UnitedHealthcare Insurance Company, Inc.

www.uhcfeds.com

Customer Service 877-835-9861

UnitedHealthcare®

2021

UnitedHealthcare Advantage

The 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 11.

IMPORTANT
- Rates: Back Cover
- Changes for 2021: Page 13
- Summary of Benefits: Page 82

Enrollment in this plan is limited to the states of: Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming. You must live or work in our Geographic Service area to enroll. See page 11 for requirements.

This is a new plan for 2020

Enrollment Codes for this Plan:

Y51 High Option - Self Only

Y53 High Option - Self Plus One

Y52 High Option - Self and Family

FEHB
Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

Important Notice from UnitedHealthcare Insurance Company, Inc. About

Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

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

Medicare's Low Income Benefits

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

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

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

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Introduction

This brochure describes the benefits of UnitedHealthcare Insurance Company, Inc. under contract (CS 2965) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 1-877-835-9861 or through our website www.uhcfeds.com. The address for our administrative offices is:

UnitedHealthcare Insurance Company, Inc.

Federal Employees Health Benefits Plan

10175 Little Patuxent Parkway, 6th Floor

Columbia, MD 21044

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2021, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually and changes are summarized on page 13. This is a new plan for January 1, 2021. 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 UnitedHealthcare Insurance Company, Inc.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.

- If the provider does not resolve the matter, call us at 1-877-835-9861 and explain the situation.

- If we do not resolve the issue:

CALL - THE HEALTH CARE 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 reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless he/she is disabled and incapable of self-support prior to age 26).

A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

The UnitedHealthcare Insurance Company, Inc. complies with all applicable Federal civil rights laws, including Title VII of the Civil Rights Act of 1964.

You can also file a civil rights complaint with the Office of Personnel Management by mail at: Office of Personnel Management Healthcare and Insurance Federal Employee Insurance Operations, Attention: Assistant Director FEIO, 1900 E Street NW, Suite 3400 S, Washington, DC 20415-3610.

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 health care 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 medications what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and the brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

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

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

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

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

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

- "What will happen after surgery?"
- "How can I expect to feel during recovery?"

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

Patient Safety Links

For more information on patient safety, please visit:

- 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 health care 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 health care providers and improve the quality of care you receive.
- www.bemedwise.org The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you 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 health care 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 UnitedHealthcare members for any amounts not paid due to the application of this reimbursement policy.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

  We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

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

- **Where you can get information about enrolling in the FEHB Program**

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

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies who participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, and give you brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

  - When you may change your enrollment
  - How you can cover your family members
  - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
  - What happens when your enrollment ends
  - When the next Open Season for enrollment begins

  We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

  Self Only coverage is for you alone. Self Plus One coverage is for you and one eligible family member. Self and Family coverage is for you, and one eligible family member, or your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

  If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31-days before to 60-days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until 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.

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

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member 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 a valid common law marriage) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse or one other eligible family member as described in the chart below.

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

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

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

- **Children's Equity Act**

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the 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 2021 benefits of your prior planor 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 2020 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

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

- **Upon divorce**

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

- **Temporary Continuation of Coverage (TCC)**

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

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

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

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

- **Converting to individual coverage**

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

  - Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
  - You decided not to receive coverage under TCC or the spouse equity law; or
  - You are not eligible for coverage under TCC or the spouse equity law.

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

  Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, 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 877-835-9861 or visit our website at www.uhcfeds.com.

- **Health Insurance Market Place**

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

Section 1. How This Plan Works

This Plan is an independent practice organization with open access benefits that provides you the freedom to choose from any health care professional in the UnitedHealthcare Choice network, including specialists, without a referral or choosing a primary care physician (PCP).

OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. UnitedHealthcare Insurance Company, Inc. holds the following accreditation: NCQA (National Committee for Quality Assurance). To learn more about this plan's accreditation(s), please visit the following website: National Committee for Quality Assurance (www.ncqa.org).

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

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

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

General Features of our High Option Plan

We have Open Access benefits

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

How we pay providers

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

Preventive care services

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

Annual Deductible

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

Your Rights and Responsibilities

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

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

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, UnitedHealthcare Insurance Company, Inc. at www.uhcfeds.com. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 1-877-835-9861 or visit our website at www.uhcfeds.com or if already a member www.myuhc.com.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website UnitedHealthcare Insurance Company, Inc. at www.uhc.com to obtain 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 includes the following states:

Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming

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 health care 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 dependents 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. We are a new plan

This plan is new to the FEHB. We are being offered for the first time during the 2021 Open Season.

Section 3. How You Get Care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-877-835-9861, or write to us at UnitedHealthcare Insurance Company, Federal Employee Health Benefits (FEHBP Program at P.O. 30432, Salt Lake City, UT 84130-0432 You may also print temporary cards and request replacement cards through our web site www.myuhc.com.

Where you get covered care

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

- **Plan providers**

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

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

- **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 physician. This decision is important since your primary care physician provides or arranges for most of your health care.

- **Primary care**

Your primary care physician will provide most of your health care, or give you a referral to see a specialist. If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

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

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 physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals.

  Your primary care physician 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 physician. If he or she decides 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 physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
-
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause;
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or
  - reduce our service area and you enroll in another FEHB plan;

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

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

- **Hospital care**

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

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 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 your coverage.

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

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

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

You need prior Plan approval for certain services

Since your provider schedules most procedures and inpatient hospitalization, the pre-service claim approval process applies to care shown under *Other services*.

"You must get prior approval for certain services. Failure to do so will result in a penalty.

- **Inpatient Hospital Admission**

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

- **Other Services**

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You or your physician must obtain prior authorization for some services, such as, but not limited to:

- Ambulance-Non-emergency
- Angioma/Hemangioma (with pictures)
- Applied Behavioral Analysis (ABA)
- Bariatric Surgery
- Blepharoplasty (with pictures)

- Breast implant, removal, breast reconstruction for non-cancer diagnosis, breast reduction
- Computed Tomography (CT scans)
- Dental procedures in a facility
- Durable medical equipment over $1,000
- Clinical Trials
- Coronary Artery bypass
- Congenital anomaly repair
- Dialysis
- Genetic testing
- Gender reassignment surgical procedures
- Gynecomastia surgery
- Hysterectomy
- Human Growth Hormone
- Implanted spinal cord stimulators
- Inpatient hospitalization
- Intensive Outpatient treatment
- Joint replacement
- Magnetic resonance angiogram and imaging (MRA) (MRI)
- PET scans (non-cancer diagnosis)
- Partial Day Treatment
- Pulmonary rehabilitation
- Radiation therapy
- Reconstructive Surgery
- Sclerotherapy
- Sleep apnea surgery and attended sleep studies (Polysomnograms)
- Substance abuse disorder treatment
- Some therapies (physical, occupational, speech) after 8th visit
- Transplants
- Uvulopalatopharyngoplasty
- Vein ablation
- Vagus nerve
- Ventricular assist device

Plan providers are notified of all prior authorization/preauthorization requirements. In addition, your admitting physician and facility must also preauthorize any elective inpatient stays.

