a prescription from physician as part of our smoking cessation program	$0	*All charges*
Not covered: • *Medications, drugs and supplies used for cosmetic purposes* • *Medical Marijuana* • *Drugs to enhance athletic performance* • *Medical supplies such as dressings and antiseptics* • *Artificial insemination fertility drugs other than used for the iatrogenic services* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them* • *Nonprescription medications unless specifically indicated elsewhere* • *Drugs for sexual performance for patients that have undergone genital reconstruction*	*All charges*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description		
Covered medications and supplies (cont.)	**In-network You pay**	**Out-of-Network You pay**
• *Drugs available over-the-counter that do not require a prescription order by federal or state law before being dispensed* • *Alcohol swabs and bio-hazard disposable containers* • *Compound drugs that do not contain at least one covered ingredient that requires a prescription order to fill* *Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation benefit. (See above)*	*All charges*	*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.*
- The calendar year deductible is: $500 Self Only, $1,000 Self Plus One and Self and Family in-network and $3,000 Self Only, $6,000 Self Plus One and Self and Family out-of-network. The calendar year deductible applies to almost all benefits in this Section. We indicate "Not subject to deductible" to show when the calendar year deductible does not apply.
- 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.
- **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.
- If you enroll in UnitedHealthcare Choice Plus Primary Plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a $150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.)
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with other coverage,* including with Medicare.

Benefit Description		
Accidental injury benefit	**In-Network You pay**	**Out-of-Network You pay**
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. A sound natural tooth is defined as 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 • is not in need of treatment except as a result of the accident, and • functions normally in chewing and speech. • Crowns, bridges, implants and dentures are not considered sound natural teeth. Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry	20% coinsurance	40% of the Plan allowance and any difference between our allowance and the billed amount

Accidental injury benefit - continued on next page

Benefit Description		
Accidental injury benefit (cont.)	**In-Network You pay**	**Out-of-Network You pay**
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 /periapical and panoral radiographs • Endodontic (root canal) treatment • Emergency, temporary splinting of teeth • Prefabricated post and core • Simple minimal restorative procedures (fillings) • Emergency extractions • Post-tramatic crows are covered if it is the only clinical treatment available • Replacement of tooth due lost due to accidental injury	20% coinsurance	40% of the Plan allowance and any difference between our allowance and the billed amount
Adjunctive dental services	**In-Network You pay**	**Out-of-Network You pay**
Benefits for dental care that is medically necessary and an integral part of the treatment of a sickness or condition for which covered health services are provided. Examples of adjunctive dental care are: • Extraction of teeth prior to radiation for oral cancer • Elimination of oral infection prior to transplant surgery • Removal of teeth in order to remove an extensive tumor Note: When alternate methods may be used, we will authorize the least costly covered health service provided that the service and supplies are considered by the profession to be an appropriate method of treatment and meet broadly accepted national standards of dental practice. You and the provider may choose a more expensive level of care, but benefits will be payable according to these guidelines.	20% coinsurance	40% of the Plan allowance and any difference between our allowance and the billed amount
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, gingiva and alveolar bone*	*All charges*	*All charges*

Section 5(h) Wellness and Other Special features

Feature	Description
UnitedHealthcare's Digital Experience	At home and on the go our digital resources can help you manage health and finances. You want to have the resources to make well informed financial and health care decisions At UnitedHealthcare, our mission is helping people live healthier lives®. We strive to make health care simpler and easier for you to understand with our suite of integrated consumer tools on myuhc.com®. For members who are on the go, digital resources are available on the UnitedHealthcare app — wherever and whenever they need to manage your health care. **Download the UnitedHealthcare app*** for access to health plan ID cards, benefits information and help answering questions. At home and on the go our digital resources can help you manage health and finances. You want to have the resources to make well informed financial and health care decisions The mobile app is designed to help you manage different aspects of your health, like searching for providers and getting health care cost estimates for specific treatments and procedures. You will have access to your health plan ID card, claims information and real-time status on account balances, deductibles and out-of-pocket spending. You can find and receive care, estimate costs and pay bills directly from the app. Virtual visits can be scheduled and held from your mobile app. (24/7 virtual visits). Register with one of the UHC providers and visits are available when you are. You can reach out to an advocate from your mobile app as well. Download the UnitedHealthcare app from the App Store® or Google Play™ **Your online web portal** can assist to Find Care and Costs to help you find and price care, at the same time. Located on myuhc.com, you can: Your personalized website, myuhc.com®, features tools designed to help you: • Find, price and save on care — you can save with Virtual Visits and other tools. You can save an average of 36% * 1 when you compare costs for providers and services • Get care from anywhere with Virtual Visits. A doctor can diagnose common conditions by phone or video 24/7 • Understand your benefits and the financial impact of care decisions • Find tailored recommendations regarding providers, products and services. You can even generate an out-of-pocket estimate based on your specific health plan status • Access claim details, plan balances and your health plan ID card quickly • Follow through on clinical recommendations and access wellness programs • Order prescription refills, get estimates and compare medication pricing • Check your plan balances, access financial accounts and more • Find a quality doctor, clinic, hospital or lab that helps meet their needs. • Use multiple search options to filter results by location, specialty, quality, cost, services offered and more. • See provider ratings created by patients. • Review cost and care options before making an appointment to help control spending and choose the right level of service. • Access personalized cost and provider information specific to the benefit plan.

