MD-Individual Practice Association, Inc.

http://www.uhcfeds.com

Customer Service 877-835-9861

2027

A Health Maintenance Organization and an Individual Practice Plan (High Option)

This Plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 7 for details. This Plan is accredited. See page 12.

Serving: District of Columbia, Maryland and Northern Virginia

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 13 for requirements.

Postal Employees and Annuitants are no longer eligible for this plan. (unless currently under Temporary Continuation of Coverage)

Enrollment codes for this Plan:

JP1 High Option - Self Only

JP3 High Option - Self Plus One

JP2 High Option - Self and Family

IMPORTANT

- Rates: Back Cover
- Changes for 2027: Page 14
- Summary of Benefits: Page 96

Authorized for distribution by the:

United States
Office of Personnel Management

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

Important Notice from M.D. IPA About

Our Prescription Drug Coverage and Medicare

OPM has determined that M.D. IPA's prescription drug coverage meets the Centers for Medicare & Medicaid Services (CMS) requirements to be considered Credible Coverage. This means, you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for the 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 most 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.

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 (1-800-633-4227), (TTY 1-877-486-2048)

Table of Contents

Introduction 3
Plain Language 3
Stop Health Care Fraud! 3
Discrimination is Against the Law 4
Preventing Medical Mistakes 5
FEHB Facts 7
- Coverage information 7
- No pre-existing condition limitation 7
- Minimum essential coverage (MEC) 7
- Minimum value standard 7
- Where you can get information about enrolling in the FEHB Program 7
- Enrollment types of coverage available for you and your family 7
- Family Member Coverage 8
- Children's Equity Act 9
- When benefits and premiums start 9
- When you retire 10
- When you lose benefits 10
- When FEHB coverage ends 10
- Upon divorce 10
- Temporary Continuation of Coverage (TCC) 10
- Converting to individual coverage 11
- Health Insurance Marketplace 11

Section 1. How This Plan Works 12
- General features of our High Option Plan 12
- How we pay providers 12
- Your rights and responsibilities 13
- Your medical and claims records are confidential 13
- Service Area 13

Section 2. Changes for 2027 14
- Changes to this Plan: 14

Section 3. How You Get Care 15
- Identification cards 15
- Where you get covered care 15
- Plan providers 15
- Plan facilities 15
- What you must do to get covered care 16
- Primary care 16
- Specialty care 16
- Hospital Care 17
- If you are hospitalized when your enrollment begins 17
- You need preauthorization from your Plan for certain services 17
- Inpatient hospital admission 17
  - Other Services 17
- How to request preauthorization for an admission or get preauthorization for other services 19
- Non-urgent care claims 20
- Urgent care claims 20
- Concurrent care claims 20
- Emergency inpatient admission 20
- Maternity care 21

If your treatment needs to be extended 21
Circumstances beyond our control....21
If you disagree with our pre-service claim decision 21
To reconsider a non-urgent care claim 21
To reconsider an urgent care claim 21
To file an appeal with OPM 21
Section 4. Your Cost for Covered Services 22
Cost-sharing 22
Copayments....22
Deductible 22
Coinsurance....22
Your catastrophic protection out-of-pocket maximum 22
Carryover 23
When Government facilities bill us 23
Section 5. High Option Benefits 24
Section 5. High Option Benefits Overview 26
Non-FEHB Benefits Available to Plan Members....77
Section 6. General Exclusions – Services, Drugs and Supplies We Do not Cover....78
Section 7. Filing a Claim for Covered Services....79
Section 8. The Disputed Claims Process....81
Section 9. Coordinating Benefits with Medicare and Other Coverage 84
When you have other health coverage 84
TRICARE and CHAMPVA 84
Workers' Compensation 84
Medicaid....84
When other Government agencies are responsible for your care 85
When others are responsible for injuries....85
When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage 85
Clinical Trials....85
When you have Medicare 86
The Original Medicare Plan (Part A or Part B)....86
Medicare cost share....87
Tell us about your Medicare coverage 87
Medicare Part B Premium Reimbursement 87
Medicare Advantage (Part C)....88
Medicare prescription drug coverage (Part D)....89
Section 10. Definitions of Terms We Use in This Brochure 91
Index....95
Summary of Benefits for the High Option of M.D. IPA - 2027 96
2027 Rate Information for MD IPA 98

Introduction

This brochure describes the benefits of M.D. IPA under contract (CS 1935) between M.D. IPA and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 877-835-9861 or through our website www. myuhc.com. The address for M.D. IPA's administrative offices is:

MD-Individual Practice Association, Inc. (M.D. IPA)
Federal Employees Health Benefit Plan
10175 Little Patuxent Parkway
MD 101-100 Suite 200
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, 2027, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates for each plan annually. Benefit changes are effective January 1, 2027, and changes are summarized on page 14. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee and each covered family member, "we" means M.D. IPA.
- 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.
- 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 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 provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services 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.

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 1-844-359-7736 or go to www. uhc.com/fraud and explain the situation.

- If we do not resolve the issue:

CALL - THE HEALTHCARE FRAUD HOTLINE 1-877-499-7295

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

The online 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 are disabled and incapable of self-support prior to age 26).

  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 family member, 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, try to obtain 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

We comply with applicable Federal nondiscrimination laws and do not discriminate on the basis of race, color, national origin, age, disability, religion, sex, pregnancy, or genetic information. We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, sex, pregnancy, or genetic information.

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual’s protected trait or traits will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined to be medically necessary.

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 medications 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.
- Understanding both the generic and brand names for all of your medication(s) is important. This helps ensure you do not receive double dosing from taking both a generic and a brand of the same medication. It also helps you avoid 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.
- https://psnet.ahrq.gov/issue/national-patient-safety-foundation. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.

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. Providers are expected to waive all costs associated with the medical error. Participating providers may not bill or collect payment from MDIPA members for any amounts not paid due to the application of this reimbursement policy.

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 updates and questions about your benefit coverage.

- **Enrollment types of coverage available for you and your family**

Self Only coverage is only 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 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 from a state that recognizes common-law marriages) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described 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, in 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 2027 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 2026 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 assistance with enrolling in 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 apply in writing to us within 31-days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must apply in writing to us within 31-days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, 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 1-877-835-9861 or visit our website at www.uhc.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 a high option Health Maintenance Organization (HMO) Individual Practice Plan. This Plan requires referrals for most services, and we require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory. OPM requires that FEHB Plans be accredited to ensure that plan operations and care management meet or exceed standards that have been validated by an independent non-profit organization. MD IPA holds accreditation through the National Committee for Quality Assurance (NCQA).

To learn more about accreditation, please visit the following website:

- National Committee for Quality Assurance (www. ncqa.org)

We require you to see specific physicians, hospitals, and other providers that contract with us. You must see a Network physician in order to obtain benefits. Benefits are not available for services provided by out-of-Network providers. This Plan does not provide an out-of-Network level of benefits. You are not required to select a Primary Care Provider (PCP) in order to obtain benefits.

These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory or access the full provider listing at uhcfeds.com or from your member portal at myuhc.com.

Benefits for facility services apply when Covered Services are provided at a Network facility. Benefits include physician services provided in a Network facility by a Network or an out-of-Network radiologist, anesthesiologist, pathologist, emergency room physician and consulting physician. Benefits also include emergency services.

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

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under a UnitedHealthcare policy. As a result, they may bill you for the entire cost of the services you receive.

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 an HMO because you prefer the plans 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.;

Questions regarding what protections apply may be directed to us at 1-877-835-9861. You can also read additional information from the U.S. Department of Health and Human Services at www. healthcare.gov,

General features of our High Option Plan

- You must have referrals from your Primary Care Physician (PCP) for most services.
- We have a wide service area of participating providers you must use to access care.
- You will not have to routinely file claims for medical services.
- We have Customer Service available at 1-877-835-9861 (TTY: 711).
- We participate in the FSAFEDS Paperless Reimbursement Program

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, coinsurance, deductibles and any non-covered services and supplies. We follow Maryland state law for payment of non-participating providers when authorized by the Plan.

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 and facilities. OPM 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.

- M.D. IPA has been in existence since 1979
- M.D. IPA is a for-profit organization

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, M.D. IPA at www. myuhc.com . You can also contact us to request that we mail a copy of that Notice.

If you want more information about us, call 1-877-835-9861, (TTY:711), 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 at www. myuhc.com to obtain a copy of our 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:

District of Columbia

Maryland

Virginia:

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

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

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other healthcare services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your covered family members live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2027

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 decrease for Self Only, Self Plus One, and Self and Family. See rates on back page of this brochure.
- Primary Care Physician (PCP) copay will increase from $25 to $30 for members 18 and over.
- Urgent Care copay will increase from $35 to $50. See page 57
- Prescription Drugs -
  - Retail pharmacy copay up to 30-day supply, increasing Tier 1 from $10 to $15, Tier 2 from $50 to $60, Tier 3 from $100 to $150, Tier 4 from $200 to $300 and GLP-1 for weight loss will increase from $100 to 50% coinsurance (up to maximum of $750).
  - Mail order copay 90-day supply, increasing Tier 1 from $30 to $45, Tier 2 from $150 to $180, Tier 3 from $300 to $450 and Tier 4 from $600 to $900, GLP-1 for weight loss will increase from $300 to 50% coinsurance (up to maximum of $1,875).
  - Specialty medication Tier 1 copay will increase from $10 to $25.
  - GLP-1 anti obesity medication coverage will change from Zepbound and Wegovy to Zepbound only.
- Allergy Care benefit will separate allergy testing from allergy treatment (allergy injections, including serum). Allergy testing will be covered in-network at $50 copay. See page 29, Section 5(a). Lab, X-ray and other diagnostic tests.
- Add a $500 copayment per trip for air ambulance. Ground ambulance coverage will remain with no cost share.
- Mental Health outpatient services such as electroconvulsive therapy, psychological testing, and medication-assisted treatment in-network will decrease from $25 copay to $0.
- Oral and maxillofacial surgery benefit will add a maximum benefit limit of $3,000 for Temporomandibular joint (TMJ) services. See page 46, Section 5(b).
- Add UHC Store, a consumer-centric, digital shopping experience available exclusively to UnitedHealthcare members via the UnitedHealthcare app and myuhc.com. UHC Store allows members to choose from a variety of health and wellness solutions at a discounted rate.
- Add Doula wellness benefit, allowance of up to $1,500 per pregnancy for certified doula support.
- Add Wondr Health - Wondr Health is a digital, evidence-based behavior change program designed to improve metabolic health and address the root causes of chronic conditions such as obesity.
- The Plan removed exception process that allowed members who were mid-treatment for diagnosed gender dysphoria to request continued coverage of otherwise excluded surgical or hormonal sex-trait modification services.
- Remove Maternity Health Solutions program.
- Remove Real Appeal program.
- Remove Sanvello/Self Care program by Able app.

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 M.D. IPA Federal Employees Health Benefits Program at P.O. Box 30432, Salt Lake City, UT 84130-0432. You may also print temporary ID Cards or request replacement cards through our member website: www.myuhc.com.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and/or coinsurance and you will not have to file claims.

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. All of our physicians are credentialed in accordance with the standards set by the National Committee for Quality Assurance (NCQA). For further information on our credentialing procedures, please contact our Customer Service Department at 1-877-835-9861.

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.

Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex, pregnancy or genetic information.

This Plan provides Care Coordinators for complex conditions and can be reached 1-877-835-9861 for assistance.