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

First, your physician, your hospital, you, or your representative, must call us at 1-877-835-9861 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

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

- number of days requested for hospital stay.

- **Non-urgent care claims**

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

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

- **Urgent care claims**

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

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

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

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

- **Concurrent care claims**

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

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

The Federal Flexible Spending Account Program – *FSAFEDS*

- **Health Care FSA (HCFSA)** – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).
- FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

- **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**

Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your baby. When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his/her own right. If the newborn is eligible for coverage , regular medical or surgical benefits apply rather than maternity benefits.

- **If your treatment needs to be extended**

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

What happens when you do not follow the precertification rules when using non-network facilities

This plan does not offer coverage for non-network facilities or providers. If you use non-network facilities or see non network providers without written authorization from the plan, you will be responsible for 100% of the charges.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

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

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

1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information.

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

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

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by phone, electronic mail, facsimile, or other expeditious methods.

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

Section 4. Your Costs for Covered Services

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

Cost-Sharing

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

Copayments

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

Deductible

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

- The calendar year deductible is $2,000 per person. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $2,000. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $4,000. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $4,000.

Note: If you change plans during Open Season, you do not have to start a new deductible under your prior plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible.

Example: In our Plan, you pay 30% of our allowance for physician services and durable medical equipment.

Differences between our Plan allowance and the bill

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

Your catastrophic protection out-of-pocket maximum

After your (copayments and coinsurance) total $7,350 for Self Only or $7,350 per person for Self Plus One, or $14,700 per Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments or coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services: expenses for services or supplies that exceed the stated maximum dollar limit or day limit, charges for non-covered services and any penalties for failure to obtain preauthorization.

Be sure to keep accurate records of your copayments and coinsurance since you are responsible for informing us when you reach the maximum.

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.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

When Government facilities bill us

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

High Option Benefits

See page 13 for how our benefits changed this year. Page 82 a benefits summary for this plan. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5. High Option Benefits Overview

This Plan offers a High Option. The benefit packages is described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

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

The Benefits Overview contains two charts of benefits.

- High Options Benefits - provides benefits for this plan. Note: **all benefits are subject to the plan deductible unless noted " not subject to deductible"**
- Medicare Advantage Value Plan: provides an overview of benefits for retired members with Medicare Part A and Medicare Part B, who elect to sign up to participate in our Advantage plan. The Advantage plan is NOT subject to deductible.

High Option Benefits	You Pay
Medical Services Provided by Physician:	
• Routine Preventive Care provided in-network	Nothing - covered at 100% Not Subject to deductible
• Diagnostic and treatment services provided in the office	Primary Care Physician: 30% coinsurance Specialist: 30% coinsurance
Urgent care services	30% coinsurance
Telehealth - Virtual visits provided by Doctor on Demand, American Well and Teladoc	30% coinsurance
Laboratory, X-ray and Diagnostic Tests	30% coinsurance
Services Provided by a hospital	
• Inpatient	30% coinsurance
• Outpatient Surgical	30% coinsurance
Emergency Benefits:	
• Emergency Room	30% coinsurance waived if admitted
Ambulance services	30% coinsurance
Mental Health and Substance Abuse	30% coinsurance
Prescription Drugs	30-Day supply at Retail: Tier 1: $15; Tier 2: $45; Tier 3: $85; Tier 4: $200 90-Day supply at Mail Order: Tier 1: $45; Tier 2: $135; Tier 3: $225; Tier 4: $600

*Note: You must have Medicare Part A and Part B, and Medicare must be primary for you to enroll in the UnitedHealthcare Medicare Advantage Value 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 $50 of your Medicare Part B premium. You need to retain enrollment in this FEHB plan to be enrolled in the Medicare Advantage Plan.

Medicare Advantage Value Plan Benefits	You pay
Deductible	No deductible for this Medicare plan
Provider visits	
• Primary Care Physician (PCP) visit	$0 copayment
• Specialist visit	$0 copayment
• Routine annual physical	$0 copayment
• Virtual doctor visits	$0 copayment
• Outpatient Rehabilitation - physical, occupational or speech/language therapy	$0 copayment
• Urgent care center	$0 copayment
Hospital services	
• Inpatient hospital	$0 copayment
• Inpatient mental health	$0 copayment
• Skilled Nursing Facility	$0 copay per day days 1-20 $0 copay per additional day up to 100 days
• Emergency Room	$0 copayment
• Ambulance	$0 copayment
Diagnostic Services	$0 copayment
Hearing Aids	Plan pays up to $500 every 3 years
Pharmacy benefits	30-day supply: Tier 1: $7, Tier 2: $35, Tier 3: $65, Tier 4: $100 90-day supply at mail order: Tier 1:$14, Tier 2: $70, Tier 3: $130, Tier 4: $200

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- The calendar year deductible is: $2,000 Self Only enrollment, $4,000 Self Plus One enrollment, or $4,000 per Self and Family enrollment. The calendar year deductible applies to almost all benefits in this Section. **We added "(Not subject to deductible)" to show when the calendar year deductible does not apply.**
- If you enroll in this plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Medicare Advantage Value 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 **$50 Part B reimbursement** per month. The UnitedHealthcare Medicare Advantage Value Plan is subject to Medicare rules. (See Section 9 for additional details.)
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay after the calendar year deductible
Diagnostic and treatment services	**High Option**
Professional services of physicians • In physician's office	30% coinsurance per Primary Care Physician (PCP) visit 30% coinsurance for specialist visit
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical opinion • At home • Advance care planning	30% coinsurance per visit
Second Opinion - is powered by 2nd MD, a third-party-vendor, to assist you with more informed decision making. The plan pays 100% for this program when the 2nd MD is the provider. This is an in-network only option. It does not change your cost sharing costs for your second opinion benefit when utilized through other providers.	Nothing

Benefit Description	You pay after the calendar year deductible
Telehealth services / Virtual visits	**High Option**
Use telehealth services/virtual visits when: • Your doctor is not available • You become ill while traveling • Conditions such as cold/coughs, allergies, seasonal flu, bladder infection, bronchitis, diarrhea, fever, migranes/headaches, pink eye, rashes, 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. Virtual Visits and prescription services are subject 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.	30% coinsurance
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • Bone scans • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	30% coinsurance
Preventive care, adult	**High Option**
Routine physical every year The **following** preventive services are covered at the time interval recommended at each of the links below. • Immunizations such as Pneumococcal, influenza, shingles, tetanus/DTaP, and human papillomavirus (HPV). For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ • Screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer screening. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org • Individual counseling on prevention and reducing health risks	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay after the calendar year deductible
Preventive care, adult (cont.)	**High Option**
• Well woman care 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 Well Women preventive care services please visit the Health and Human Services (HHS) website at https://www.healthcare.gov/preventive-care-women/	Nothing
Routine mammogram - covered for women	Nothing
Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC); based on the Advisory Committee on Immunization Practices (ACP) schedule.	Nothing
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.	
BRCA genetic counseling and evaluation are covered in preventive service when a woman's family history is associated with an increased risk for deleterious mutations in *BRCA1* or *BRCA2* genes and medical necessity criteria has been met	Nothing
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*
Preventive care, children	**High Option**
• 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 • Immunizations such as DTaP, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/index.html • You can also find a complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) online at https://www.uspreventiveservicestaskforce.org	Nothing
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.	