Feature	Description
Myuhc.com Behavioral Health Resources	With myuhc.com®, your personalized member website, behavioral health support services are available for you and your family to access anytime, anywhere — whether you're in a time of greater need or may want to work on personal growth. myuhc.com is available at no additional cost to you and your family. Find the right care for you Using the provider search tool, you can: • Locate therapists, psychiatrists or other behavioral health clinicians and facilities near you • Narrow your search by provider name, location, area of expertise and more • Schedule an in-person or virtual appointment with the provider you select Tap into behavioral health support See which benefits and programs you may be eligible for at myuhc.com. Once there, you can also visit your personalized emotional support page to explore the resources and tools that may help you with the ins and outs of everyday life — even if you might not have any pressing concerns. Tools and resources at your fingertips: Learn about a variety of behavioral health and well-being topics at myuhc.com Health Resources>Mental Health and Substance Use • You'll get access to: • Articles • Podcasts • Videos • Other tools To find behavioral health care, sign in or register on myuhc.com and then go to Find Care Behavioral Health Directory
Sanvello/ Self Care by Able To	Support for those looking to manage day-to-day stress or those who need but are not yet ready to seek treatment or are looking for an adjunct to treatment. This program delivers personalized, on-demand support that can be accessed anytime, anywhere to help you build resilience with new skills and daily habits. • Assessments and tracking • Mental health skills and tools – Cognitive Behavioral Therapy skills, mediations and mindful techniques and sleep tracking • Interactive activities and content to assist with specific needs such as parenting stress, work-related burnout or coping with social injustice • Community support – Peer to peer sharing and learning, see others' experiences.
Specialist Management Solutions (SMS)	*Specialist Management Solutions (SMS) is part of your health plan and exists to simplify your path to affordable, quality surgery and specialty care. Think of SMS as a concierge service. In one phone call to SMS, you get instant access to a care advocate who will help you find a local surgeon who specializes in your condition, schedule an appointment for you, and talk to you about your options for where you can receive care for a surgery or other outpatient procedure. SMS will be available for you or your family member throughout the experience of getting surgery, available to answer questions and provide assistance at any time.* *Specialties include: Cardiovascular, ENT, Gastrointestinal, General Surgery, MSK/Spine, Ophthalmology, Orthopedic, Pain Management, Podiatry, Urology, Women's Health*

	**Payment for medical appointments and treatments remain member's responsibility and are subject to plan benefits*
The Second Opinion service through 2nd.MD	**Supporting informed decisions with access to personalized second opinions** The Second Opinion service through 2nd.MD helps our members with a diagnosis get an expert opinion from leading medical experts. This service is available at no additional charge and includes: • Virtual and phone consultations • A written summary within 24 hours • Chat and text capabilities with a dedicated nurse • Referrals and appointment scheduling for local peer-to-peer consults, if needed **Offering a concierge-like experience** You can request a consult online or by phone. After receiving the request, a care team nurse: 1. Performs triage and intake 2. Sends the employee's medical records and recommends a medical expert 3. Schedules the consultation; the employee meets with the expert and receives a written summary 4. Coordinates any follow-up needs within 9–14 days **Providing expert help throughout the care journey** The Second Opinion service provides second opinions for a variety of needs. Providers are hand-selected to help give you access to leading physicians who specialize in your condition. Consultations may cover: • New diagnoses • Changes in treatment • Chronic conditions • Potential surgeries 2nd.MD works with top physicians across the country who are world-class medical experts and have trained and worked at elite institutions such as Cleveland Clinic, Boston Children's Hospital, and Hospital for Special Surgery.
Real Appeal - A Lifestyle and Weight Management Program	Real Appeal® provides tools and support to help members lose weight and prevent weight-related health conditions. Real Appeal is provided **at no additional cost** to eligible members as part of your medical benefit plan. The program can help motivate members to improve their health and reduce risk of developing costly, chronic conditions like cardiovascular disease and diabetes. The program combines clinically proven science with engaging content that teaches members how to eat healthier and be active, without turning their lives upside down, to help them achieve and maintain their weight-loss goals. Real Appeal includes: **Social community resources such as:** Real Appeal LinkedIn community; Facebook community; YouTube videos including getting started, workouts and success stories **A Success Kit** - After attending their first group coaching session, members receive a Success Kit with tools to help them kick-start their weight loss. The kit includes items such as: • Balanced Portion plate • Electronic food scale