We list Plan providers in our Directory of Health Care Professionals which we update periodically. We do recommend you utilize the electronic version as it is more up to date than a published directory. The list is available on our Website at www.myuhc.com and www.uhcfeds.com. You can also contact our Customer Service Department at 1-877-835-9861 and they can perform a search for you.

- **Plan facilities**

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

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care provider (PCP). This decision is important since your PCP provides or arranges for most of your health care. **Contact customer care at 1-877-835-9861 for questions regarding to accessing care, prior authorization requirements and Behavioral Health services.**

To choose a PCP, check our *Directory of Health Care Professionals* or register on the member website, www.myuhc.com and follow the instructions to select a PCP. You may also call the Customer Service Department at 1-877-835-9861 and we will process your selection for you over the phone. Or, if you wish, you may complete the "Federal Information Form" included in your open season information packet and mail to us at P.O. Box 30778, Salt Lake City, UT 84130-0778 or fax to 1-248-733-6257.

- **Primary care**

Your primary care provider (PCP) can be an internist, an obstetrician/gynecologist for a woman, a pediatrician for a child, or a general/family practitioner for any member of the family. Your PCP will provide most of your healthcare, or give you a referral to see a specialist. As our network can change please be sure to ensure that the specialist is a provider in our network. You can do this by contacting customer service at 1-877-835-9861.

If you want to change primary care provider or if your primary care provider leaves the Plan, call us. We will help you select a new one. You may change your primary care provider (PCP) by submitting the "Federal Information Form", by mail to P.O. Box 30778, Salt Lake City, UT 84130-0778, by calling 1-877-835-9861, by faxing to 1-248-733-6257, or by submitting the change through the member website, www.myuhc.com. If we receive your request by the twentieth (20th) of the month, your change will become effective on the first day of the following month. If you change your PCP after the 20th of the month, the change will not be effective until the 1st day of the second month following the date of the change. For example, if you change your PCP on June 25, it would be effective August 1.

- **Specialty care**

Your primary care provider will refer you to a specialist for needed care. When you receive a referral from your primary care provider, you must return to the primary care provider after the consultation, unless your primary care provider authorized a certain number of visits without additional referrals. The primary care provider must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care provider gives you a referral.

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

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care provider will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals.

  Your primary care provider will create your treatment plan. The physician may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care provider. If they decide to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care provider, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

- You may continue seeing your specialist for up to 90 days if you are undergoing treatment for a chronic or disabling condition and you lose access to your specialist because:
  - we terminate our contract with your specialist for other than cause;
  - we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
  - we reduce our service area and you enroll in another FEHB Plan;
- Contact us at, 877-835-9861 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.

Note: If you lose access to your specialist because you changed your carrier or plan option enrollment, contact your new plan.

- **Hospital Care**

Your Plan 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 1-877-835-9861. 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 coverage.

If you change 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 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 day of enrollment.

You need preauthorization from your Plan for certain services

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

You must get preauthorization for certain services. Failure to do so may result in your claim being denied.

- **Inpatient hospital admission**

Preauthorization 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**

Your primary care provider (PCP) has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. All care must be arranged with Plan providers except for emergencies. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. Precertification is also required for members when Medicare is primary.

We call this review and approval process precertification. Your physician must obtain precertification for some services, such as, but not limited to the following services:

- ABA (Applied Behavioral Analysis)

- Air Ambulance (non-emergent)
- Angiomas/hemangioma (with pictures)
- Blepharoplasty (with pictures/visual fields)
- Bariatric surgery
- Breast implant removal, breast reconstruction for non-cancer diagnoses, breast reduction
- Capsule endoscopy
- Clinical trials, experimental services/new technologies, and virtual procedures
- Cochlear Implants
- Colonoscopy screening (virtual)
- Congenital anomaly repair
- Computed Tomography (CT) scans
- Coronary artery bypass graft
- Dental procedures in a facility, general anesthesia for dental procedures, dental services considered medical (not dental), except for fracture care and removal of cysts and tumors
- Dialysis
- Discectomy/fusion
- Durable medical equipment and cochlear implants
- Electro-convulsive therapy (ECT)
- Genetic testing for hereditary breast and/or ovarian cancer syndrome (HBOC)
- Growth hormone therapy (GHT) and continuous hormone replacement therapy
- Gynecomastia surgery
- Home care
- Hysterectomy
- Implanted Spinal cord stimulators for pain management
- Iatrogenic Infertility services
- Infertility Services
- Inpatient hospitalization
- Intensive Outpatient treatment
- Joint replacement (hip, knee, ankle, shoulder)
- Laminectomy/fusion
- Certain mental health and substance abuse services (including partial hospitalization)
- Morbid obesity surgery
- Magnetic resonance angiogram (MRA),
- Magnetic resonance imaging (MRI) (brain, chest, heart, musculoskeletal)
- Occupational therapy after the 8th visit
- Orthopedic and prosthetic devices
- Partial day hospitalization
- PET Scans (non-cancer diagnosis)
- Physical therapy after the eighth (8th) visit
- Psychological, neurophysiological and extended developmental testing
- Pulmonary rehabilitation

- Radiation therapy
- Reconstructive surgery
- Rhinoplasty/septo-rhinoplasty
- Sclerotherapy
- Sleep apnea - surgery & appliance (with sleep studies); sleep studies (polysomnograms)- attended
- Speech therapy after the 8th visit
- Substance Misuse services
- Temporomandibular disorder and/or related myofascial pain dysfunction(MDP) treatments
- Transplants
- Uvulopalatopharyngoplasty
- Vagus nerve stimulator
- Vein ablation
- Ventricular assist device
- Virtual colonoscopy screening

This list is subject to change upon notification to Plan providers. In addition, your admitting physician and facility must also preauthorize any elective inpatient stays. We suggest that you call the number on your ID card to verify if your services require preauthorization.

It is your PCP's or specialist's responsibility to obtain precertification/prior authorization for the procedures listed above before performing them. If the PCP or specialist does not do this, you will not be liable for the cost of covered services.

We will decide whether or not to precertify a procedure within two working days of the receipt of the information we need to make a decision.

If you are not satisfied with our decision, you, or your PCP or specialist on your behalf, may appeal the decision.

How to request preauthorization for an admission or get preauthorization 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 preauthorization are rendered. Please note that members with Medicare as primary are also required to follow the preauthorization process.

Next, provide the following information:

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

- **Non-urgent care claims**

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

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

- **Urgent care claims**

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

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 1-877-835-9861.

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 care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30-days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay or, if applicable, arrange for the 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 Cost 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 a primary care provider (PCP), you pay a copayment of $30 per office visit, and when you are admitted to the hospital, you pay $150 per day for up to 3-days per admission.
Deductible	We do not have a deductible.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Example: In our Plan, you pay 50% of our allowance for durable medical equipment.
Differences between our Plan allowance and the bill	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 (deductible, copayments and coinsurance) reaches the out-of-pocket maximum you do not have to pay any more for covered services, with the exception of certain cost sharing for the services below which do not count toward your catastrophic protection out-of-pocket maximum. Your out-of-pocket maximum for services rendered during the 2027 calendar year is: Self Only $5,000 in-network Self Plus One $10,000 in-network Self and Family $10,000 in-network ***The maximum annual limitation on cost sharing listed under Self Only of $5,000 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.*** Example Scenario: Your plan has a $5,000 Self Only maximum out-of-pocket limit and a $10,000 Self Plus One or $10,000 Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of $5,000 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket maximum of $10,000, an aggregate of other eligible family members will continue to contribute toward the out-of-pocket maximum up to the individual maximum of $5,000 or when qualified medical expenses for the family reaches the $10,000 maximum for the calendar year. 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: • Dental Discount benefits • Eyeglasses or contact lenses • Expenses for services and supplies that exceed the stated maximum dollar or day limit • Chiropractic services

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.

In addition, your health plan adopts and complies with the surprise billing laws of the State of Maryland.

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

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

- **Healthcare FSA (HCFSA)** – Reimburses an FSA participant for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, over-the-counter drugs and medications, vision and dental expenses, and much more) for their tax dependents, and their 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

See Section 2 for how our benefits changed this year.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals 28
Diagnostic and treatment services 28
Virtual visits 29
Lab, X-ray and other diagnostic tests 29
Preventive care, adult 29
Preventive care, children 31
Maternity care 32
Family planning 33
Infertility services 34
Allergy care 36
Treatment therapies 36
Physical and occupational therapies 36
Speech therapy 37
Habilitative therapies 37
Hearing services (testing, treatment, and supplies) 37
Vision services (testing, treatment, and supplies) 37
Foot care 38
Orthopedic and prosthetic devices 38
Durable medical equipment (DME) 39
Home health services 41
Chiropractic 42
Alternative treatments 42
Educational classes and programs 42
Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals 44
Surgical procedures 44
Bariatric Surgery (Surgical Treatment of Morbid Obesity) 45
Reconstructive surgery 45
Oral and maxillofacial surgery 46
Organ/tissue transplants 47
Anesthesia 52
Section 5(c.). Services Provided by a Hospital or Other Facility, and Ambulance Services 53
Inpatient hospital 53
Outpatient hospital or ambulatory surgical center 54
Extended care benefits/Skilled nursing care facility benefits 54
Hospice care 54
Ambulance 55
Section 5(d). Emergency Services/Accidents 56
Emergency within or outside our service area 57
Ambulance 57
Section 5(e). Mental Health and Substance Use Disorder Benefits 58
Professional services 58
Diagnostics 59
Inpatient hospital or other covered facility 59
Outpatient hospital or other covered facility 59
Not Covered 59

Section 5(f). Prescription Drug Benefits 60
Preventive care medications 63
Covered medications and supplies 63
Section 5(g). Dental Benefits 66
Accidental injury benefit 66
Adjunctive dental services 67
Non-dental oral surgery 68
Dental anesthesia 68
Dental anesthesia and associated facility charges 69
Section 5(h). Wellness and Other Special features 70
UnitedHealthcare's Digital Experience 70
Myuhc.com Behavioral Health Resources 71
Smoking cessation program 71
UHC Rewards and One Pass 71
UHC Store: Expanding Consumer Choice Through a Personalized Digital Health Marketplace 72
Wondr Health, a Digital Lifestyle & Behavior Change Program 73
Calm Health App 73
UnitedHealth Premium 73
Specialty Pharmacy 74
Cancer Clinical Trials 74
Summary of Benefits for the High Option of M.D. IPA - 2027 96
2027 Rate Information for MD IPA 98

Section 5. High Option Benefits Overview

This Plan is a High Option plan. Benefits are described in Section 5. Make sure that you review the benefits that are available.