Benefit Description	You pay after the calendar year deductible
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women • Delivery • Postnatal care	30% coinsurance
Breastfeeding support, supplies and counseling for each birth	Nothing
Note: Here are some things to keep in mind: • You do not need to precertify your vaginal delivery; see page 14 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • 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 confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.	
Family planning	**High Option**
Contraceptive counseling and treatment	Women pay nothing for Tier 1 contraceptives Men 30% coinsurance
A range of voluntary family planning services, limited to: • Voluntary sterilization for women (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (s) (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragms	Nothing
Note: We cover oral contraceptives under the prescription drug benefit Genetic testing is covered when medically necessary for certain conditions such as pregnancy testing for cystic fibrosis, coverage of certain cancer drugs, certain autosomal recessive conditions, audosomal dominant less penetrant conditions, x-linked conditions and certain chromosome abnormalities.	30% coinsurance
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling unless medically necessary*	*All charges*

Benefit Description	You pay after the calendar year deductible
Infertility services	**High Option**
Diagnosis and treatment of the cause of infertility	30% coinsurance
Not Covered - • *The services listed below are not covered as treatments for infertility or as alternatives to conventional conception:* *• Assisted reproductive technology (ART) and assisted insemination procedures, including but not limited to:* *- Artificial insemination (AI)* *- In vitro fertilization (IVF)* *- Embryo transfer and Gamete Intrafallopian Transfer (GIFT)* *- Zygote Intrafallopian Transfer (ZIFT)* *- Intravaginal insemination (IVI)* *- Intracervical insemination (ICI)* *- Intracytoplasmic sperm injection (ICSI)* *- Intrauterine insemination (IUI)* *• Services, procedures, and/or supplies that are related to ART and/or assisted insemination procedures* *• Cryopreservation or storage of sperm (sperm banking), eggs, or embryos* *• Preimplantation diagnosis, testing, and/or screening, including the testing or screening of eggs, sperm, or embryos* *• Drugs used in conjunction with ART and assisted insemination procedures (see Prescription Drug section)* *• Services, supplies, or drugs provided to individuals not enrolled in this Plan*	*All charges*
Allergy care	**High Option**
• Testing and treatment • Allergy injections	30% coinsurance
Allergy serum	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	**High Option**
• Chemotherapy and radiation therapy **Note:** High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 40. • Respiratory and inhalation therapy (pulmonary rehabilitation) is provided for up to 20 sessions • Cardiac rehabilitation following qualifying event/condition is provided for up to 60 sessions • Cognitive rehabilitation therapy is provided for up to 20 visits when medically necessary following sudden external injuries such as car accidents or falls; or sudden internal injuries such as stroke (cerebral vascular accident), aneurysm, anoxia, enchapalitis or brain tumors • Post-cochlear implant rehabilitation	30% coinsurance

Treatment therapies - continued on next page

Benefit Description	You pay after the calendar year deductible
Treatment therapies (cont.)	**High Option**
• Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services* on page 16.	30% coinsurance
Applied Behavioral Analysis (ABA) - Children with autism spectrum disorder	30% coinsurance
Physical and occupational therapies	**High Option**
60 visits combined for physical therapy and occupational therapy provided by: • 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. Habilitative services for children under age 19 with congenital or genetic birth defects are covered with no visit limits. (This applies to speech, occupational and physical therapy)	30% coinsurance
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*
Speech therapy	**High Option**
20 visits per year per condition for speech therapy Habilitative services for children under age 19 with congenital or genetic birth defects are covered with no visit limit	30% coinsurance
Not covered: • *Exercise programs, gyms or pool memberships* • *Work hardening/functional capacity programs or evaluations* • *Voice therapy*	*All charges*

Benefit Description	You pay after the calendar year deductible
Hearing services (testing, treatment, and supplies)	**High Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist. Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	30% coinsurance
• External hearing aids - A single purchase (including repair/replacement per hearing impaired ear every three (3) years. • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, see Section 5(a) Orthopedic and prosthetic devices.	External hearing aids - 30% coinsurance up to $2,500 per ear - limited to one (1) per hearing impaired ear every 3 years.
Not covered: • *Hearing services that are not shown as covered*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**
• Diagnoses and treatment of diseases of the eye • Initial pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Routine Eye Examination - Eye refraction every two years - examination to provide written lens prescriptionNote: Eye examinations for children follow the Bright Futures Guidelines (American Academy of Pediatrics) at no charge	30% coinsurance
Not covered: • *Eyeglassesor contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	30% coinsurance
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*

Benefit Description	You pay after the calendar year deductible
Orthopedic and prosthetic devices	**High Option**
• Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. • Hair prosthesis (wig for hair loss due to cancer treatment) -up to $350 per year • Ostomy supplies • Orthotic braces and splints not available over the counter that straighten or change the shape of a body part • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome and/or Myofascial Pain Dysfunction (MPD). • External hearing aids - see hearing services page 32. • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants 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 • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. • Single purchase of each type of prosthetic device every three (3) years in-network only. Prior authorization is required for prosthetic devices in excess of $1,000. Note: For information on the professional charges for the surgery to insert an implant, see *Section 5(b) Surgical procedures.* For information on the hospital and/or ambulatory surgery center benefits, see *Section 5(c) Services provided by a hospital or other facility, and ambulance services.* **Note:** 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.*	30% coinsurance
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay after the calendar year deductible
Orthopedic and prosthetic devices (cont.)	**High Option**
• *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Speech prosthetics (except electrolarynx)* • *Prosthetic replacements provided less than 3 years after the last one we covered* • *Prosthetic replacements provided less than 5 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)	**High Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Audible prescription reading devices • Speech generating devices • Blood glucose monitors/continuous glucose monitors • Insulin pumps and pump supplies • CPAP for sleep apnea - and covered CPAP supplies • Surgical dressings not available over-the-counter • Therapeutic shoes for diabetics • Braces including necessary adjustments to shoes to accommodate braces, which are used for the purpose of supporting a weak or deformed body part • Braces restricting or eliminating motion in a diseased or injured part of the body **Note:** Many durable equipment items must be preauthorized. Call us at 1-877-835-9861 as soon as your Plan physician prescribes this equipment and you need assistance locating a health care physician or health care practitioner to rent or sell you durable medical equipment. You may also call us to see if a certain piece of equipment is covered.	30% coinsurance