	• Digital weight scale • Fitness guide **A personalized Health Coach** - Coaches guide members through the program step-by-step, customizing it to help fit their needs, personal preferences, goals and medical history. 24/7 online support and mobile app through our Rally Coach portal or directly through our Rally Coach mobile app. Staying accountable to goals may be easier than ever. • Customizable food, activity, weight and goal trackers. • Unlimited access to digital content. • An online lifestyle program to help you learn new ways to be your healthiest self
Smoking Cessation Program	Our smoking cessation program provides our members with resources and support for tobacco cessation. Included are: • Portal and mobile app • Online learning with interactive and personalized content and a community support forum • Integrated online and telephonic experience • Live coaching sessions with coaches with degrees in counseling, addiction studies, and related fields • Nicotine replacement therapy counseling • 24/7 support for easier access to services • Nicotine replacement therapy both prescription medications and over the counter products (with prescription) Get started today. Go to myuhc.com, visit the "Health Resources" tab on the top right, Choose the "Quit for Life" tile Available from the App Store; Android available in Google play
Maternity Health Solutions	Maternity Health Solutions is designed to help improve outcomes and lower costs by providing moms-to-be with personalized care for clinical, behavioral and other holistic needs. • Maternity-related courses available on myuhc.com regarding course topics such as: - Preconception: Preparing for a healthy pregnancy - Pregnancy in the first trimester - Pregnancy in the second trimester - Pregnancy in the third trimester - The fourth trimester after pregnancy: Postpartum - Pregnancy nutrition and exercise - Exploring breastfeeding • Maternity risk assessment on Myuhc.com • Additional support for high-risk cases
UnitedHealth Premium	Choosing a doctor is one of the most important health decisions you'll make. The UnitedHealth Premium® program can help you find doctors who are right for you and your family. You can find quality, cost-efficient care. Studies show that people who actively engage in their health care decisions have fewer Hospitalizations, fewer emergency visits, higher utilization of preventive care and overall lower medical costs. The program evaluates physicians in various specialties using evidence-based medicine and national standardized measures to help you locate quality and cost-efficient providers. It's easy to find a UnitedHealth Premium Care Physician. Just go to myuhc.com® and click on Find a Doctor. Choose smart. Look for blue hearts.

	• **Premium Care Physician** meets UnitedHealth Premium program quality **Quality Care Physician** meets UnitedHealth Premium program quality care criteria, but does not meet the program's cost efficient care criteria or is not evaluated for cost-efficient care. Physician is not eligible for a Premium designation. • **Not Evaluated for Premium Care** physician's specialty is not evaluated and/or does not have enough claims data for program evaluation or the physician's program evaluation is in process.
Real Appeal	Real Appeal® provides tools and support to help members lose weight and prevent weight-related health conditions. Real Appeal is **provided at no additional cost** to eligible members as part of your medical benefit plan. The program can help motivate members to improve their health and reduce risk of developing costly, chronic conditions like cardiovascular disease and diabetes. The program combines clinically proven science with engaging content that teaches members how to eat healthier and be active, without turning their lives upside down, to help them achieve and maintain their weight-loss goals. **Real Appeal includes:** **A Success Kit** - After attending their first group coaching session, members receive a Success Kit with tools to help them kick-start their weight loss. The kit includes: • Nutrition guide with recipes • Portion plate • Electronic food scale • Digital weight scale • Fitness guide • 12 fitness DVDs • Resistance bands • After 8 weeks of the program members receive a blender before the class on healthy smoothie options. **A personalized Transformation Coach** - Coaches guide members through the program step-by-step, customizing it to help fit their needs, personal preferences, goals and medical history. **24/7 online support and mobile app** - Staying accountable to goals may be easier than ever. • Customizable food, activity, weight and goal trackers. • Unlimited access to digital content. • Success group support, which lets employees chat with others who are doing the Real Appeal program. • Online TV shows that is fun, engaging and helps members learn new ways to be healthier **Why Real Appeal works -** Real Appeal is guided by a Clinical Advisory Board of obesity, nutrition and behavior change experts that create customized content to help keep members engaged throughout their weight-loss journey. Members will learn steps to help with long-term transformation, which may translate to a happier, healthier member.
Specialty Pharmacy	**What are the benefits of using Optum Specialty Pharmacy?** Optum Specialty Pharmacy provides personalized support and resources at no extra cost to help you manage your condition. **How does Optum Specialty Pharmacy support you?** • Pharmacists to answer questions 24/7 • A clinical care team to help you understand your medication • 1-on-1 video chats with your care team • Helpful videos from other specialty patients • Supplies you may need to take your medication at no extra cost • Refill reminders