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

High Option Benefits	You pay
Medical services provided by physicians: Routine preventive care	Nothing
Medical services provided by physicians: Diagnostic and treatment services provided in the office/telehealth	Office visit copayment: $30 primary care provider ages 18 and older; $0 through age 17; Office visit copayment: $40 specialist
Medical services provided through Virtual Visits	Use virtual visits when: • Your doctor is not available • You become ill while traveling • Conditions such as: cold, flu, bladder infection, bronchitis, diarrhea, fever, pink eye, rash, sinus problem, sore throat, stomachache 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. You pay: $0 copayment per visit with Designated provider.
Urgent Care	$50 copayment
Services provided by a hospital: Inpatient	$250 per day up to 3-days per admission
Outpatient Surgery	You pay $150 per visit to an approved free standing facility or $300 per visit to a hospital based facility
Emergency benefits: In-area or out-of-area	You pay: $350 copayment per emergency room visit, waived if admitted
Mental health and substance use treatment	Regular cost-sharing
Prescription drugs at retail (30-day supply)	You pay: Tier-1 $15 copayment; Tier-2 $60 copayment; Tier-3 $150 copayment; Tier-4 $300 copayment GLP-1s for weight loss: 50% coinsurance (up to a maximum of $750)
Prescription drugs for Maintenance Medications:(90-day supply)	You pay : Tier-1 $45 copayment, Tier-2 $180 copayment, Tier-3 $450 copayment, Tier-4 $900 copayment GLP-1s for weight loss: 50% coinsurance (up to a maximum of $1,875)

High Option Benefits	You pay
Specialty Drugs **30 Day supply at Designated Specialty Pharmacy**	Tier 1- $25 copayment, Tier 2- $150 copayment, Tier 3- $350 copayment, Tier 4- $500 copayment
Dental care	Accidental Injury, Discount Dental and Non-FEHB PPO Preventive care
Vision care	$40 copayment for an annual eye refraction exam; Hardware - see Non FEHB Benefits Page
Special Features	See Section 5(h) for detailed information on available programs and features

UnitedHealthcare Retiree Advantage Plan (if selected)

Medical Benefit - UnitedHealthcare Retiree Advantage Plan (if selected)	Member Pays	Brochure Section
Deductible	No Deductible	Section 9
Primary Care Physician Visit	Nothing	Section 9
Preventive Care	Nothing	Section 9
Specialist visit	Nothing	Section 9
Virtual Visit	Nothing	Section 9
Urgent Care	Nothing	Section 9
Emergency Room	Nothing	Section 9
Pharmacy (30-day supply)	Tier 1 - $5 Tier 2 - $25 Tier 3 - $60 Tier 4 - $90	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.

*Note: 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.

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.
- Plan physicians must provide or arrange your care.
- We have no deductible.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- Please read *Important things you should keep in mind* at the beginning of the subsections. Also read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also read the general exclusions in Section 6; they apply to the benefits in the previous subsections.
- **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 MD IPA 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.)
- 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	**You pay**
Professional services of physicians • In physician's office/telehealth/Optum primary care • Office medical consultations • Second surgical opinion • Advanced care planning • At home	$0 per office visit to your primary care provider (PCP) for children under age 18. $30 per office visit to your primary care provider ages 18 and up $40 per visit to your specialist
Professional services of physicians • In an emergency room • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child	$0

Benefit Description	
Virtual visits	**You pay**
Use virtual visits when : • Your doctor is not available • You become ill while traveling • Conditions such as: cold, flu, bladder infection, bronchitis, diarrhea, fever, pink eye, rash, sinus problem, sore throat, stomachache 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 per visit
Lab, X-ray and other diagnostic tests	**You pay**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG	You pay nothing if you receive these services during your office visit; otherwise, $30 per visit to your PCP ages 18 and above $40 per specialist visit $50 per outpatient non-surgical visit
• CT Scans/MRI • PET Scans • Nuclear Medicine	$100 per outpatient non-surgical visit
Preventive care, adult	**You pay**
Routine annual physical every year The following preventive services are covered at the time interval recommended at each of the links below: • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. For a complete list of screenings go to the website at https ://www. uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks	$0

Preventive care, adult - continued on next page

Benefit Description	
Preventive care, adult (cont.)	**You pay**
• 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 go to the Health and Human Services (HHS) website at https ://www. hrsa.gov/womens-guidelines • To build your personalized list of preventive services go to https:// health.gov/myhealthfinder	$0
One annual biometric screening, to include age appropriate screenings such as : • Body mass index (BMI) • Blood pressure • Lipid/cholesterol levels • Glucose/hemoglobin A1C measurement Note: Services must be coded by your doctor as preventive to be covered in full. Members can access the HRA (Health Risk Assessment) on www. myuhc.com.	$0
Routine mammogram	$0
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. Routine use of adult immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) and adopted by the Centers for Disease Control and Prevention (CDC) are covered. A recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention. For the current immunization schedule, visit https ://www. cdc.gov/vaccines/imz-schedules/index.html 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 copayment, coinsurance and deductible.	$0 $0
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy, • Family centered programs when medically identified to support obesity prevention and management by an in-network provider. Note: When anti-obesity medication is prescribed. See Section 5(f)	$0

Preventive care, adult - continued on next page

Benefit Description	
Preventive care, adult (cont.)	**You pay**
Note: When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b)	$0
Not covered: • *Physical exams and immunizations 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*
Preventive care, children	**You pay**
• Well-child visits, examinations and other preventive services as described in the Bright Future Guidelines 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. For preventive immunizations see guidance below. • Routine use of children's immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) schedule and adopted by the Centers for Disease Control and Prevention (CDC) are covered. A recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention. For the current immunization schedule, visit https ://www. cdc.gov/vaccines/imz-schedules/index.html • You may also find a complete list of U.S. Preventive Services Task Force (USPSTF) A and B recommendations 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
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy, • Family centered programs when medically identified to support obesity prevention and management by an in-network provider. Note: When anti-obesity medication is prescribed. See Section 5(f) Note: When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b)	$0

Benefit Description	
Maternity care	**You pay**
Complete maternity (obstetrical) care, such as: • Prenatal and Postpartum care • Screening for gestational diabetes • Bacteriuria screening • Delivery • Screening and counseling for prenatal and postpartum depression • Breastfeeding and lactation support, supplies and counseling for each birth Notes: You do not need to precertify your vaginal delivery; see Section 3 for other circumstances, such as extended stays for you or your baby. • As part of your coverage, you have access to in-network Certified Nurse Midwives (CNM), Certified Midwives (CM), home nurse visits and board-certified lactation specialists during the prenatal and post-partum period. • 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 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. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). 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. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits.	$0 for routine prenatal care $30 PCP office visit $40 specialist visit for all postpartum visits thereafter. $0 visit to certified nurse midwives
Doula Wellness Benefit This benefit provides coverage for certified doula support services with an allowance of up to $1,500 per pregnancy, paid at 100% with no deductible. Covered services include: • Up to 8 total hours of prenatal and/or postnatal support • One labor and delivery visit • Services provided within 12 months of diagnosis Doula support includes, but is not limited to: • Social determinants of health assessments • Evidence-based education • Birth plan development	$0

Maternity care - continued on next page

Benefit Description	
Maternity care (cont.)	**You pay**
• Referrals to social services • Communication support and advocacy • Labor coaching • Family support during the perinatal period	$0
Not covered: • *Routine sonograms to determine fetal age, size or sex.*	*All charges*
Family planning	**You pay**
A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories in the HRSA supported guidelines. This list includes: • Voluntary female sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragms Note: See additional Family Planning and Prescription drug coverage in Section 5(f). Note: Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below. 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. To request an exception, please call customer service at 877-835-9861 Once we have been contacted with exception request information sufficient for us to make a determination, you will receive a response within 24 hours or the next business day. Contraceptive exception requests are not subject to Section 8. The Disputed Claims Process. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov.	$0
Voluntary male sterilization	$30 per PCP office visit $40 per specialist visit
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling not outlined above*	*All charges*

Benefit Description	
Infertility services	**You pay**
Diagnosis and treatment of the cause of infertility	$30 per PCP visit $40 Specialist Visit
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. Covered benefits include the following procedures: • Intravaginal insemination (IVI) • Intracervical insemination (ICI) • Intrauterine insemination (IUI) • In-Vitro Fertilization (IVF) services as follows: 3 Complete oocyte retrievals with unlimited embryo transfers from those oocyte retrievals. Medical costs related to an embryo transfer to be made from an enrollee to a third-party; except, that the enrollee's coverage shall not extend to any medical costs of the surrogate or gestational carrier after the embryo transfer procedure. • Drugs used in conjunction with ART • Collection of sperm • Cryopreservation of sperm • Oocyte cryopreservation • Embryo cryopreservation • Ovarian stimulation, retrieval of eggs and fertilization • Embryo transfer • Gamete Intrafallopian Transfer (GIFT) • Zygote Intrafallopian Transfer (ZIFT) • Intracytoplasmic sperm injection (ICSI) • Services, procedures, and/or supplies that are related to ART and/or assisted insemination procedures • Cryopreservation or storage of sperm (sperm banking), eggs, or embryos, donor sperm and related costs, donor eggs and related costs except for those services included in the iatrogenic infertility services (Section 5a) • Preimplantation diagnosis, testing, and/or screening, including the testing or screening of eggs, sperm, or embryos except for those services included in the iatrogenic infertility services benefit (Section 5a) Fertility drugs see Section 5(f) Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	50% coinsurance of the plan allowance

Infertility services - continued on next page

Benefit Description	
Infertility services (cont.)	**You pay**
Note: Prior Authorization required	50% coinsurance of the plan allowance
Not Covered: • *Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue (**Note**: Short Term storage under one year may be eligible for benefits.)* • *Infertility treatment when the cause of the Infertility was a procedure that produces sterilization, e.g., vasectomy or tubal ligation* • *In-vitro fertilization that is not an assisted reproductive technology for the treatment of Infertility; this would include but is not limited to elective fertility preservation, embryo accumulation/banking* • *Services, supplies, or drugs provided to individuals not enrolled in this Plan* • *medical costs of the surrogate or gestational carrier after the embryo transfer procedure*	*All charges*
Iatrogenic Infertility Services	**You pay**
Coverage is available for fertility preservation for medical reasons that cause irreversible infertility such as surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes. Fertility preservation for iatrogenic infertility: • Procurement of sperm or eggs including medical, surgical, and pharmacy claims associated with retrieval; • Cryopreservation of sperm and mature oocytes; and • Cryopreservation storage costs for one year(s). Prior authorization is required. Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit. Note: If members change their FEHB enrollment, UnitedHealthcare will not renew storage payment after yearly increment expires	$40 per specialist visit $150 copayment per outpatient surgical visit as an approved free-standing surgical facility $300 per outpatient surgical visit at a hospital based facility
Not covered • *Long-term storage costs (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue* • *Elective fertility*	*All charges*

Benefit Description	
Allergy care	**You pay**
• Allergy testing	$50 per outpatient non-surgical visit
• Allergy treatment • Allergy injections - including serum	$30 per primary care provider visit for age 18 and older; $0 for under 18 $40 per specialist visit
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	**You pay**
• Intravenous Chemotherapy • Radiation oncology Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants in Section 5(b). • Respiratory and inhalation therapy (pulmonary rehabilitation) is provided for up to 20 visits per year • Cochlear therapy following implant -30 visits per year • Cardiac rehabilitation following qualifying event/condition is provided for up to 36 sessions in an outpatient setting. Not covered in inpatient setting. • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: We only cover Growth Hormone Therapy 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 Other services under You need prior Plan approval for certain services in Section 3.	$30 per PCP visit $20 per home health care visit $40 per specialist visit $50 when received in outpatient facility visit
Physical and occupational therapies	**You pay**
60 visits per year, for rehabilitative/habilitative services of the following: • Qualified physical therapists • Occupational therapists 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 • indicates the length of time the services are needed	$40 per specialist visit $50 per outpatient non-surgical visit $0 per visit during covered inpatient admission