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay after the calendar year deductible
Durable medical equipment (DME) (cont.)	**High Option**
	30% coinsurance
Not covered: • *Motorized wheelchairs unless medically necessary and preauthorized* • *Audible prescription reading devices Hearing aids* • *Speech generating devices* • *Talkers* • *Story boards* • *Scooters* • *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* • *Augmentative communication devices* • *Infertility monitors* • *Physical fitness equipment* • *Continuous pulse oximetry unless skilled nursing is involved in home care and it is part of their medically necessary equipment*	*All charges*
Home health services	**High Option**
• Medically necessary home healthcare ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Skilled care is skilled nursing, skilled teaching and skilled rehabilitation 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 • 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	30% coinsurance

Home health services - continued on next page

Benefit Description	You pay after the calendar year deductible
Home health services (cont.)	**High Option**
• Services include administration of oxygen therapy, intravenous therapy and medications. • Limit of 60 visits per year Prescription foods covered as follows: • Amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases which are prescribed for the therapeutic treatment of inherited metabolic diseases and are administered under the direction of a physician • Specialized formulas for the treatment of a disease or condition and are administered under the direction of a Physician • Medical foods which are determined to be the sole source of nutrition and cannot be obtained without a physician's prescription	30% coinsurance
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family.* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.* • *Private duty nursing* • *Foods that can be obtained over the counter (without a prescription) even if prescribed by a physician*	*All charges*
Chiropractic	**High Option**
• Diagnosis and related services for the manipulation of the spine and extremities to remove nerve interference or its effects. Limited to one treatment per day up to 20 visits per calendar year **Note:** The interference must be the result of, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column.	30% coinsurance
Alternative treatments	**High Option**
Acupuncture up to 12 visits per year : • Anesthesia • Pain relief • Nausea that is related to surgery, pregnancy or chemotherapy. Acupuncture services must be performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body. • Doctor of Medicine • Doctor of Osteopathy • Chiropractor • Acupuncturist	30% coinsurance
Not covered: • *Naturopathic services*	*All charges*

Alternative treatments - continued on next page

Benefit Description	You pay after the calendar year deductible
Alternative treatments (cont.)	**High Option**
• *Hypnotherapy* • *Biofeedback* • *Massage therapy* • *Herbal medicine* • *Homeopathy* • *Rolfing* • *Ayurvdea* • *Other alternative treatments unless specifically listed as covered*	*All charges*
Educational classes and programs	**High Option**
• Diabetes self-management classes: • 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. • Initial training visit; up to 10 hours, after you are diagnosed with diabetes for the care and management of diabetes	30% coinsurance
Coverage is provided for : • Tobacco Cessation program "Quit for Life" which includes online learning, Quit Coach, Nicotine Replacement Therapy Coaching and over the counter and prescription drugs approved by the FDA (subject to age and treatment therapy recommendations) to treat tobacco dependence. Learn more about this program in Section 5(h) Wellness and other Special Features.	Nothing

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Health Care Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The calendar year deductible is: $2,000 Self Only enrollment, $4,000 Self Plus One enrollment or $4,000 Self and Family enrollment. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- If you enroll in this plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Medicare Advantage Value 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 **$50 Part B reimbursement per month.** The UnitedHealthcare Medicare Advantage Value Plan is subject to Medicare rules. (See Section 9 for additional details.)
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES**. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay After the calendar year deductible
Surgical procedures	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies(see *Reconstructive surgery*) • Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., vasectomy) • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	30% coinsurance
Voluntary sterilization for women (tubal ligation)	Nothing
Not covered: • *Reversal of voluntary sterilization*	*All charges*

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible
Surgical procedures (cont.)	**High Option**
• *Routine treatment of conditions of the foot; (see Foot care)*	*All charges*
Surgical treatment of morbid obesity (bariatric surgery) • Eligible members must be age 18 or older or for adolescents, have achieved greater than 95% of estimated adult height AND a minimum Tanner Stage of 4 • have a minimum Body Mass Index (BMI) of 40, or greater than or equal to 35 with at least 1 co-morbid condition present • must enroll in the Bariatric Resource Services Program (BRS) • must use a designated Bariatric Resource Services (BRS) provider and facility • must have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation • The member's physician must submit clinical records documenting the completion of a 6-month physician supervised structured weight loss program • This benefit must be coordinated by UnitedHealthcare Bariatric Resources Program and the Bariatric Center of Excellence facility • One surgery per lifetime unless complications	30% coinsurance
Reconstructive surgery	**High Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance; and - the condition can reasonably be expected to be corrected by such surgery. • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see *Prosthetic devices*) • Gender reassignment surgery is limited to the following procedures: - Mastectomy - Hysterectomy - Oophorectomies - Gonadectomy - Orchiectomy • **Note:** If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	30% coinsurance
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury*	*All charges*

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible
Reconstructive surgery (cont.)	**High Option**
• *Gender reassignment surgical procedures not listed above*	*All charges*
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	30% coinsurance
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants-must be provided in a Plan designated Center for Transplants	**High Option**
These **solid organ transplants** are covered. Solid organ transplants are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung: single/bilateral/lobar • Pancreas These **tandem blood** or **marrow stem cell transplants for covered transplants** are subject to medical review by the Plan. Refer to *Other services* in Section 3 for your authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent gem cell tumors (including testicular cancer)	30% coinsurance

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

Benefit Description	You pay After the calendar year deductible
Organ/tissue transplants-must be provided in a Plan designated Center for Transplants (cont.)	**High Option**
Blood or marrow stem cell transplants The plan extends coverage for the diagnoses as indicated below: • Allogenic 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) - 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 - 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	30% coinsurance

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

Benefit Description	You pay After the calendar year deductible
Organ/tissue transplants-must be provided in a Plan designated Center for Transplants (cont.)	**High Option**
- Multiple myeloma - Medulloblastoma - Multiple myeloma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	30% coinsurance
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 - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	30% coinsurance
These blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols.	30% coinsurance

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

Benefit Description	You pay After the calendar year deductible
Organ/tissue transplants-must be provided in a Plan designated Center for Transplants (cont.)	**High Option**
If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Sickle Cell Anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic 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 - 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	30% coinsurance

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

Benefit Description	You pay After the calendar year deductible
Organ/tissue transplants-must be provided in a Plan designated Center for Transplants (cont.)	**High Option**
- Aggressive non-Hodgkin's lymphoma - Breast Cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial ovarian cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	30% coinsurance
National Transplant Program (NTP) - 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: 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.	
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	30% coinsurance
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered* • *All services related to non-covered transplants* • *All services associated with complications resulting from the removal of an organ from a non-member*	*All charges*

Benefit Description	You pay After the calendar year deductible
Anesthesia	**High Option**
Professional services provided in – • Hospital (inpatient)	30% coinsurance
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory • Office	30% coinsurance