	• Talk with a nurse about infusion services, if applicable **Tips for working with our Optum Specialty Pharmacy care team.** • Tell your pharmacist or nurse about any side effects or issues you may be facing with your care, such as forgetting to take your medication. • We're here to help with more than your medication. Our pharmacists and nurses can help you find resources to stay on track with your health. We're here to help. Call Optum Specialty Pharmacy at 1-855-427-4682 to learn more and transfer your prescriptions. Or, call the number on the back of your member ID card to find a designated specialty pharmacy near you.
Flexible Benefits Option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. 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. 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 cannot guarantee you will get it in the future. • The decision to offer an alternative benefit 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 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 claim process (see Section 8).
Cancer Clinical Trials	To be a qualifying clinical trial, a trial must meet all of 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 that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals. Benefits are not available for preventive clinical trials. • The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

Feature	Description
Medicare Part B Reimbursement for Retire Advantage Members	*Receive reimbursement for your Medicare Part B Premium* • *$150.00 will be paid on your behalf directly to Medicare* • *See a reduction in your quarterly Medicare bill, or an increase in your Social Security payment or annuity payment* • *Receive this benefit for every month you're enrolled in the plan*
Renew Active Fitness Program for Retiree Advantage Members	Renew Active is a fitness benefit which is included in the Medicare Advantage plan which provides: • A free gym membership to participating facilities - To view participating facilities, please visit www.uhcrenewactive.com • Access to an extensive network of gyms and fitness locations near members • A personalized fitness plan • Access to a wide variety of fitness classes • An online brain health program, exclusively from AARP® Staying Sharp • Connecting with others at local health and wellness events, and through the Fitbit® Community for Renew Active
First Line Essentials for Retiree Advantage Members	*Shop for hundreds of over-the-counter items such as toothpaste, vitamins, and personal care from the Health Products catalog.* • *Members will receive $40 allowance each quarter to spend on items from the provided catalog* • *Items are delivered directly to your door* • *Orders can be place over the phone, by mail, or online*
House Calls for Retiree Advantage Members	*With the UnitedHealthcare® HouseCalls program, you get an annual in-home preventive care visit from one of our health care practitioners at no extra cost.* *What does HouseCalls include?* • *One 45 to 60-minute at-home visit from a health care practitioner, each year.* • *A head-to-toe exam, health screenings and plenty of time to talk about your health questions.* • *A custom care plan made just for you.* • *Help connecting you with additional care you may need.*
Healthy at Home for Retiree Advantage Members	*Healthy at Home provides the following benefits up to 30 days following all inpatient and skilled nursing facility discharges when referred by a UnitedHealthcare Advocate:* • *Home-Delivered Meals* *Receive 28 home-delivered meals provided by Mom's Meals* • *Non-emergency transportation* *Receive 12 one-way rides to medically related appointments and to the pharmacy provided by ModviCare* • *In-home Personal Care* • *Receive 6 hours of in-home personal care through our exclusive national provider CareLinx*
Real Appeal for Retiree Advantage Members	Real Appeal is a weight loss program that can help members feel and look better. The program provides everything they need to lose weight and keep it off. This program is a pilot for select members residing in Wisconsin. • The online program includes:

	• Personalized diabetes prevention coaching • 24/7 online support and mobile app • Customizable food, activity, weight and goal trackers • Success group support, which lets members chat with others who are doing the Real Appeal program • The weekly Real Appeal All-Star Show featuring healthy tips from celebrities, athletes and health experts Success Kit includes: • Program, nutrition, and fitness guides • Tools to help cook healthier, tasty meals • Delivered right to their front door after attending their first group coaching session
UnitedHealthcare Hearing for Retiree Advantage Members	*UnitedHealthcare Hearing provides members with greater technology, choice and convenience* • *Rechargeable hearing aids, remote adjustments and other advanced feature devices are available at up to 80% less than standard industry prices through direct delivery, including top brands in multiple styles* • *6,500+ locations nationwide* • *Chose home delivery or in person options* • *3-minute online hearing test to assess hearing loss/need for in-person test* • *Members receive $1500 allowance every 36 months towards the purchase of hearing aids* • *Members must use a UHC hearing provider to use their hearing aid benefit*
Quit For Life for Retiree Advantage Members	Quit For Life has helped 3.5 million members quit smoking or using tobacco. It provides the tools and one-on-one support to help you quit your way. And for UnitedHealthcare members, it's offered at $0 out of pocket. With a 95% satisfaction rate, Quit for Life provides • Tools and support to help members quit cigarettes, e-cigarettes, vaping and tobacco • A personal, one-on-one Quit Coach to help you create a customized quit plan • The Quit for Life mobile app, which offers 24/7 urge management support • Text2Quit text messages for daily tips and encouragement • Quit medications – Such as nicotine gum or patches – for no charge, based on eligibility
PERS (Personal Emergency Response System) for Retiree Advantage Members	**UnitedHealthcare®** works with Lifeline to provide a personal emergency response system at no cost for Retiree Advantage plan members Lifeline personal emergency response system (PERS) allows you to ask for help whenever you need it, anytime of day or night – 365 days of the year, 24/7. All you need to do is press the help button, worn as a wristband or pendant, and a Trained Care Specialist will assist you to make sure you quickly get the help you need. **Features include:** • Optional AutoAlert fall detection technology automatically provides access to help if it detects a fall – even if wearer is disoriented, immobilized or unconscious and cannot press their help button • Cellular or landline compatible, Lifeline works anywhere in the U.S., where current telephone service is provided • Lightweight, waterproof help button can be worn on the wrist or as a pendant