Physical and occupational therapies - continued on next page

Benefit Description	
Physical and occupational therapies (cont.)	**You pay**
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs, gym or pool memberships* • *Work hardening/functional capacity programs or evaluations* • *Voice therapy*	*All charges*
Speech therapy	**You pay**
Up to 60 visits per year for speech therapy.	$40 per specialist visit $50 per outpatient non-surgical visit
Habilitative therapies	**You pay**
Habilitative Services - There are no visit limits for these services for children ages 0-21 with congenital or genetic birth defects. Treatment is provided to enhance the child's ability to function. A congenital disorder means a significant structural or functional abnormality that was present from birth. Services include: • Speech therapy • Occupational therapy; and • Physical therapy	$40 per specialist visit $50 per outpatient non-surgical visit
Hearing services (testing, treatment, and supplies)	**You pay**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist • Hearing aid examinations for children under 19; hearing aids covered under *Durable Medical Equipment* • Implanted hearing-related devices, such as bone anchored hearing aids and cochlear implants Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.* Note: Routine hearing screenings for children age 17 and under are included as part of children's preventive care at no charge.	$30 per PCP visit $40 per Specialist visit
Not covered: • *Hearing aids, except as covered for children under Durable Medical Equipment in this section or bone anchored hearing aids under Orthopedic and Prosthetic devices in this section*	*All charges*
Vision services (testing, treatment, and supplies)	**You pay**
Diagnosis and treatment of diseases of the eye	$30 per PCP visit $40 per Specialist visit
One pair of eyeglasses or contact lenses per surgical event to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	50% coinsurance of the plan allowance
Annual basic eye refraction exam to provide a written lens prescription Note: You do not have to obtain a referral from your PCP for this service	$40 per specialist visit

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

Benefit Description	
Vision services (testing, treatment, and supplies) (cont.)	**You pay**
Note: Routine vision screens for children age 17 and under are covered as preventive care with no copayment or coinsurance.	$40 per specialist visit
Not covered: • *Eyeglasses, contact lenses or related contact fittings except initial pair for accidental ocular injury or intraocular surgery* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	**You pay**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$30 per PCP visit $40 per Specialist visit
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 (except for surgical treatment)*	*All charges*
Orthopedic and prosthetic devices	**You pay**
• Artificial limbs and eyes • Prosthetic sleeve or sock • External lenses following cataract removal • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Enteral equipment and supplies • Urinary catheters (indwelling and intermittent) catheters for incontinence or retention • Covered ostomy supplies • Orthotic braces and splints not available over-the-counter that straighten or change the shape of a body part • Surgical dressings not available over-the-counter; (see Durable medical equipment) • A hair prosthesis for hair loss resulting from chemotherapy or radiation treatment for cancer. There is a limit of one hair prosthesis per lifetime with a maximum cost of $350. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. • Bone-anchored hearing aids, 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	50% coinsurance of the plan allowance

Orthopedic and prosthetic devices - continued on next page

Benefit Description	
Orthopedic and prosthetic devices (cont.)	**You pay**
• Corrective orthotic appliances for non-dental treatment of temporomandibular disorder (TMD) and/or Myofascial Pain Dysfunction (MPD). 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 a certain device is covered. Internal prosthetic devices are paid as hospital benefits. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(*c*) Services provided by a hospital or other facility, and ambulance services.	50% coinsurance of the plan allowance
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 3 years after the last one we covered (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 splits* • *Deodorants, filters, lubricants, tape, appliance cleaners, adhesive and adhesive removers related to ostomy supplies*	*All charges*
Durable medical equipment (DME)	**You pay**
We cover rental or purchase of prescribed durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks) • Dialysis equipment • Negative pressure wound therapy pumps (wound vacuums) • Burn garments • Standard hospital beds • Wheelchairs • Crutches • Walkers • Blood glucose monitors (some meters provided at no charge)	50% coinsurance of the plan allowance

Durable medical equipment (DME) - continued on next page

Benefit Description	
Durable medical equipment (DME) (cont.)	**You pay**
• Insulin pumps and insulin pump supplies • CPAP for sleep apnea • Surgical dressings not available over-the-counter • Therapeutic shoes for diabetics • Covered CPAP supplies • Braces, including necessary adjustments to shoes to accommodate braces, which are used for the purpose of supporting a weak or deformed body part • Braces restricting or eliminating motion in a diseased or injured part of the body Note: Most durable medical equipment must be preauthorized. Call us at 1-877-835-9861 if your Plan physician prescribes this equipment and you need assistance locating healthcare provider to rent or sell you durable medical equipment. You may also call us to see if a certain piece of equipment is covered.	50% coinsurance of the plan allowance
Hearing aids for children under age 19, prescribed, fitted and dispensed by a licensed audiologist	50% coinsurance of the plan allowance up to $1,400 per ear every 36 months, and you pay all charges exceeding $1,400
Not covered: • *Power-operated vehicles* • *Duplicate or backup equipment* • *Parts and labor costs for supplies and accessories replaced due to wear and tear such as wheelchair tires and tubes* • *Educational, vocational, or environmental equipment* • *Deluxe or upgraded equipment and supplies* • *Home or vehicle modifications, seat lifts* • *Over-the-counter medical equipment and supplies* • *Activities of daily living aids (such as grab bars and utensil holders)* • *Personal hygiene equipment* • *Paraffin baths, whirlpools, and cold therapy* • *Infertility monitors* • *Physical fitness equipment* • *Hearing aids for those over 19 years old* • *Continuous pulse oximetry unless skilled nursing is involved in home care and it is part of their medically necessary equipment* • *Medical supplies such as dressings and antiseptics*	*All charges*

Benefit Description	
Home health services	**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. Services include oxygen therapy, intravenous therapy and medications. - 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 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 • Provided on a part-time, Intermittent Care schedule • One visit equals up to four hours of skilled care services • The visit limit does not include any service which is billed only for the administration of intravenous • We will determine if benefits are available by reviewing both the skill nature of the service and the need for Physician directed medical management. A service will not be determined to be skilled simply because there is not an available • Limit of 60 visits per year • Enteral Nutrition - Benefits are provided for enteral formulas administered either orally or by tube feeding for certain conditions under the direction of a Physician.	$20 per home health care visit
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Private duty nursing* • *Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to specialized enteral formula or medically necessary foods for which Benefits are provided as described under Enteral Nutrition.*	*All charges*

Benefit Description	
Chiropractic	**You pay**
Benefits for Chiropractic services are limited to $500 per calendar year.	50% coinsurance of the plan allowance up to the maximum benefit and all charges thereafter
Alternative treatments	**You pay**
• Acupuncture - provided by a Doctor of Medicine or osteopathy, or licensed or certified acupuncture practitioner in an office setting for: - Dry Needling – by a licensed or certified practitioner • Biofeedback for pain management, migraine treatment, bowel training and pelvic floor training for urinary incontinence Up to twelve (12) visits per calendar year for postoperative and chemotherapy nausea and vomiting, nausea of pregnancy, postoperative dental pain and as part of a comprehensive treatment program for chronic pain	$40 per specialist visit
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Massage therapy* • *Herbal medicine* • *Homeopathy* • *Rolfing* • *Ayurveda* • *Other alternative treatments unless specifically listed as covered*	*All charges*
Educational classes and programs	**You pay**
Childbirth education classes: When you complete the childbirth education class, submit a copy of the certificate of completion with the dates attended, as well as a copy of your canceled check or receipt to the claims submission address shown on the back of your ID Card.	We will reimburse up to $50 for childbirth education classes
Coverage is provided for: Tobacco cessation program to include counseling and over the counter and prescription drugs approved by the FDA (subject to age and treatment therapy recommendations) to treat nicotine tobacco dependence. Learn more about this program in Section 5(h) Wellness and other Special Features.	$0 for counseling for up to two quit attempts per year. $0 for OTC and prescription drugs approved by the FDA to treat tobacco dependence.
Diabetes self-management classes: • Outpatient self-management training for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin using diabetes. • Must be prescribed by a licensed healthcare professional who has appropriate state licensing authority • Outpatient self management training includes, but is not limited to, education and medical nutrition therapy. The training must be provided by a certified registered or licensed healthcare professional trained in the care and management of diabetes.	$30 per PCP visit $40 per specialist visit $50 outpatient non-surgical in hospital.

Educational classes and programs - continued on next page

Benefit Description	
Educational classes and programs (cont.)	**You pay**
• Includes medical eye examination (dilated retinal exams) and preventive foot care for diabetes • Initial training visit; up to 10 hours, after you are diagnosed with diabetes for the care and management of diabetes	$30 per PCP visit $40 per specialist visit $50 outpatient non-surgical in hospital.

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.
- Plan physicians must provide or arrange your care.
- We have no deductible.
- Be sure to read Section 4, Your Costs for Covered Services, for valuable information about how cost-sharing works. Also, read Section 9, Coordinating benefits with other coverage, including with Medicare.
- In certain geographic areas, the Health Plan has designated Centers for Cardiac Surgery, Ambulatory Surgery, Transplants and Joint Replacement.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(*c*) for charges associated with a 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 MD IPA 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	**You pay**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Routine pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Insertion of internal prosthetic devices See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Treatment of burns Note: For female surgical family planning procedures see Family Planning Section 5(a) Note: For male surgical family planning procedures see Family Planning Section 5(a)	$40 per specialist visit $150 copayment per outpatient surgical visit as an approved free-standing surgical facility $300 per outpatient surgical visit at a hospital based facility

Surgical procedures - continued on next page

Benefit Description	
Surgical procedures (cont.)	**You pay**
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.	$40 per specialist visit $150 copayment per outpatient surgical visit as an approved free-standing surgical facility $300 per outpatient surgical visit at a hospital based facility
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; (see Section 5(a) Foot care)*	*All charges*
Bariatric Surgery (Surgical Treatment of Morbid Obesity)	**You pay**
Surgical treatment of obesity when provided by or under the direction of a Physician when either of the following criteria is met: • You have a body mass index (BMI) of greater than 40. • You have a body mass index (BMI) of greater than 35 with complicating coexisting medical conditions or diseases (such as sleep apnea or diabetes) directly related to, or made worse by, obesity. Enrollment in Bariatric Resource Services (BRS) and selecting a Center of Excellence (COE) facility for surgery is mandatory for network benefits. If you do not enroll in BRS prior to surgery and select a BRS COE facility for surgery benefits will not be covered. To enroll in BRS, contact 888-936-7246.	$40 per specialist visit $150 copayment per outpatient surgical visit as an approved free-standing surgical facility $300 per outpatient surgical visit at a hospital based facility
Not covered: *• Panniculectomy, unless medically necessary* *• Second bariatric surgery unless there are complications; or as part of a two-stage procedure for people with BMI 50 kg/m2 prior to first bariatric procedure*	*All charges*
Reconstructive surgery	**You pay**
Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance, and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. Your physician must precertify repair of congenital anomalies. • All stages of breast reconstruction surgery following a mastectomy, such as:	$40 per specialist visit $150 copayment per outpatient surgical visit as an approved free-standing surgical facility $300 per outpatient surgical visit at a hospital-based facility

Reconstructive surgery - continued on next page

Benefit Description	
Reconstructive surgery (cont.)	**You pay**
- surgery to produce a symmetrical appearance on the other breast - treatment of any physical complications, such as lymphedemas - breast prostheses and surgical bras and replacements (see Section 5(a) *Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$40 per specialist visit $150 copayment per outpatient surgical visit as an approved free-standing surgical facility $300 per outpatient surgical visit at a hospital-based facility
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury (See Section 5(d) Accidental injury)* • *Surgery for Sex-Trait Modification to treat gender dysphoria*	*All charges*
Oral and maxillofacial surgery	**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; facial defects due to congenital syndromes such as cleft lip/cleft palate, Crouzon's and Pierre-Robin's • 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 **Note:** We will only cover these services when we preauthorize the treatment. See *Services requiring our prior approval* in Section 3. See page 65 under Section 5(g) for non-dental oral surgery.	$40 per specialist visit $150 per visit to an approved free standing facility $300 per visit to a hospital based facility
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.	$40 per specialist visit $150 per visit to an approved free standing facility $300 per visit to a hospital based facility

Oral and maxillofacial surgery - continued on next page

Benefit Description	
Oral and maxillofacial surgery (cont.)	**You pay**
Benefits for surgical services include: • Arthrocentesis. • Arthroscopy. • Arthroplasty. • Arthrotomy. • Open or closed reduction of dislocations. $3,000 Limit for all benefits related to TMJ	$40 per specialist visit $150 per visit to an approved free standing facility $300 per visit to a hospital based facility
Not covered: • *Oral implants and transplants 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)* • *Surface electromyography* • *Doppler or vibration analysis;* • *Computerized mandibular scan or jaw tracking;* • *Craniosacral therapy;* • *Dental restoration, orthodontics or occlusal adjustment*	*All charges*
Organ/tissue transplants	**You pay**
These **solid organ and tissue transplants** are covered and 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 liver - Small intestine with multiple organs, such as the liver, stomach and pancreas] • Kidney • Kidney-pancreas • Liver • Lung: single/bilateral/lobar • Pancreas	$150 per outpatient surgical visit at an approved free-standing surgical facility $300 per outpatient surgical visit at hospital.
These **tandem blood 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	$40 per specialist visit $150 per outpatient surgical visit at an approved free-standing surgical facility $300 per outpatient surgical visit at hospital.