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.
- The calendar year deductible is: $2,000 Self Only enrollment, $4,000 Self Plus One enrollment or $4,000 Self and Family enrollment. The calendar year deductible applies to almost all benefits in this Section. **We added "(Not subject to deductible)" to show when the calendar year deductible does not apply.**
- If you enroll in this plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Medicare Advantage Value 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 $50 Part B reimbursement per month**. The UnitedHealthcare Medicare Advantage Value Plan is subject to Medicare rules. (See Section 9 for additional details.)
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay After the calendar year deductible
Inpatient hospital	**High Option**
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.	30% coinsurance
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	30% coinsurance
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay After the calendar year deductible
Inpatient hospital (cont.)	**High Option**
• *Personal comfort items, such as phone, television, barber services, guest meals and beds* • *Private nursing care unless medically necessary*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service **Note:** We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	30% coinsurance
Extended care benefits/Skilled nursing care facility benefits	**High Option**
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 in a semi-private room • General nursing • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor • Benefits up to 60-days when full time skilled nursing care is necessary and confinement is medically appropriate.	30% coinsurance
Not covered: • *Custodial care* • *Rest cures, domiciliary or convalescent care* • *Personal comfort items such as phone, barber services, guest meals and beds*	*All charges*

Benefit Description	You pay After the calendar year deductible
Hospice care	**High Option**
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 • Social, spiritual and respite care for the terminally ill patient • Short-term grief counseling for immediate family members.	30% coinsurance
Not covered: Private duty or Independent nursing, and homemaker services	*All charges*
Ambulance - Non Emergency	**High Option**
Local professional ambulance service (non-emergency) when medically appropriate	30% coinsurance

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $2,000 Self Only enrollment, $4,000 Self Plus One enrollment, or $4,000 Self and Family enrollment. The calendar year deductible applies to almost all benefits in this Section. **We added "(Not subject to deductible)" to show when the calendar year deductible does not apply.**
- If you enroll in this plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Medicare Advantage Value 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 $50 Part B reimbursement per month.** The UnitedHealthcare Medicare Advantage Value Plan is subject to Medicare rules. (See Section 9 for additional details.)
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within or outside our service area

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

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

Benefit Description	You pay After the calendar year deductible
Emergency within or outside our service area	**High Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	30% coinsurance per visit
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*	*All charges*

Benefit Description	You pay After the calendar year deductible
Ambulance - Emergency	**High Option**
• Professional ambulance service when medically appropriate. See 5(c) for non-emergency service.	30% coinsurance
Not covered: Air ambulance	*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.
- The calendar year deductible is: $2,000 Self Only enrollment, $4,000 Self Plus One enrollment or $4,000 Self and Family enrollment. The calendar year deductible applies to almost all benefits in this Section. **We added "(Not subject to deductible)" to show when the calendar year deductible does not apply.**
- If you enroll in this plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Medicare Advantage Value 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 $50 Part B reimbursement per month**. The UnitedHealthcare Medicare Advantage Value Plan is subject to Medicare rules. (See Section 9 for additional details.)
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay After the calendar year deductible
Professional services	**High Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders and services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug use, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	30% coinsurance

Benefit Description	You pay After the calendar year deductible
Diagnostics	**High Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	30% coinsurance
Inpatient hospital or other covered facility	**High Option**
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	30% coinsurance
Outpatient hospital or other covered facility	**High Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	30% coinsurance
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* • *Services that are not medically necessary* • *Methadone maintenance unless it is a part of an approved treatment program*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- Important things you should keep in mind about these benefits:
- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their prescribers obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- The calendar year deductible is: $2,000 Self Only enrollment, $4,000 Self Plus One enrollment or $4,000 Self and Family enrollment. The calendar year deductible applies to almost all benefits in this Section. **We added "(Not subject to deductible)" to show when the calendar year deductible does not apply.**
- If you enroll in this plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Medicare Advantage Value 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 $50 Part B reimbursement per month. The UnitedHealthcare Medicare Advantage Value Plan is subject to Medicare rules. (See Section 9 for additional details.)
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription**. A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice.
- **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 Some drugs are only available at the retail pharmacy for safety or other reasons. To locate the name of a Plan pharmacy near you, call our Customer Service Department 1-877-835-9861 or visit our website, www.uhcfeds.com. The PDL consists of Tiers 1, 2, 3 and 4.
- **We use a Prescription Drug List (PDL) called the Advantage PDL.** Our PDL Management Committee creates this list that includes FDA approved prescription medications, products, or devices. Our Plan covers all prescription medications written in accordance with FDA guidelines for a particular therapeutic indication except for medications listed under "Not Covered" in this section of the brochure as well as specific drug exclusions. The PDL Management Committee decides the tier placement based upon clinical information from the UnitedHealthcare Pharmacy and Therapeutics (P economic and financial considerations. You will find important information about our PDL as well as other Plan information on our member web site myuhc.com or our pre-member website at www.uhcfeds.com along with a listing of specific drug exclusions and medications that are recommended. Please familiarize yourself with the Advantage PDL as it offers both generic and brand drug on all of its tiers.

- The PDL consists of Tiers 1, 2, 3 and 4.
- **Tier 1** is your **lowest** copayment option (**$15** for up to a 30-day supply or $45.00 for up to a 90-day supply through mail order), and includes a number of generic medications, as well as select preferred brand medications. Brand medications in Tier 1 include select insulin products, select inhalers for asthma, and select medications for migraine headaches for which no generic alternative(s) are available. For the lowest out-of-pocket expense, you should always consider Tier 1 medications if you and your provider decide they are appropriate for your treatment.
- **Tier 2** is your **middle** copayment option (**$45** for up to a 30-day supply or $135 for up to a 90-day supply through mail order), and contains preferred brand medications not included in Tier 1. Preferred medications placed in Tiers 1 and 2 are those the PDL Management Committee has determined to provide better overall value than those in Tier 3. If you are currently taking a medication in Tier 2, ask your provider whether there are Tier 1 alternatives that may be appropriate for your