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 1-877-835-9861 TTY 711.

PPO Dental Plan* - Your plan includes preventive benefits for each family member covered under your policy. Eligible family members receive $500 per member per year in preventive dental services both in and out of network, such as; Oral exams, cleanings, X-rays, sealants & fluoride treatments. Visit www.uhcfeds.com. For your dental benefit certificate of coverage.

UnitedHealthcare Hearing*- You have access to a wide selection of hearing aid styles and technology from name brand and private label manufacturers at significant savings. Plus, you'll receive personalized care from experienced hearing providers along with professional support every step of the way, helping you to hear better and live life to the fullest. Visit www.uhchearing.com or call 1-855-523-9355, Monday through Friday, 8:00 am to 8:00 pm CT. **Please reference code HEARFEHBP when accessing services.**

Rally* - Offers an experience designed to help people feel empowered and motivated through simple, fun interactions and personalization. The experience includes; health survey, goal setting and challenges to compete. Visit www.myuhc.com for additional details.

***Programs available at no additional premium cost to you, as part of your health plan benefits. Get started today at myuhc.com.**

Financial Wellness Options: United Health ONE helps individuals with plans that fit your financial picture.

SafeTrip – You have available travel benefits if an emergency arises while out of the country. As part of your SafeTrip travel protection plan, UnitedHealthcare Global provides you with medical and travel-related assistance services. To enroll visit http://cloud.uhone.uhc.com/federal or call 1-844-620-4814 (worldwide 24-hour a day).

Accidental Insurance - Program options that offer benefits paid in a lump sum directly to you for eligible expenses related to accidental injury. These benefits are paid regardless of other insurance coverage you have, up to your chosen annual maximum. Visit http://cloud.uhone.uhc.com/federal or call 1-844-620-4814.
For details and plan cost and availability in your area.

Term Life - Program offers benefits if your family relies on your income to keep up with their day-to-day living expenses, the financial implications of your death could be devastating for them. Term Life Insurance from UnitedHealthcare, underwritten by UnitedHealthcare Life Insurance Company [or Golden Rule Insurance Company], can play a part in helping you to protect your family's finances in your absence. Visit http://cloud.uhone.uhc.com/federal or call 1-844-620-4814 for details and plan cost and availability in your area.

Critical Illness Insurance - Critical Illness insurance, also known as critical Care insurance or Critical Illness coverage, pays a lump sum cash benefit directly to the policyholder in the event of a qualifying serious illness. Visit http://cloud.uhone.uhc.com/federal or call 1-844-620-4814 for details and plan cost and availability in your area.

UnitedHealthOne® is a brand name used for many UnitedHealthcare individual insurance products. UnitedHealthcare and UnitedHealthOne® family and individual insurance plans are underwritten by Golden Rule Insurance Company and UnitedHealthcare Life Insurance Company. Prior to being purchased by UnitedHealthcare in 2003, Golden Rule Insurance Company had served the insurance needs of families and individuals for decades. The expertise brought in by Golden Rule has now become an important component of UnitedHealthcare and UnitedHealthOne® insurance products offered on UHOne.com. Shopping here or calling, means browsing products supported by over 75 years of personal insurance experience.

Section 6. General Exclusions – Services, Drugs and Supplies We Do not Cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, contact 1-877-835-9861.**

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational or unproven treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Fetal reduction surgery;
- Surrogate parenting;
- The reversal of voluntary sterilization;
- Extra care 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;
- 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.
- Research costs related to conducting a clinical trial such as research physician and nurse-time, analysis of results, and clinical tests performed only for research purposes.
- Services or supplies we are prohibited from covering under the Federal law.