Organ/tissue transplants - continued on next page

Benefit Description	
Organ/tissue transplants (cont.)	**You pay**
- AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	$40 per specialist visit $150 per outpatient surgical visit at an approved free-standing surgical facility $300 per outpatient surgical visit at hospital.
Blood or marrow stem cell transplants **The plan extends coverage for the diagnoses as indicated below:** • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - 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, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo'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	$40 per specialist visit $150 per outpatient surgical visit at an approved free-standing surgical facility $300 per outpatient surgical visit at hospital.

Organ/tissue transplants - continued on next page

Benefit Description	
Organ/tissue transplants (cont.)	**You pay**
- 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 - Multiple myeloma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	$40 per specialist visit $150 per outpatient surgical visit at an approved free-standing surgical facility $300 per outpatient surgical visit at hospital.
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 (MPDs) - 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	$40 per specialist visit $150 per outpatient surgical visit at an approved free-standing surgical facility $300 per outpatient surgical visit at hospital.

Organ/tissue transplants - continued on next page

Benefit Description	
Organ/tissue transplants (cont.)	**You pay**
- Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	$40 per specialist visit $150 per outpatient surgical visit at an approved free-standing surgical facility $300 per outpatient surgical visit at hospital.
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 if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneurophy (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 - Myelodysplasia / Myelodysplastic syndromes	$40 per specialist visit $150 per outpatient surgical visit at an approved free-standing surgical facility $300 per outpatient surgical visit at hospital.

Organ/tissue transplants - continued on next page

Benefit Description	
Organ/tissue transplants (cont.)	**You pay**
- Myeloproliferative disorders (MDDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for: - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin's lymphoma - Breast cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma(CLL/SLL) - Chronic myelogenous leukemia - Early state (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis National Transplant Program (NTP) - OptumHealth Care Solutions (URN) used for organ tissue transplants. Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient. Transplants must be provided in a Plan designated Center for Transplants. These centers do a large volume of these procedures each year and have a comprehensive program of care. A listing of these Centers can be found in the Plan Directory of Health Care Providers, at our member web site www. myuhc.com, or call our Customer Service Department at 1-877-835-9861 to request an up-to-date listing.	$40 per specialist visit $150 per outpatient surgical visit at an approved free-standing surgical facility $300 per outpatient surgical visit at hospital.

Organ/tissue transplants - continued on next page

Benefit Description	
Organ/tissue transplants (cont.)	**You pay**
Donor testing for bone marrow/stem cell transplants for up to 4 potential donors whether family or non-family	50% coinsurance of the plan all
Not covered: • *Donor screening tests (beyond 4 potential donors) and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered* • *All services related to non-covered transplants* • *All services associated with complications resulting from the removal of an organ from a non-member*	*All charges*
Anesthesia	**You pay**
Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	$0

Section 5(c.). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no deductible.
- Be sure to read Section 4, *Your Costs for Covered Services* for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with other coverage*, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST 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 MD IPA 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	
Inpatient hospital	**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.	$250 per day for up to 3 days per admission
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • 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	$0
Not covered and not covered under extended care:	*All charges*

Inpatient hospital - continued on next page

Benefit Description	
Inpatient hospital (cont.)	**You pay**
• *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*
Outpatient hospital or ambulatory surgical center	**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 products, derivatives and components, artificial blood products and biological serum • 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.	$50 per outpatient non-surgical visit $150 outpatient surgical at an approved free-standing surgical facility visit $300 per at outpatient surgical hospital visit
Extended care benefits/Skilled nursing care facility benefits	**You pay**
Extended care benefit: Skilled nursing facility (SNF): All necessary services provided for up to 60-days per calendar year in a skilled nursing facility when full-time nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan physician and approved by the Plan. Services include: • Bed, board and general nursing care • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan physician	$0 if transferred from inpatient facility or $250 per day up to 3 days per admission if not transferring directly from an inpatient facility
Not covered: • *Custodial care* • *Rest cures, domiciliary or convalescent care* • *Personal comfort items, such as phone, television, barber services, guest meals and beds*	*All charges*
Hospice care	**You pay**
Supportive or palliative care for a terminally ill member in the home or hospice facility. These services are provided under the direction of a Plan physician who certifies that you are in the terminal stages of illness, with a life expectancy of approximately six (6) months or less. Must be received from a licensed hospice agency. Services include: • In home care or hospice facility • Family counseling	$0 if transferred from inpatient facility or $250 per day up to 3 days per admission if not transferring from an inpatient facility.

Hospice care - continued on next page

Benefit Description	
Hospice care (cont.)	**You pay**
• Social, spiritual and respite care for the terminally ill patient • Short-term grief counseling for immediate family members.	$0 if transferred from inpatient facility or $250 per day up to 3 days per admission if not transferring from an inpatient facility.
Not covered: • *Private duty nursing and homemaker services*	*All charges*
Ambulance	**You pay**
Non-Emergency ambulance transportation by a licensed ambulance service 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. • 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 air 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.	$500 copayment for air ambulance $0 ground ambulance
Not Covered: • *International Transportation*	*All charges*

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- We have no deductible.
- Be sure to read Section 4, Your Costs for Covered Services, for valuable information about how cost sharing works.
- 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 MD IPA 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 Provider. 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 Provider within 48 hours, unless it was not reasonably possible to notify us within that time. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify us within that time. If you are hospitalized in a non-Plan facility and Plan physicians believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full, unless the Plan physician or health care practitioner believes this would result in death, disability or significant jeopardy to your condition. To be covered by this Plan, any follow-up care recommended by non-Plan physicians or health care practitioners must be approved by the Plan or provided by Plan physicians or health care practitioners.

Benefit Description	
Emergency within or outside our service area	**You pay**
• Emergency care at a doctor's office	$30 per PCP visit for ages 18 and older, no PCP copayment for children through age 17 $40 per Specialist visit;
• Emergency care at an urgent care center	$50 per urgent care center visit
• Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital	$350 per emergency room hospital visit, waived if admitted, then the inpatient hospital copay applies
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	**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. Note: See 5(*c*) for non-emergency ambulance service.	$500 copayment for air ambulance $0 for ground ambulance
Not Covered: • *International Transportation*	*All charges*

Section 5(e). Mental Health and Substance Use Disorder 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.
- We have no deductible.
- Once you have been referred for mental health services, you will have an unlimited number of visits in a 12 month period for most mental health services.
- Go to www. myuhc.com to find a list of mental health and substance abuse practitioners. Click on "Physicians & Facilities" and then click on "Find Mental Health Clinicians".
- 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.
- Contact 877-835-9861 for any questions on these benefits.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- Some services may require preauthorization, please refer to the preauthorization information shown in Section 3 or call customer service to be sure which services require preauthorization.
- 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.
- If you enroll in MD IPA 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	**You pay**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for medical illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of substance use disorders, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting	$25 copayment

Professional services - continued on next page

Benefit Description	
Professional services (cont.)	**You pay**
• Intensive Behavioral Therapy, including Applied Behavioral Analysis (ABA), commonly used for autism spectrum disorder	$0
• Electroconvulsive therapy • Psychological testing • Medication Assisted Treatment (MAT)	$0
Diagnostics	**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	$25 per office visit $0 per outpatient non-surgical visit
Inpatient hospital or other covered facility	**You pay**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Inpatient diagnostic tests provided and billed by a hospital or other covered facility • Residential Treatment	$250 per day (up to $750 max) for inpatient admission
Outpatient hospital or other covered facility	**You pay**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, day treatment or facility-based intensive outpatient treatment	$0
Not Covered	**You pay**
Not Covered: • *Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan physician to be necessary and appropriate* • *Services and supplies when paid for directly or indirectly by a local, state, or Federal Government agency* • *Room and board at therapeutic boarding schools* • *Services rendered or billed by schools* • *Methadone maintenance for substance use unless part of our treatment program.* • *Services that are not medically necessary*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescription medications, as described in the chart beginning on the next page. Some injectable medications are provided by your medical benefit. Please see below for more information.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary. Some prescription medications have Quantity Level Limits (QLL) and Quantity per Duration Limits (QD). Please refer to the next page for more information.
- Federal or state laws may prevent the pharmacy from accepting unused drugs.
- Your prescribers must obtain preauthorization for certain prescription drugs and supplies before coverage applies. A preauthorization must be renewed periodically.
- We have no deductible.
- Drugs requiring preauthorization may be limited to quantities prescribed in accordance to acceptable practice standards in the United States.
- 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.
- A PDP EGWP provides prescription drug coverage only, while an MAPD EGWP combines prescription drug, physician, and hospital coverage. Enrollees are encouraged to review their options under the plan to choose what best serves their needs as the PDP EGWP or MAPD EGWP may not offer the same coverage or pricing.
- If you enroll in MD IPA 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.)
- **The exclusion for hormone treatments for Sex-Trait Modification for gender dysphoria** only pertains to chemical and surgical modification of an individual's sex traits (including as part of "gender transition" services). **We do not exclude coverage for entire classes of pharmaceuticals,** e.g., GnRH agonists may be prescribed during IVF, for reduction of endometriosis or fibroids, and for cancer treatment or prostate cancer/tumor growth prevention.

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

- **Who can write your prescription:** A licensed physician or dentist, and in some 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, go to www. myuhc.com, www. uhcfeds.com or call our Customer Service Department 877-835-9861.
- **We use a formulary.** We cover non-formulary drugs prescribed by a Plan doctor.
- **We have a managed Formulary/Prescription Drug List (PDL):** Our PDL Management Committee creates this list that includes FDA approved prescription medications, products, or devices. You will find important information about our PDL as well as other Plan information on our web site. Please see our online formulary and drug pricing search tools at the following www. uhcfeds.com. The PDL consists of Tiers 1, 2, 3 and 4. Your plan PDL is the Traditional PDL.
- Specialty Drugs are on a separate 4 Tier PDL which is explained in detail below.