- **Tier 3** is your **higher** copayment option (**$85** for up to a 30-day supply or $225 for up to a 90-day supply through mail order), and consists of non-preferred medications. Sometimes there are alternatives available in Tier 1 or Tier 2. If you are currently taking a medication in Tier 3, ask your provider whether there are Tier 1 or Tier 2 alternatives that may be appropriate for your treatment.
- **Tier 4** is your **highest** copayment option (**$200** for up to a 30-day supply or $600 for up to a 90-day supply through mail order) non-preferred medications that do not add clinical value over their covered Tier 1, Tier 2, or Tier 3 alternatives. Some medications on Tier 4 may also have an over-the-counter alternative which can be purchased without a prescription.
- Changes to Tier level for all covered medications and supplies may occur January 1 and July 1 of each year. Newly marketed brand medications will be evaluated by our PDL Management Committee and they will be placed in the appropriate Tier. A prescription medication may be moved to the 4th tier of PDL at anytime if the medication changes to over-the-counter status, or is removed from the PDL due to safety concerns declared by the Food and Drug Administration (FDA).These are the dispensing limitations.• Special dispensing circumstances:
  - The Plan will give special consideration to filling prescription medications for members covered under the FEHB if:
    - You are called to active duty, or
    - You are officially called off-site as a result of a national or other emergency, or
    - You are going to be on vacation for an extended period of time
  - **Specific drug exclusions**: The plan will exclude higher cost medications that have therapeutic alternatives available and do not offer any additional clinical value over other options in their class. These drugs cost significantly more than those alternatives. A listing of these drugs can be found on uhcfeds.com or you may call customer service at 877-835-9861 and they will provide a copy to you.
  - 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 1-877-835-9861 for additional information.
  - **Refill Frequency**: A process that allows you to receive a refill once when you have used 75 percent of the medications for most prescription drugs. For example, a prescription that was filled for a 30-day supply can be refilled after 24 days. While this process provides advancement on your next prescription refill, we cannot dispense more than the total quantity your prescription allows.
  - **Half Tablet Program:** With certain medications, you may elect to join the voluntary Half Tablet Program. This Program allows you to save money in copayments by electing a double strength medication, receiving half the quantity, and splitting the tablet in half. If you take advantage of this Program, you will pay half a copayment at a retail pharmacy or through mail order. Your provider must write the prescription for the increased dosage, with the instructions to “take a half tablet”. A free tablet splitter is provided. For more information on this Program please contact customer service.
  - **Mandatory Specialty Pharmacy Program:** Our Specialty Pharmacy Program is designed to address the rare, complex and life-threatening diseases. We want to make these medications accessible and cost effective for our members. That’s why we offer the Specialty Pharmacy Program. This program supports the health care provider/patient relationship and provides focused support to help better manage rare and complex conditions by offering: **Members who have been prescribed specialty medications must obtain these medications from one of the designated specialty pharmacies.** You will continue to pay the applicable Tier copay for your specialty medications. Prescriptions for specialty medications must be filled for a maximum of a 30-days. To locate a specialty pharmacy for your particular needs members can contact customer service at 1-877-835-9861 and you will be connected to the specialty pharmacy. Your specialty pharmacy will be able to help you transfer your active prescriptions from your current pharmacy. If you’re out of refills, the specialty pharmacy will contact your doctor to get a new prescription.
    - **Better use of benefits** — Members can make the most of their health benefits by getting the right specialty medications from our network providers when they need them.
    - **Specialty pharmacies and home health care providers** — Our network providers have the resources and expertise needed to store and dispense specialty medications and ancillary
    - **Expert support** — Members get 24/7 phone access to specially trained pharmacists who can provide answers, patient education materials, proactive refill monitoring, counseling on side effects and more.
    - **Individualized services** — experienced nurses and pharmacists trained in specialty medications and rare and complex conditions offer personalized therapy support that can lead to better health outcomes.
    - **Supplies, such as sharps containers, needles, syringes** and tubing necessary to administer an injectable specialty drug are provided at **no cost** to you by the specialty pharmacy. Talk with your specialty pharmacy to learn

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

Benefit Description	You pay After the calendar year deductible
Preventive medications	**High Option**
The following are covered: The following drugs and supplements are covered without cost-share, even if over-the- counter, are prescribed by a health care professional and filled at a network pharmacy. • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 & 800 mcg • Liquid iron supplements for children age 0-1 year • Vitamin D supplements (prescription strength) (400 & 1000 units) for members 65 or older • Pre-natal vitamins for pregnant women • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 • Certain statins to treat cardiovascular disease for adults age 40 to 75 will be covered without a copayment as recommended by the United States Preventive Services Task force (USPSTF) when the following criteria is met: Age 40 to 75 years; and one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and a calculated 10-year risk of a cardiovascular event of 10% or Note: Preventive Medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a health care professional and filled by a network pharmacy. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations Note: To receive this benefit a prescription from a doctor must be presented to pharmacy. Benefits available at in-network pharmacy only.	Nothing (Not subject to deductible)
Covered Medications and Supplies	**High Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medications that by Federal law of the United States require a physician's prescription for their purchase, except those listed as Not covered. • Insulin with a copayment charge applied every 2 vials • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction are limited. Contact the plan for dosage limits/ • Oral and some injectable contraceptive drugs **Note:** Intravenous fluids and medications for home use, implantable drugs, and some injectable drugs are covered under *Medical services and supplies Section (5a)* or *Surgical and anesthesia services Section (5b).*	Plan retail pharmacy up to a maximum of a 30-day supply: Tier 1- $15 Tier 2- $45 Tier 3- $85 Tier 4 -$200 Plan mail order pharmacy for up to a maximum of up to a 90-day supply: Tier 1- $45 Tier 2- $135 Tier 3- $255 Tier 4- $600

Covered Medications and Supplies - continued on next page

Benefit Description	You pay After the calendar year deductible
Covered Medications and Supplies (cont.)	**High Option**
Woman's contraceptive drugs and devices - Tier 1 hormonal contraceptives Implanted contraceptive drugs and devices such as Norplant are covered under the medical benefit The "morning after pill" (tier 1) is provided at no cost if prescribed by a physician and purchased at the network pharmacy	Nothing (Not subject to deductible)
• Diabetic supplies limited to insulin syringes, needles, glucose test tape, Benedict's solution or equivalents and acetone test • Please note: For coverage of glucose monitors please refer to the Section 5(a) Durable Medical Equipment Page 34 as some monitors may be covered under the medical benefit. Please contact customer service 877-835-9861 for additional information.	30% coinsurance
Prescription tobacco cessation medications and FDA approved over the counter tobacco cessation medications with prescription from physician. Note quantity limits and age restrictions may apply.	Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Medical supplies such as dressings and antiseptics* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed* • *Drugs available over-the-counter that do not require a prescription order by federal or state law before being dispensed, and any drug that is therapeutically equivalent to an over- the-counter* • *Compound drugs that do not contain at least one covered ingredient that requires a Prescription Order or Refill* • *Alcohol swabs and bio-hazard disposable containers* • *Medical Marijuana* • *Fertility drugs* • *Drugs for sexual performance for patients that have undergone genital reconstruction* • *Nonprescription medications* Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation programs benefit. (See page 37.)	*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.
- The calendar year deductible is: $2,000 Self Only enrollment, $4,000 Self Plus One enrollment or $4,000 Self and Family enrollment. The calendar year deductible applies to almost all benefits in this Section. **We added "(Not subject to deductible)" to show when the calendar year deductible does not apply.**
- If you enroll in this plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Medicare Advantage Value 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 $50 Part B reimbursement per month.** The UnitedHealthcare Medicare Advantage Value Plan is subject to Medicare rules. (See Section 9 for additional details.)
- 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 We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit 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. • The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. You may request an extension of this time period provided you do so within 60-days of the injury and if extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wire from fracture care.) • Benefits for treatment of accidental injury are limited to the following: - Emergency examination - Necessary X-rays - Endodontic (root canal) treatment - Temporary splinting of teeth - Prefabricated post and core - Simple minimal restorative procedures (fillings) - Extractions - Placement of a crown if such treatment is the only clinical treatment and in cases of an injury as described above in this section - Replacement of lost teeth due to injury - Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry 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;	30% coinsurance