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 providers, 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. Providers must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 1-877-835-9861.

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 provider or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

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

Submit domestic medical claims to:

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

Submit international medical claims to:

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

Prescription drugs

Submit your claims to:

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

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

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

Other supplies or services

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

Deadline for filing your claim	Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.
When we need more information	Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond.
Post-service claims procedures	We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected. If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information. If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.
Authorized Representative	You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a healthcare professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.
Notice Requirements	If you live in a county where at least 10% 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 phone 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 healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry 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 call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing UnitedHealthcare, Federal Employees Health Benefits Program at P.O. Box 30432, Salt Lake City, UT 84130-0432 or by calling 1-877-835-9861.

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 healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

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

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

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

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

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

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

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

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

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

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

a) Pay the claim or

b) Write to you and maintain our denial or.

c) Ask you or your provider for more information

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

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

3

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

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, FEHB 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 healthcare 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 or notify you of the status of OPM's review within 60-days. There are no other administrative appeals.

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

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

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

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

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

Section 9 Coordinating Benefits With Other Coverage

When you have other health coverage

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

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

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

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

If you elect to enroll in the UnitedHealthcare Retiree Advantage plan, your FEHB plan will not coordinate benefits. The UnitedHealthcare Retiree Advantage plan will take over as the primary and only payer.

TRICARE and CHAMPUS

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

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

Workers' Compensation

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

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.

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 or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

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

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

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

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone 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, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.

- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare?

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

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

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

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

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

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

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

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 1-877-835-9861 or see our member website at www.myuhc.com.

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

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

- **Medicare (In-Network)**

Benefit Description: Deductible
High Option You Pay **without** Medicare In-Network: $500 Self Only; $1,000 Self Plus One or Self and Family
High Option You Pay **with** Medicare Part B In-Network: $500 Self Only; $1,000 Self Plus One or Self and Family

Benefit Description: Out-of-Pocket Maximum
High Option You Pay **without** Medicare In-Network: $3,000 Self Only/$6,000 Self Plus One or Self and Family
High Option You Pay **with** Medicare Part B In-Network: $3,000 Self Only/$6,000 Self Plus One or Self and Family

Benefit Description: Part B Premium Reimbursement
High Option You Pay **without** Medicare In-Network: N/A
High Option You Pay **with** Medicare Part B In-Network: N/A

Benefit Description: Primary Care Provider
High Option You Pay **without** Medicare In-Network: Nothing- Not subject to deductible
High Option You Pay **with** Medicare Part B In-Network: Nothing- Not subject to deductible

Benefit Description: Specialist
High Option You Pay **without** Medicare In-Network: $60 copayment - Not subject to deductible
High Option You Pay **with** Medicare Part B In-Network: $60 copayment - Not subject to deductible

Benefit Description: Inpatient Hospital
High Option You Pay **without** Medicare In-Network: 20% after annual deductible
High Option You Pay **with** Medicare Part B In-Network: 20% after deductible

Benefit Description: Outpatient
High Option You Pay **without** Medicare In-Network: 20% after deductible
High Option You Pay **with** Medicare Part B In-Network: 20% after deductible

Benefit Description: Incentives Offered
High Option You Pay **without** Medicare In-Network: N/A
High Option You Pay **with** Medicare Part B In-Network: N/A

- **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 Part B Premium Reimbursement

We offer a plan designed to help members with their Medicare Part B premium. This plan is called, UnitedHealthcare Retiree Advantage. If you have Medicare Parts A and B primary and enroll in the UnitedHealthcare Retiree Advantage, you will be **reimbursed $150.00 of your Medicare Part B monthly premium**. Part B reimbursements will begin approximately 90 days following the approval of your Retiree Advantage application.

To learn more about UnitedHealthcare Retiree Advantage and how to enroll, call us at 1-844-481-8821, 8 a.m. to 8 p.m., local time 7 days per week, For TTY for the deaf, hard of hearing, or speech impaired, call 711. We will send you additional information.

- **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 healthcare choices (like HMOs and regional PPOs) in some areas of the country.

To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE, 1-800-633-4227, TTY 1-877-486-2048 or at www.medicare.gov or UnitedHealthcare Retiree Solutions at 1-844-481-8821.

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

This Plan and our Retiree Advantage plan: If you enroll in our Medicare Advantage plan you MUST also remain enrolled in our FEHB plan. Do not suspend or terminate your FEHB coverage. For more information on our Medicare Advantage plan, please contact us at 1-844-481-8821.