- **Tier 1** is your **lowest** copayment option and includes most generic medications, and may contain select preferred brand name medications. Brand name medications placed in Tier 1 are those the PDL Management Committee has determined to provide better overall value for treating certain conditions than those in Tier 2 or Tier 3. Brand name 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 and contains preferred brand name 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 and consists of non-preferred medications. Sometimes there are alternatives available in Tier 1 or Tier 2. If you are currently taking a medication in Tier 3, ask your provider whether there are Tier 1 or Tier 2 alternatives that may be appropriate for your treatment.
- **Tier 4** consists of the **highest** priced 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.
- **GLP-1 medications** prescribed for weight loss are covered at 50% coinsurance. To receive coverage for anti-obesity medications, members must enroll in the Wondr Health® program and meet applicable participation requirements. See Section 5(h), Wellness and Other Special Features.
- **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. Certain Specialty medications may be covered under the medical or pharmacy section of this brochure depending on how and where the medication is administered. Often specialty drugs require special handling, storage and shipping. You will pay the applicable Tier copay for your specialty medications and receive up to a maximum of a consecutive 30-day supply of your prescription medication. Our specialty pharmacy providers will give you superior assistance and support during your treatment. For more information please call 877-835-9861. This Program offers the following benefits to members:
  - Expertise in storing, handling and distributing these unique medications
  - Access to products and services that are not available through a traditional retail pharmacy
  - Access to nurses and pharmacists with expertise in complex and high cost diseases
  - Free supplies such as syringes and needles
  - Educational materials, as well as, support and development of a necessary care plan
- The costs for your specialty drugs are as follows:
  - Tier 1 $25
  - Tier 2 $150
  - Tier 3 $350
  - Tier 4 $500
- **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.

- Changes to Tier level for all covered medications and supplies may occur January 1 and July 1 of each year. If new generic medications come to market throughout the Plan year, they will be placed on Tier 1. Newly marketed brand name medications will be evaluated by our PDL Management Committee and they will be placed in the appropriate Tier. A prescription medication may be removed from the PDL at any time if the medication changes to over-the-counter status, or due to safety concerns declared by the FDA.

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

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

  - **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 at no cost to the member.
  - **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 (QD) and Quantity Level Limits** (QLL) may occur on January 1 and July 1 of each year. We base these processes upon the manufacturer's package size, FDA-approved dosing guidelines as defined in the product package insert and/or the medical literature or guidelines that support the use of doses other than the FDA-recommended dosage. If your prescription written by your provider exceeds the allowed quantity, please refer to Section 7, to file an appeal with the Plan.
  - **Refill Frequency -** A process that allows you to receive a refill (for most medications) once 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.
  - **Injectable medications -** Medications typically covered under the pharmacy benefit and received through a retail or mail order pharmacy are those that are self-administered by you or a non-skilled caregiver. However, injectable medications that are typically administered by a health care professional are covered under your medical benefit and need to be accessed through your provider or Specialty pharmacy. Contact the Health Plan at 877-835-9861 for more information on these medications. Some pharmacies are not able to bill medical benefits for these injections and if those facilities are used you may need to file a claim for reimbursement of those services.
  - **Special dispensing circumstances -** M.D. IPA 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
  - **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.

Benefit Description	
Preventive care medications	**You pay**
The following are covered when prescribed by a healthcare professional and filled by a network pharmacy. • Preventive Medications with a USPSTF A and B recommendations. 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.	$0
Covered medications and supplies	**You pay**
We cover the following Non-specialty 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-copayment applies to each 30-day supply • Disposable needles and syringes for the administration of covered, prescribed medications • Drugs for sexual dysfunction are limited. Contact the Plan for dosage limits. • Oral and injectable drugs associated with artificial insemination and IVF (3 cycles annually) procedures • Medications prescribed to treat obesity* Some drugs may require prior authorization Note: To be eligible for coverage of anti-obesity medications, members must enroll in the Wondr Health® program and satisfy applicable participation requirements. See Section 5(h) Wellness and other Special Features. *For a complete list of drugs and medications, visit www. uhcfeds.com or call our Customer Service Department 877-835-9861	Non-maintenance medications at a retail pharmacy: • Up to a 30-day supply: - Tier 1 - $15 - Tier 2 - $60 - Tier 3 - $150 - Tier 4 - $300 - GLP-1s for weight loss: 50% coinsurance (up to a maximum of $750) Maintenance medications from the Plan mail order pharmacy for up to a maximum of a 90-day supply - Tier 1 - $45 - Tier 2 - $180 - Tier 3 - $450 - Tier 4 - $900 - GLP-1s for weight loss: 50% coinsurance (up to a maximum of $1,875) Note: If there is no generic equivalent available, you will still have to pay the brand name copayment.
Specialty Medications	30-Day supply Tier 1 $25 Tier 2 $150 Tier 3 $350 Tier 4 $500
Tier 1 contraceptive drugs and devices as listed in the Health Resources and Services Administration site https ://www. hrsa.gov/womens-guidelines.	$0

Covered medications and supplies - continued on next page

Benefit Description	
Covered medications and supplies (cont.)	**You pay**
Contraceptive coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories 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 may 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. Once we have been contacted with exception request information sufficient for us to make a determination, you will receive a response within 24 hours or the next business day. Contraceptive exception requests are not subject to Section 8. The Disputed Claims Process. If you have difficulty accessing contraceptive coverage or other reproductive healthcare you can contact contraception@opm.gov. • Reimbursement for over-the-counter contraceptives can be submitted in accordance with Section 7. • The "morning after pill" is covered at no cost to the member if prescribed by a physician and obtained at a network pharmacy. • Over-the-counter contraceptives drugs and devices approved by the FDA require a written prescription by an approved provider. • Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy. Note: For additional Family Planning benefits see Section 5(a)	$0
• Smoking cessation medications are covered as follows: - Prescription medications - Age appropriate over-the-counter medications with a prescription from a Plan provider Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Educational Classes and Programs in Section 5(a)	$0
Opioid rescue agents are covered under this Plan with no cost sharing when obtained with a prescription from a network pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at https ://www. fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/	$0
Not covered:	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	
Covered medications and supplies (cont.)	**You pay**
• *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Medical supplies such as dressings and antiseptics* • *Medical Marijuana* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Replacement prescription drug products resulting from loss, theft, spoilage, or breakage of original product* • *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 available over-the-counter that do not require a prescription order by federal or state law before being dispensed, and any drug that is therapeutically equivalent to an over-the-counter drug* • *Alcohol swabs and bio-hazard disposable containers* • *Drugs for sexual performance for patients that have undergone genital reconstruction* • *Compound drugs that do not contain at least one covered ingredient that requires a prescription order or refill*	*All charges*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employees Dental Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9, *Coordinating benefits with other coverage*.
- Plan dentists must provide or arrange your care.
- We have no deductible.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(*c*) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works.
- **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.
- Also, read Section 9, *Coordinating benefits with other coverage*, including with Medicare.
- If you enroll in MD IPA 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	You pay
Accidental injury benefit	**High Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. 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. Treatment must be initiated within seventy-two (72) hours after the accident occurs. The Plan may grant an extension if the injury cannot be reasonably treated within seventy-two (72) hours after the accident occurs due to extenuating circumstances (such as prolonged hospitalization). All accidental injury services must be completed within twelve (12) months of the injury.	$40 per specialist visit $50 per outpatient non-surgical visit $150 per visit to an approved free standing facility or $300 per visit to a hospital based facility $250 per day up to 3 days per inpatient hospitalization

Accidental injury benefit - continued on next page

Benefit Description	You pay
Accidental injury benefit (cont.)	**High Option**
Note: Follow-up dental care or services must be received from a participating Doctor of Dental Surgery, (D.D.S.) or Doctor of Medical Dentistry, (D.M.D.). The member must use a participating provider with the Plan and have a valid referral from their PCP. These services are part of the medical health plan, not to be confused with any non-FEHB Dental Plans. Dental treatment for accidental injury is a limited benefit intended to stabilize your dental condition and includes only the following: • Emergency examination • Periapical and panoral radiographs • Root canal therapy • Emergency, temporary splinting of the teeth • Prefabricated post and core • Simple, minimal restorative procedures (fillings) • Emergency extractions • Post-traumatic crowns are covered if it is the only treatment available • Replacement of a tooth lost due to accidental injury	$40 per specialist visit $50 per outpatient non-surgical visit $150 per visit to an approved free standing facility or $300 per visit to a hospital based facility $250 per day up to 3 days per inpatient hospitalization
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*

Benefit Description	You Pay
Adjunctive dental services	**High Option**
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 services 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.	$40 per specialist visit, or $50 per outpatient non-surgical visit; and $300 per outpatient surgical visit, or $250 per day up to 3 days per inpatient hospitalization
Not covered: • *Treatment of dental disease that results from a medical condition such as but not limited to:* • *Caries as a result of "dry mouth" caused by disease or medication* • *Restoration of teeth damaged by acid reflux*	*All charges*

Adjunctive dental services - continued on next page

Benefit Description	You Pay
Adjunctive dental services (cont.)	**High Option**
• *Care by non-Plan providers except for authorized referrals or emergencies (see Emergency services/accidents).* • *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*
Non-dental oral surgery	**High Option**
Benefits are provided for non-dental oral surgery for the correction of deformities of the jaws due to congenital defects, sickness or injury. Examples of congenital syndromes are: • Pierre Robin Syndrome • Treacher-Collins Syndrome • Crouzon's Syndrome Cleft lip or cleft palate treatment includes orthodontics, oral surgery, otologic, and audiologic and are provided under the direction of a Physician. See Section 5(b) for oral and maxillofacial surgery including TMJ.	$40 per specialist visit, or $50 per outpatient non-surgical visit; and $150 per outpatient surgical visit at an approved free-standing surgical facility or $300 per outpatient surgical visit or $250 per day up to 3 days per inpatient hospitalization
Not covered: • *Procedures to correct open bites, cross bites, retruded or protruded jaws which are not related to congenital syndromes or a severe functional malocclusion* • *Pre or post-surgical orthodontics*	*All charges*
Dental anesthesia	**High Option**
Benefits may be provided for outpatient facilities when there exists an underlying medical condition, co-morbidity, or significant risk factor which, as we determine, requires such a facility to control, monitor or treat the medical condition during or immediately after the procedure. Examples include: • Hemophilia • Severe asthma • Unstable heart disease • Unstable diabetes In such cases benefits are provided for general anesthesia and associated facility charges. Note: These outpatient dental services are separate from and in addition to those provided for below under *Dental anesthesia and associated facility charges*	$40 per specialist visit or $50 per outpatient non-surgical visit; and $150 per outpatient visit at a free-standing surgical facility or $300 per outpatient surgical visit or $250 per day up to 3 days per inpatient hospitalization
Not covered: • *Dental procedures themselves unless the dental procedure is specifically stated as a Covered Health Service in this FEHB Brochure*	*All charges*

Benefit Description	You Pay
Dental anesthesia and associated facility charges	**High Option**
General anesthesia and associated facility charges for dental services performed in a hospital or alternate facility when the dentist and the physician determine that such services are necessary for the safe and effective treatment of a dental condition. Such treatment is limited to a covered person who meets all requirements in one of the two following sets of conditions: • Is 7 years of age or younger or is developmentally disabled • Is an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the enrollee or insured • Is an individual for whom a superior result can be expected from dental care provided under general anesthesia **Or** • Is an extremely uncooperative, fearful, or uncommunicative child who is 17 years of age or younger with dental needs of such magnitude that treatment should not be delayed or deferred • Is an individual for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity Note: Such covered health services must be provided under the direction of a physician or dentist.	$40 per specialist visit or $50 per outpatient non-surgical visit; and $150 per outpatient surgical visit at an approved free-standing surgical facility or $300 per outpatient surgical visit or $250 per day up to 3 days per inpatient hospitalization
Not covered: • *Benefits are not provided for the diagnosis or treatment of dental disease.*	*All charges*