Accidental injury benefit - continued on next page

Benefit Description	You Pay
Accidental injury benefit (cont.)	**High Option**
• 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 • 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. **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	
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*
Adjunctive dental	**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 service and supplies are considered by the profession to be an appropriate method of treatment and meet broadly accepted national standards of dental practice. You and the provider may choose a more expensive level of care, but benefits will be payable according to these guidelines.	30% coinsurance

Section 5(h). Wellness and Other Special features

Feature	Description
UnitedHealthcare app	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. UnitedHealthcare has created tools to help members maximize their benefits. 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. • 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. • Members have access to their health plan ID card, claims information and real-time status on account balances, deductibles and out-of-pocket spending. • With the UnitedHealthcare app, you can manage the health care for your entire family, 24/7. They can find a physician or facility near them using the GPS location search feature. • The UnitedHealthcare app is the go-to resource to help you manage your health care. Anywhere. Anytime. • Members can find and receive care, access financial accounts, view claims status, estimate costs and pay bills directly from the app. Available from the Apple Store or Google play 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, members can: • 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 *Download the UnitedHealthcare app from the App Store® or Google Play™
Quit for Life ®	Quit for Life provides our members with resources and support for tobacco cessation. Included are: • Portal and mobile app • Online learning with interactive and personalized content and a community support forum • Integrated online and telephonic experience • Live coaching sessions with coaches with degrees in counseling, addiction studies, and related fields • Nicotine replacement therapy counseling • 24/7 support for easier access to services • Nicotine replacement therapy both prescription medications and over the counter products (with prescription) Get started today. Go to myuhc.com, visit the "Health Resources" tab on the top right, Choose the "Quit for Life" tile. For Medicare Advantage members please contact the number on your UnitedHealthcare Medicare Advantage Card.

Feature	Description
Maternity Support Program	If you are thinking about having a baby or are expecting, the **Maternity Support Program** allows UnitedHealthcare® members the opportunity to build a longer-term relationship with a nurse. After you enroll, you will be able to work directly with an experienced maternity nurse who is available to answer your questions and help you with things like: **Staying Connected** • Click to call a registered nurse 24/7 • Access personalized pregnancy information and content • Link to your pregnancy benefits and cost estimator tools **Staying Healthy** • Monitor your pregnancy with a weight tracker • Set reminders to take vitamins • Keep track of calendar appointments and user-specified events • Take health assessments, with the ability to consult a maternity program nurse by phone **Staying More Informed** • Read weekly developments that typically occur throughout your pregnancy • Search symptoms and concerns that may arise during your pregnancy • Track your baby's movements with a kick counter To get started you can reach us online https://phs.com/maternity or by phone 1-877-201-5328, TTY 711, 24 hours a day 7 days a week. Enroll in the **Maternity Support Program** by calling or downloading the app (Available for iPhone in Apple Store or Android in Google Play) and completing a Welcome Pregnancy Questionnaire where you can access maternity support. Like the app, it's provided at no extra cost as part of your benefit plan.
Spine and Joint Program	Our Spine and Joint Program provides access to surgeons and expert facilities that qualify for our Center of Excellence (COE) designation. Facilities, surgeons and teams are independently evaluated and have been vetted by the NCQA-accredited Optum Clinical Sciences Institute and effective management of complex but common procedures. • Care delivered at facilities with lower risk of readmissions and • Predictable medical • Support from a Centers of Excellence care navigator while a facility patient This program helps support our members while ensuring overall better experience and recovery. Members can experience reduced out of pocket costs when participating in the Spine and Joint Program.
UnitedHealth Premium	Choosing a doctor is one of the most important health decisions you'll make. The UnitedHealth Premium® program can help you find doctors who are right for you and your family. You can find quality, cost-efficient care. Studies show that people who actively engage in their health care decisions have fewer Hospitalizations, fewer emergency visits, higher utilization of preventive care and overall lower medical costs. The program evaluates physicians in various specialties using evidence-based medicine and national standardized measures to help you locate quality and cost-efficient providers. It's easy to find a UnitedHealth Premium Care Physician. Just go to **myuhc.com®** and click on Find a Doctor. Choose smart. Look for blue hearts. • **Premium Care Physician** meets UnitedHealth Premium program quality & 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** physician's specialty is not evaluated and/or does not have enough claims data for program evaluation or the physician's program evaluation is in process
Real Appeal	Real Appeal® provides tools and support to help members lose weight and prevent weight-related health conditions. Real Appeal is **provided at no additional** cost to eligible FEHB members as part of your medical benefit plan**. Medicare Advantage Members please refer to Real Appeal for Medicare Advantage members on the next page.** The program can help motivate members to improve their health and reduce risk of developing costly, chronic conditions like cardiovascular disease and diabetes. The program combines clinically proven science with engaging content that teaches members how to eat healthier and be active, without turning their lives upside down, to help them achieve and maintain their weight-loss goals. **Real Appeal includes:** **A Success Kit -** After attending their first group coaching session, members receive a Success Kit with tools to help them kick-start their weight loss. The kit includes: • Nutrition guide with recipes • Portion plate • Electronic food scale • Digital weight scale • Fitness guide • 12 fitness DVDs • Resistance bands After 8 weeks of the program members receive a blender before the class on healthy smoothie options. **A personalized Transformation Coach -** Coaches guide members through the program step-by-step, customizing it to help fit their needs, personal preferences, goals and medical history. **24/7 online support and mobile app -** Staying accountable to goals may be easier than ever. • Customizable food, activity, weight and goal trackers • Unlimited access to digital • Success group support, which lets employees chat with others who are doing the Real Appeal program. • Online TV shows that is fun, engaging and helps members learn new ways to be healthier **Why Real Appeal works -** Real Appeal is guided by a Clinical Advisory Board of obesity, nutrition and behavior change experts that create customized content to help keep members engaged throughout their weight-loss journey. Members will learn steps to help with long-term transformation, which may translate to a happier, healthier member.
Specialty Pharmacy	Appropriate use of specialty medications can be important to maintaining or improving your health and your quality of life. Our specialty program provides the resources and personalized, condition-specific support you need to help you better manage your condition. These specialty medications are used to treat complex long-term conditions that require additional care and support. It may be injected, inhaled or taken by mouth. In addition, they may require additional education and support for best management, have unique storage or shipping requirements and may not be available at retail pharmacies. The OptumRx® Specialty Services and BriovaRx Infusion Services, offers support to help you manage these conditions. Take advantage of personalized support - at no charge to you - from knowledgeable pharmacies and nurses who specialize in your condition. In addition you will receive: • Access to your medications at the lowest cost • Pharmacists available 24/7 • Support through clinical and adherence programs