You may enroll in the UnitedHealthcare Retiree Advantage Plan if:

- You are enrolled in this UnitedHealthcare FEHBP plan and have both Medicare Part A and Part B
- You are retired and live in our geographic service area (See page 13 for details on our service area).
- You are a United States citizen or are lawfully present in the United States
- You do NOT have End-Stage Renal Disease (ESRD), with limited exceptions
- You complete an application for enrollment in the UnitedHealthcare Retiree Advantage Plan.

Part B reimbursements will begin within approximately 90 days following the approval of your Retiree Advantage application. As part of this process CMS will verify your Medicare Part B enrollment. If the FEHB subscriber and/or dependent enrolls in the Retiree Advantage plan, each family member will have to complete an application by calling into our Retiree Solutions team (1-844-481-8821). **If you enroll in the Retiree Advantage Plan do not suspend or terminate your FEHB plan or all benefits will be termed in both FEHB and Retiree Advantage and you will be without any coverage.** Members who are not are not eligible for Medicare Part A and B will remain on the FEHB plan benefits. If, for any reason, you do not meet the enrollment requirements, you will no longer be eligible to participate in the Retiree Advantage plan. Your contributions will end and your regular FEHB benefits will resume. You may be required to repay any reimbursements paid to you in error.

We offer a plan designed:

- To help members with their Medicare Part B premium costs
- To provide access to our national network of providers, (in-network or out-of-network) at the same cost share
- To cover eligible medical benefits with little to no out of pocket costs
- Provide prescription coverage through the gap or "donut hole" with no increased copays

The UnitedHealthcare Retiree Advantage plan provides monthly **reimbursement of $150.00 of your Medicare Part B monthly premium**. In addition, we cover benefits, including office visit copayments at ($0), for urgent care and emergency care plus coverage for hearing aid discounts and wellness programs. See chart on next page.

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

If you enroll in the UnitedHealthcare Retiree Advantage Group Medicare Advantage plan you must retain your FEHB coverage. Do not suspend your FEHB coverage as this will make you ineligible for the Retiree Advantage plan. **The UnitedHealthcare Retiree Advantage plan includes Medicare part D. Your FEHB plan will not coordinate benefits. The UnitedHealthcare Retiree Advantage plan will take over as the primary and only payer.**

Benefit Description: Deductible
Member Cost without Medicare (In-Network): $500 Self Only; $1,000 Self Plus One and Self and Family
Member Cost with Medicare Part B (In-Network): $500 Self Only; $1,000 Self Plus One and Self and Family
Member Cost with UnitedHealthcare Retiree Advantage Health Plan: No plan deductible

Benefit Description: Out-of-Pocket Maximum
Member Cost without Medicare (In-Network): $7,350 Self Only; $14,700 Self Plus One and $14,700 Self and Family
Member Cost with Medicare Part B (In-Network): $7,350 Self Only; $14,700 Self Plus One and $14,700 Self and Family
Member Cost with UnitedHealthcare Retiree Advantage Health Plan: You pay nothing for Medicare-covered service from any **provider**

Benefit Description: Primary Care Provider
Member Cost without Medicare (In-Network): $0
Member Cost with Medicare Part B (In-Network): $0
Member Cost with UnitedHealthcare Retiree Advantage Health Plan: $0

Benefit Description: Specialist
Member Cost without Medicare (In-Network): $60 per visit
Member Cost with Medicare Part B (In-Network): $60 per visit
Member Cost with UnitedHealthcare Retiree Advantage Health Plan: $0

Benefit Description: Virtual Visits
Member Cost without Medicare (In-Network): $0 per visit
Member Cost with Medicare Part B (In-Network): $0 per visit
Member Cost with UnitedHealthcare Retiree Advantage Health Plan: $0

Benefit Description: Urgent Care
Member Cost without Medicare (In-Network): $50 per visit
Member Cost with Medicare Part B (In-Network): $50 per vis**it**
Member Cost with UnitedHealthcare Retiree Advantage Health Plan: $0

Benefit Description: Emergency
Member Cost without Medicare (In-Network): 20% after deductible
Member Cost with Medicare Part B (In-Network): 20% after deductible
Member Cost with UnitedHealthcare Retiree Advantage Health Plan: $0

Benefit Description: Inpatient Hospital
Member Cost without Medicare (In-Network): 20% after deductible
Member Cost with Medicare Part B (In-Network): 20% after deductible
Member Cost with UnitedHealthcare Retiree Advantage Health Plan: $0

Your FEHB plan will not coordinate benefits with the Retiree Advantage plan. The UnitedHealthcare Retiree Advantage plan will take over as the primary and only payer.

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

- **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. If you elect to enroll in the UnitedHealthcare Retiree Advantage plan which includes Medicare part D, your FEHB plan will not coordinate benefits. The UnitedHealthcare Retiree Advantage plan will take over as the primary and only payer.

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		✓*
9) Are a Federal employee receiving 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

Assignment

An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.