Section 5(h). Wellness and Other Special features

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.
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 & Costs>Behavioral Health Directory
Smoking cessation program	We provide our members with resources and support for tobacco cessation. Included are: • Online learning with interactive and personalized content and a community support forum • Integrated online and telephonic experience • Benefits for counseling • Nicotine replacement therapy • 24/7 support for easier access to services • Nicotine replacement therapy both prescription medications and over the counter products (with prescription) • Get started today.
UHC Rewards and One Pass	Your health plan comes with a new way to earn up to $300. With UnitedHealthcare Rewards, you can earn up to $300 for tracking your steps or sleep, getting an annual checkup and more. The activities you go for are up to you. When you activate UHC Rewards, you can also get started with One Pass Select™, a fitness program that gives you unlimited access to a nationwide network of thousands of fitness centers. Plus, you can use your earnings to help pay for a One Pass Select membership. Start earning with UHC Rewards by:

	• Download the UnitedHealthcare® app and then: Sign in or register • Select UHC Rewards • Activate UHC Rewards • Select Redeem rewards to access One Pass Select ***UnitedHealthcare Rewards*** *is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you. If any fraudulent activity is detected (e.g., misrepresented physical activity), you may be suspended and/or terminated from the program. If you are unable to meet a standard related to health factor to receive a reward under this program, you might qualify for an opportunity to receive the reward by different means. You may call us toll-free at 1-866-230-2505 or at the number on your health plan ID card, and we will work with you (and, if necessary, your doctor) to find another way for you to earn the same reward. Rewards may be limited due to incentive limits under applicable law. Components subject to change. This program is not available for fully insured members in Hawaii, Vermont and Puerto Rico.* ***One Pass Select*** *is a voluntary program featuring a subscription-based nationwide gym network, digital fitness and grocery delivery service. The information provided under this program is for general informational purposes only and is not intended to be nor should it be construed as medical advice. Individuals should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for them. Purchasing discounted gym and fitness studio memberships, digital fitness or grocery delivery services may have tax implications. Employers and individuals should consult an appropriate tax professional to determine if they have any tax obligations with respect to the purchase of these discounted memberships or services under this program, as applicable. One Pass Select is a program offered by Optum. Subscription costs are payable to Optum.*
UHC Store: Expanding Consumer Choice Through a Personalized Digital Health Marketplace	UHC Store enhances consumer choice by offering a streamlined, digital shopping experience that enables members to explore and purchase solutions that complement their employer-sponsored benefits. Accessible through the UnitedHealthcare app and myuhc.com, UHC Store provides a convenient, centralized destination for trusted health, wellness, and lifestyle offerings, many available at exclusive member pricing. The platform is organized into four core solution areas to support a broad range of member needs across the health continuum: • **Everyday Health** - Solutions that support daily well-being, including women's health, mental health resources, and other essential services. • **Family Wellness** - Offerings that address key life moments and caregiving needs, including family planning, pregnancy and postpartum support, and caregiver resources. • **Fitness & Nutrition** - Programs and tools designed to promote healthy lifestyles, including weight management, nutrition support, coaching, and fitness options. • **Health Coordination** - Resources and support for individuals managing complex or chronic conditions, such as diabetes, autoimmune disorders, and gastrointestinal conditions, helping improve care coordination and outcomes.

	Member Value and Experience - UHC Store is designed to empower members with greater flexibility, choice, and control over their health and wellness journey. Key advantages include: • **Convenient Access:** A single, integrated experience within the UnitedHealthcare digital ecosystem to browse, select, and manage solutions. • **Personalized Choice:** The ability to select products and services aligned with individual preferences, lifestyles, and health goals. • **Cost Savings**: Member discounts of up to 15% off manufacturer suggested retail price (MSRP) on select offerings • **Simplified Management**: Seamless payment, billing, and subscription management within myuhc.com. **Ongoing Innovation -** UHC Store will continue to evolve, expanding its portfolio of offerings to address emerging consumer needs and enhance member engagement. By broadening access to high-quality, innovative health and wellness solutions, UHC Store supports improved outcomes while reinforcing a more personalized and consumer-centric healthcare experience.
Wondr Health, a Digital Lifestyle & Behavior Change Program	Wondr Health is a digital, evidence-based behavior change program designed to improve metabolic health and address the root causes of chronic conditions such as obesity. The program takes a whole-person approach, supporting sustainable lifestyle changes across nutrition, physical activity, sleep, and emotional health. Available at no cost to employees through UnitedHealthcare, Wondr provides a personalized experience delivered through a mobile app and web platform. Participants receive tailored guidance through interactive lessons, coaching support, and digital tools, with the ability to track progress and engage in the program anytime, anywhere. Wondr supports all anti-obesity medication (AOM) management through a behavior-linked eligibility model that connects medication access to active program participation. Eligibility follows FDA guidelines (BMI 30, or 27 with at least one weight-related comorbidity). Members beginning AOM therapy are required to enroll as a participant in Wondr to be approved for medication. Members already using AOM medications will be required to enroll as a participant in Wondr to continue coverage. Members are expected to stay engaged in the program, at least every 30 days. Engagement may include participating in lessons, tracking progress, meeting with a registered dietician, and/or interacting with coaching support. Participation is monitored and helps ensure medication use is supported by ongoing lifestyle and behavior change. Wondr securely tracks enrollment and engagement and shares participation status with the pharmacy benefit manager (Optum Rx) to support prior authorization.
Calm Health App	Calm is a mindfulness and mental wellness app designed to help users enhance overall well-being. If offers a wide range of features including: • Guided meditations, soothing sleep stories, breathing exercises, calming music, expert-led masterclasses and more.
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 **www.myuhc.com**®and click on Find a Doctor. Choose smart. Look for blue hearts. • **Premium Care Physician** meets UnitedHealth Premium program quality & cost-efficient care criteria. • **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 p**hysician'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.
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.
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.
Medicare Part B Reimbursement for Retiree Advantage Members	***$150 Medicare Part B premium subsidy*** *Each enrolled individual will receive $150 per month Medicare Part B premium subsidy. Your Medicare Part B premium subsidy will be automatically applied to your current Part B payment method in the form of a reduced premium.* *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* • *Access to an extensive network of gyms and fitness locations* • *To view participating facilities, please visit uhcrenewactive.com* • *Access to a wide variety of fitness classes*
Over-the-counter (OTC) item allowance for Retiree Advantage Members	*Shop for over-the-counter items such as toothpaste, vitamins, cough drops and more.* *Each enrolled individual will get a $40 credit each quarter added to their UCard® to buy covered OTC products from network retail locations. The credit is automatically loaded every quarter. All credits will expire quarterly.*
House Calls for Retiree Advantage Members	*Optum HouseCalls* *Get a yearly preventive care check-in that helps you stay on-track with your health between your regular provider visits. It's done in the comfort of your home and allows plenty of time for you to ask questions about your health. We send a summary of your HouseCalls visit to both you and your primary care provider so your provider stays informed. A HouseCalls visit is designed to support but not take the place of your provider's care.*
Healthy at Home for Retiree Advantage Members	*With UnitedHealthcare Healthy at Home you are eligible for the following benefits up to 30 days following all inpatient and skilled nursing facility discharges*:* • *28 home-delivered meals* • *12 one-way rides to medically related appointments and to the pharmacy* • *6 hours of non-medical personal care provided through a professional caregiver to perform tasks such as preparing meals, bathing, medication reminders, and more.* **Call Customer Service for more information, to request a referral after each discharge and to use your benefits.*
Let's Move by UnitedHealthcare® for Retiree Advantage Members	*At no additional cost to you, Let's Move by UnitedHealthcare is designed to help keep your mind, body and social life active. With simple resources, tools, fun events and personalized support, we'll help you explore ways to eat well, stay connected and be financially, physically and mentally fit. Including support for the following:*

	• ***Let's eat well***—*Treat yourself to tasty recipes, fun cooking events and support.* • ***Let's get fit***—*Get free access to at-home workouts, participating gyms and local fitness events.* • ***Let's live well***—*From helping to manage your financial well-being to supporting caregivers to helping stop tobacco use, we're here for your wellness.* • ***Let's be mentally fit***—*Support your mental health with services, online tools and resources.* • ***Let's make friends***—*Find ways to connect through local and online events, classes, volunteering and more.*
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* • *Choose 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* • *Call customer service to access your hearing aid benefit*

Non-FEHB Benefits Available to Plan Members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 877-835-9861 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, fillings, sealants & fluoride treatments. Visit www. myuhc.com for your dental benefit certificate of coverage**.**

Discount Dental Plan* - Your plan includes a PPO discount dental plan which offers you discount on dental services such as crowns, dentures, oral surgery and other dental services.

UnitedHealthcare Hearing® - Your hearing health is closely connected to your overall wellness. Addressing hearing loss can help you stay engaged in daily activities, connect with loved ones, and maintain a healthier lifestyle. Through UnitedHealthcare Hearing, you have access to a large national network of hearing care professionals who provide expert guidance and personalized support throughout your hearing journey, including a hearing exam, individualized recommendations, hearing aid fitting, and follow-up care. To learn more about your hearing benefits and available hearing care options, visit uhchearing.com or call 1-866-926-6632 (TTY 711), Monday through Friday, 8 a.m. to 8 p. m. CT. Please reference code HEARFEHBP when accessing services.

Eyewear Benefits* - Members may select *UnitedHealthcare Vision* preferred, participating, or out of network providers. At no additional cost to you, your plan offers the following in network benefits; glasses or contact lenses once every 24 months, lenses, frames and contact lenses. Please go to www. uhcfeds.com for more details.

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

Financial Wellness Options: United Health ONE helps with individuals 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 fo**r** 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. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3** ***When you need prior Plan approval for certain services.***

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency services/accidents)
- Services, drugs, or supplies you receive while you are not enrolled in this Plan
- Services, drugs, or supplies not medically necessary
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice
- Experimental, investigational, or unproven procedures, treatments, drugs or devices (see specifics regarding transplants)
- Services, drugs, or supplies related to abortions, 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
- 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, 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
- Services or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption
- Services or supplies we are prohibited from covering under the Federal law
- Medical supplies such as dressings and antiseptics
- Any benefits or services required solely for your employment are not covered by this Plan.
- Chemical or surgical modification of an individual's sex traits through medical interventions (to include "gender transition" services).

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 HIPAA compliant electronic claims for you. Providers must file on the form CMS-1500, Health Insurance Claim Form. In cases where a paper claim must be used, the facility will file on the UB-94 form. For claims questions and assistance, call us 877-835-9861.

When you must file a claim - such as for services you receive outside the Plan's service area-submit it on the HCFA-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:

M.D. IPA, a UnitedHealthcare Company, P.O. Box 740825, Atlanta, GA 30374-0825.

Submit international medical claims to:

Submit your international claims to: M.D. IPA, a UnitedHealthcare Company, P.O. Box 740825, Atlanta, GA 30374-0825.

Prescription drugs

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, such as when you are outside the service area in a medical emergency. If this happens, contact customer service at 877-835-9861 for a prescription drug claim form and 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 650540, Dallas, TX 75265-0540

Other supplies or services

Submit your claims to: M.D. IPA, a UnitedHealthcare Company, P.O. Box 740825, Atlanta, GA 30374-0825.

Records	Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.
Deadline for filing your claim	Send us all 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. If you could not file on time because of Government administrative operations or legal incapacity, you must submit your claim as soon as reasonably possible. Once we pay benefits, there is a one year limitation on the re-issuance of uncashed checks.
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.
Overseas claims	For covered services you receive by providers and hospitals outside the United States and Puerto Rico, send a completed Medical Claim Form and the itemized bills to: UnitedHealthcare, P.O. Box 740825, Atlanta, GA 30374-0825. Obtain Overseas Medical Claim Forms from: www.myuhc.com or www.uhc.com/member-resources/forms. If you have questions about the processing of overseas claims, contact 877-835-9861.
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. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.
Authorized Representative	You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a healthcare professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.
Notice Requirements	If you live in a county where at least 10% 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 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 (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 to M.D. IPA Federal Employees Health Benefits Program at P.O. Box 30432, Salt Lake City, UT 84130-0432 or calling 877-835-9861.

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

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a 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 original decision.

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: M.D. IPA, a UnitedHealthcare Company's Federal Employee Health Benefits (FEHB) Program 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, Federal Employees Insurance Operations, 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 family member 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 Medicare and Other Coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays healthcare 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 order of benefit determination rules. For more information on NAIC rules regarding the coordinating of benefits, our website at www.uhc.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 pays 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 CHAMPVA

TRICARE is the healthcare 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 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 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 www.BENEFEDS.gov, or by phone at 877-888-3337, (TTY 877-889-5680), you will be asked to provide information on your FEHB Plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

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

If you are a participant in a clinical trial, and the related care is not covered within the clinical trial, this plan will provide coverage for related costs based on the criteria listed below.

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

Please see the special features page of the brochure for specific requirements for cancer related trials.

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 877-835-9861 or see our member Website at www.myuhc.com.

We waive some costs if the Original Medicare Plan is your primary payor – We will waive some out-of-pocket costs as follows:

- All copayment and coinsurance amounts will be applied until you meet your Medicare Part B deductible. Once the Medicare Part B deductible has been met, all copayments and coinsurance are waived.
- We will pay all amounts identified as "patient responsibility" on the Medicare Explanation of Benefits as long as the service rendered is covered by our plan.
- We will pay the Inpatient Medicare deductible.

- **Medicare cost share**

Please review the following examples which illustrates your cost share if you are enrolled in Medicare Part B. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

Benefit: Deductible
High Option you pay **without** Medicare: No deductible
High Option you pay **with** Medicare Part B**:** No deductible

Benefit: Out-of-Pocket Maximum
High Option you pay **without** Medicare: $5,000 Self-only; $10,000 Self Plus One or Self and Family
High Option you pay **with** Medicare Part B**:** $5,000 Self-only; $10,000 Self Plus One or Self and Family

Benefit: Part B Premium Reimbursement
High Option you pay **without** Medicare: N/A
High Option you pay **with** Medicare Part B**:** N/A

Benefit: Primary Care Provider
High Option you pay **without** Medicare: $30
High Option you pay **with** Medicare Part B**:** Nothing after Medicare Part B deductible has been reached

Benefit: Specialist
High Option you pay **without** Medicare: $40
High Option you pay **with** Medicare Part B**:** Nothing after Medicare Part B deductible has been reached

Benefit: Inpatient hospital
High Option you pay **without** Medicare: $250 per day up to 3 days per admission ($750)
High Option you pay **with** Medicare Part B**:** Nothing

Benefit: Outpatient hospital
High Option you pay **without** Medicare: $150 free-standing facility; $300 hospital-based facility
High Option you pay **with** Medicare Part B**:** Nothing

Benefit: Incentives offered
High Option you pay **without** Medicare: Nothing
High Option you pay **with** Medicare Part B**:** Nothing

- **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., 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 (800-633-4227), (TTY:800-486-2048) or at www.medicare.gov or UnitedHealthcare Retiree Solutions at 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 the UnitedHealthcare FEHB Plan and have both Medicare Part A and Part B
- You are retired and live in our geographic service area which is described on page 14.
- 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.

We offer a Medicare Advantage plan designed:

- To help members with their Medicare Part B premium costs
  - The Retiree Advantage plan provides **monthly reimbursement of $150.00 of your Medicare Part B monthly premium**.
  - 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.
- 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
- Medicare Part D prescription drug coverage with a low $2,400 out of pocket max

If you enroll in the UnitedHealthcare Retiree 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.** 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).

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. See chart below.

Benefit Description: Deductible
Member Cost with UnitedHealthcare Retiree Advantage Health Plan: No plan deductible

Benefit Description: Primary Care Provider
Member Cost with UnitedHealthcare Retiree Advantage Health Plan: $0

Benefit Description: Specialist
Member Cost with UnitedHealthcare Retiree Advantage Health Plan: $0

Benefit Description: Virtual Visits
Member Cost with UnitedHealthcare Retiree Advantage Health Plan: $0

Benefit Description: Urgent Care
Member Cost with UnitedHealthcare Retiree Advantage Health Plan: $0

Benefit Description: Emergency Room
Member Cost with UnitedHealthcare Retiree Advantage Health Plan: $0

Benefit Description: Inpatient Hospital
Member Cost with UnitedHealthcare Retiree Advantage Health Plan: $0

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

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement 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.

- **Medicare prescription drug coverage (Part D)**

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

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

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation	✓*	
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 22.

Copayment

See Section 4, page 22.

Cost-sharing

See Section 4, page 22.

Covered services

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

Custodial Care

Medical or non-medical services:

- Which are furnished mainly to assist you in the activities of daily living (feeding, dressing, bathing, transferring and ambulating)
- For which professional skills or training is not required
- Which are not likely to result in the improvement of your condition or in your recovery

Custodial care that lasts 90 days or more is sometimes known as long term care.

Deductible

See Section 4. page 22.

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.

Genetic Testing

Examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

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, 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 M.D. IPA.

You

You refers to the enrollee and each covered family member.

Index

Accidental Injury.....27, 66-67, 97
Allergy.....36
Alternative treatments.....42
Ambulance.....23, 53-55, 93
Anesthesia.....44-52, 68
Biopsy.....44-45
Blood products.....53-55
Casts.....53-54
Catastrophic Protection.....22-23
Changes for 2027.....14
Chemotherapy.....28-43
Chiropractic.....42
Claims.....15-21, 79-83, 91-94
Coinsurance.....22-23, 91
Colorectal cancer screening.....17-19, 44-52
Congenital anomalies.....44-45
Contraceptive drugs and devices.....63-65
Cost Sharing.....27-43
Covered charges.....86
Crutches.....39-40
Cryopreservation.....28-43
Deductible.....15, 22-23, 27, 91
Definitions.....28, 91-94
Dental.....27, 66-69, 97
Diagnostic and treatment services.....26, 28
Durable Medical Equipment.....39-40
Educational.....42-43
Effective date.....9-10, 15, 17, 23
Emergency.....56-57, 96
Endoscopy.....44-45
Experimental or investigational.....92
Eyeglasses.....28-43
Family planning.....33
Foot care.....38
Fraud.....3
General exclusions.....78
Hearing services.....37
Home health services.....41
Hospice.....54-55
Hospital.....15-21, 53-55, 58-59, 96-97
Iatrogenic infertility.....34-35
Immunizations.....28-43
Infertility.....28-43, 92
Insulin.....39-40, 63-65
Lab.....29
Mammogram.....29
Maternity benefits.....21, 32-33
Medicaid.....74-75, 84-85
Medically necessary.....15, 28, 92-93
Medicare.....84-90
Mental Health and Substance Use...26-27, 58-59, 71
MRI - Magnetic resonance imaging...29, 47-52
No Surprises Act.....22, 93
Nurses.....5-6, 74
Occupational therapy.....37
Office visits.....12-13
Oral and maxillofacial surgery.....46-47
Organ Transplant.....44-52
Orthopedics and Prosthetics.....28-43
Out-of-pocket expenses.....22-23
Oxygen.....39-40, 53-55
Pap test.....29
Physical Therapy.....37
Physician.....12-13, 15, 17-19, 28-43, 96-97
Precertification.....15-21, 91-94
Prescription drugs.....26-27, 60-65, 79
Preventive care, adult.....29-31
Preventive care, child.....31
Prior approval.....15-21, 82-83, 93
Prosthetic devices.....38-39, 44-45, 84
Radiation therapy.....15-21
Reimbursement...23, 26-27, 44-52, 84-86, 93
Room and board.....53-55, 58-59
Second surgical opinion.....28
Skilled nursing facility.....44-55, 75
Speech therapy.....37
Splints.....38-39, 46-47, 53-54
Subrogation.....85, 91-94
Substance Misuse.....17-19
Surgery.....44-52, 96-97
Temporary Continuation of Coverage (TCC).....3, 10-11
Transplants.....36, 47-52, 78
Treatment Therapies.....36
Virtual Visits.....26, 29
Vision services.....28-43, 84-86
Wheelchairs.....39-40
X-rays.....29, 47-52

Summary of Benefits for the High Option of M.D. IPA - 2027

- Do not rely on this chart alone. This is a summary. 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 as required by the Affordable Care Act 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.

High Option Benefits	You pay	Page
Medical services provided by physicians: Routine preventive care	Nothing	29
Medical services provided by physicians: Diagnostic and treatment services provided in the office	Office visit copay: $30 primary care physician ages 18 and older; $0 under age 18; $40 specialist	28
Services provided by a hospital: Inpatient	$250 per day for up to 3 days per admission	53
Services Provided by a Hospital (Outpatient Surgery)	$150 per visit at approved free-standing surgical center $300 per visit at hospital-based facility;	44
Services provided by a hospital: Outpatient Non-Surgical	$50 per visit	54
Emergency benefits: • **In-area or out-of-area**	$350 per emergency room visit (waived if admitted)	57
Urgent care visit	$50 per visit to urgent care center	57
Mental health and substance use disorder treatment	Regular cost-sharing	58
Prescription drugs: Plan Retail Pharmacy Up to a 30-day supply:	Tier 1 - $15 Tier 2 - $60 Tier 3 - $150 Tier 4 - $300 GLP-1s for weight loss: 50% coinsurance (up to a maximum of $750)	63
Prescription drugs: Plan mail order Up to a 90-day fill	Tier 1 - $45 Tier 2 - $180 Tier 3 - $450 Tier 4 - $900 GLP-1s for weight loss: 50% coinsurance (up to a maximum of $1,875)	63

High Option Benefits	You pay	Page
Specialty Pharmacy 30-day supply	Tier 1- $25 Tier 2 - $150 Tier 3 - $350 Tier 4 - $500	63
Dental care	Adjunct dental services, accidental injury	66
Vision care	$40 copayment for eye refraction exam adults $0 Annual routine eye examination children 17 and under	37
Wellness and other Special features:	UHC Rewards, Calm Health App, Wondr Health, UHC Store, Smoking Cessation, Educational Resources, other programs and UnitedHealthcare® mobile tools	70
Non-FEHB Benefits Available to Plan Members	PPO Dental Plan, UnitedHealthcare Hearing, SafeTrip and other individual insurance products.	77
Protection against catastrophic costs (out-of-pocket maximum)**:** **Note:** Some costs do not count toward this protection	Nothing after: $5,000 for Self Only, $10,000 Self Plus One or $10,000 for Self and Family enrollment per year	22

2027 Rate Information for MD IPA

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
High Option Self Only	JP1	$349.88	$116.62	$758.06	$252.69
High Option Self Plus One	JP3	$683.30	$227.77	$1,480.49	$493.50
High Option Self and Family	JP2	$843.82	$464.23	$1,828.28	$1,005.83