- We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.
- Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.
- OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

Calendar year

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

Clinical trials cost categories

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

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

Coinsurance

See Section 4. page 8

Copayment

See Section 4 - page 8.

Cost Sharing

See Section 4, page 8.

Covered services

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

Deductible

See Section 4, page 8.

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.

Healthcare professional

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

Infertility

A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. It is defined by the failure to achieve a successful pregnancy after 12 months or more of unprotected intercourse or artificial insemination for individuals under age 35. Earlier evaluation and treatment for those individuals actively looking to achieve a conception may be justified based on medical history and diagnostic testing and is warranted after six (6) months for individuals aged 35 years or older.

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.

You should also see Important Notice About Surprise Billing – Know Your Rights in Section 4 that describes your protections against surprise billing under the No Surprises Act.

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.

Surprise bill

An unexpected bill you receive for:

· emergency care – when you have little or no say in the facility or provider from whom you receive care, or for

· non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for

· air ambulance services furnished by nonparticipating providers of air ambulance services.

Unproven Service(s)

Unproven services, including medications, are services 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 determine whether or not 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
You	You refers to the enrollee and each covered family member.

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Summary of Benefits - Choice Plus Primary Plan - 2024

- Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage at www.uhcfeds.com.
- 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.
- All benefits are subject to deductible unless noted that they are not subject to deductible. The calendar year deductible is: $500 Self Only $1,000 Self Plus One and Self and Family in-network and $3,000 Self Only and $6,000 Self Plus One and Self and Family out-of-network.

High Option Benefits	You Pay
Medical services provided by physicians: Diagnostic and treatment services provided in the office	In-network: Primary care physician (PCP) You pay nothing - not subject to deductible **Specialist:** In-network: $60 copayment not subject to deductible Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Services provided by a hospital: Inpatient	In-network: 20% coinsurance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Services provided by a hospital: Outpatient (Non-surgical)	In-network: 20% coinsurance Out-of-network: 40% of the plan allowance and any difference between our allowance and the billed amount
Emergency benefits: Emergency Room of Hospital	In-network 20% coinsurance (waived if admitted) Out-of-network 40% of the plan allowance and any difference between our allowance and the billed amount
Emergency benefits: Urgent Care Facility	In-network: $50 copayment per visit- Not subject to deductible *Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Mental health and substance use disorder treatment:	Regular cost sharing
Prescription drugs: Retail pharmacy (in-network only)	Up to 30-day supply at retail Tier 1: $5 copayment Tier 2: $50 copayment Tier 3: $100 copayment * subject to pharmacy deductible - See Section 5(f) Tier 4: $150 copayment * subject to pharmacy deductible - See Section 5(f)
Prescription drugs: Mail order	Up to 90-days at Mail Order (in-network only) Tier 1: $12.50 copayment Tier 2: $50 copayment

	Tier 3: $100 copayment * Subject to pharmacy deductible - See Section 5(f) Tier 4: $150 copayment * Subject to pharmacy deductible - See Section 5(f)
Specialty Pharmacy 30-day supply	Tier 1 $5 Tier 2 $150 Tier 3 $350 Tier 4 $500
Vision care:	Routine eye examination for children as described in the Bright Future Guidelines is covered at 100% - not subject to deductible Routine Eye Examination for Adults* *In-network: 20% coinsurance *Out-of-Network:40% of the Plan allowance and any difference between our allowance and the billed amount
• **Annual Deductible**	**In-network** • $500 Self only • $1,000 Self Plus One and Self and Family **Out-of-network:** • $3,000 Self only • $6,000 Self Plus One and Self and Family **Pharmacy:** • Tier 3 and Tier 4 Only subject to deductible • $250 Self Only • $500 Self Plus One and Self and Family
Protection against catastrophic costs (out-of-pocket maximum)**:**	You pay nothing after: **In-network:** • $7,350 Self Only • $14,700 Self Plus One and Self and Family **Out-of-Network:** • $15,000 Self Only • $30,000 Self Plus One and Self and Family

Notes

2024 Rate Information for UnitedHealthcare Insurance Company, Inc.

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

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium.

Premiums for Tribal employees are shown under the Monthly Premium Rate column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Alabama, Arkansas, District of Columbia, Florida, Georgia (Atlanta Area), Illinois, Iowa, Kentucky, Louisiana, Maryland, Mississippi, Missouri (St. Louis), North Carolina, Pennsylvania, Tennessee, Texas and Virginia					
High Option Self Only	AS1	$271.43	$93.88	$588.10	$203.41
High Option Self Plus One	AS3	$586.50	$198.94	$1,270.75	$431.04
High Option Self and Family	AS2	$646.18	$217.81	$1,400.06	$471.92