	• Any medication-related supplies at no additional cost • Proactive refill reminders • Timely delivery and shipping in confidential, temperature-sensitive packaging **C**ontact 1-877-835-9861 or contact Briova directly at 1-855-4BRIOVA (1-855-427-4682)
Flexible Benefits Option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review • By approving an alternative benefit, we cannot guarantee you will get it in the • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claims process (see Section 8).
Fitness Program **for Medicare Advantage Members:**	Renew Active is a fitness benefit which is included in the Medicare Advantage plan which provides: • A free gym membership to participating facilities - To view participating facilities, please visit www.uhcrenewactive.com • Access to an extensive network of gyms and fitness locations near members • A personalized fitness plan • Access to a wide variety of fitness classes • An online brain health program, exclusively from AARP® Staying Sharp • Connecting with others at local health and wellness events, and through the Fitbit® Community for Renew Active
Health Navigators **for Medicare Advantage Members**	Health Navigators work with individuals to assist in guiding them through the complexities of the healthcare system due to a complex health event such as diabetes, congestive heart failure, or multiple chronic conditions. Health Navigators work with individuals to assist in coordinating care with multiple providers and/or facilities and find additional clinical and community programs which may be available.
HouseCalls **for Medicare Advantage** **Members**	With the UnitedHealthcare® HouseCalls program, you get an annual in-home preventive care visit from one of our health care practitioners at no extra cost. What does HouseCalls include? • One 45 to 60-minute at-home visit from a health care practitioner, each year. • A head-to-toe exam, health screenings and plenty of time to talk about your health questions. • A custom care plan made just for you. • Help connecting you with additional care you may need.

Feature	Description
Meal Delivery Program **for Medicare Advantage** **Members**	As a member, you can receive up to 84 home delivered meals immediately following an inpatient hospitalization when referred by your UnitedHealthcare® case manager. • Meals are delivered to your door in a climate-controlled cooler in "Fresh-Lock" packaging in shipments of 14 meals or greater • Meals can be refrigerated for up to 14 days or frozen for up to three months • Meals are available to support 9 different health conditions • Meals are provided through our national provider Mom's Meals®
Real Appeal for **Medicare Advantage Members**	Real Appeal is a weight loss program that can help members feel and look better. The program provides everything they need to lose weight and keep it off. This program is a pilot for select members residing in Wisconsin. The online program includes: • Personalized diabetes prevention coaching • 24/7 online support and mobile app • Customizable food, activity, weight and goal trackers • Success group support, which lets members chat with others who are doing the Real Appeal program • The weekly Real Appeal All-Star Show featuring healthy tips from celebrities, athletes and health experts Success Kit includes: • Program, nutrition, and fitness guides • Tools to help cook healthier, tasty meals • Delivered right to their front door after attending their first group coaching session
Quit For Life **for Medicare Advantage** **Members**	Quit For Life has helped 3.5 million members quit smoking or using tobacco. It provides the tools and one-on-one support to help you quit your way. And for UnitedHealthcare members, it's offered at $0 out of pocket. With a 95% satisfaction rate, Quit for Life provides • Tools and support to help members quit cigarettes, e-cigarettes, vaping and tobacco • A personal, one-on-one Quit Coach to help you create a customized quit plan • The Quit for Life mobile app, which offers 24/7 urge management support • Text2Quit text messages for daily tips and encouragement • Quit medications – Such as nicotine gum or patches – for no charge, based on eligibility.

Non-FEHB Benefits Available to Plan Members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 1-877-835-9861 TTY 711.

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

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

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

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

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

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

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

For details and plan cost and availability in your area.

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

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

UnitedHealthOne® is a brand name used for many UnitedHealthcare individual insurance products. UnitedHealthcare and UnitedHealthOne® family and individual insurance plans are underwritten by Golden Rule Insurance Company and UnitedHealthcare Life Insurance Company. Prior to being purchased by UnitedHealthcare in 2003, Golden Rule Insurance Company had served the insurance needs of families and individuals for decades. The expertise brought in by Golden Rule has now become an important component of UnitedHealthcare and UnitedHealthOne® insurance products offered on UHOne.com. Shopping her**e** 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 or investigational 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.
- Surrogate parenting
- Fetal reduction surgery
- Reversal of voluntary sterilization
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Extra care costs or research costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine
- 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.

Section 7. Filing a Claim for Covered Services

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

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

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

Medical and hospital benefits

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

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

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

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

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

Prescription drugs

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

International Claims

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

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

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

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as 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 health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by calling 1-877-835-9861.

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

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

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

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: UnitedHealthcare Federal Employees Health Benefits (FEHB) Program Appeals, P.O. Box 30573, Salt Lake City, 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) Your email address, if you would like to receive our decision via email. Please note that by providing your email address, you may receive our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30-days from the date we receive your request to: a) Pay the claim or

b) Write to you and maintain our denial or.

c) Ask you or your provider for more information

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

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

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, Federal Employee 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 health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

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

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

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

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

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

Note: **If you have a serious or life-threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 877-835-9861. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's FEHB 3 at 202 606-0755 between 8 a.m. and 5 p.m. Eastern Time.

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

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 1-877-835-9861. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's FEHB 3 at 202-606-0755 between 8 a.m. and 5 p.m. Eastern Time.

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

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

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

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit 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, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

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

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

Clinical trials

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

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

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

When you have Medicare

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. You will not need to do anything. To find out if you need to do something to file your claim, call us at 1-877-835-9861 or see our website at: www.myuhc.com.

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

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Please review the following table it 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.

Medicare

Benefit Description	**High Option** **You Pay without Medicare**	**High Option** **You Pay with Medicare Part B**
Deductible	$2,000 Self Only, $4,000 Self Plus One or $4,000 Self and Family	$2,000 Self Only, $4,000 Self Plus One or $4,000 Self and Family
Out-of-Pocket Maximum	$7,350 Self Only, $14,700 Self Plus One or $14,700 Self and Family	$7,350 Self Only, $14,700 Self Plus One or $14,700 Self and Family
Part B Premium Reimbursement	N/A	N/A
Primary Care Physician	30% coinsurance	30% coinsurance
Specialist	30% coinsurance	30% coinsurance
Inpatient Hospital	30% coinsurance	30% coinsurance
Outpatient	30% coinsurance	30% coinsurance
Incentives offered	N/A	N/A

- **Tell us about your Medicare Coverage**

You can find more information about how our plan coordinates benefits with Medicare at www.myuhc.com.

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

- **Medicare Advantage (Part C)**

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

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

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

This Plan and our Medicare Advantage plan:

You may enroll in our UnitedHealthcare Medicare Advantage Value Plan and also remain enrolled in our FEHB plan. **YOU MUST BE ENROLLED IN THIS FEHB PLAN** participating in this program to be eligible for the UnitedHealthcare Medicare Advantage Value Plan - For more information on our Medicare Advantage Value plan, please contact us at 1-844-481-8821.

You may enroll in the UnitedHealthcare Medicare Advantage Value Plan if:

- You are enrolled in this UnitedHealthcare FEHBP active plan and have both Medicare Part A and Part B
- You are retired and live in our geographic service area. See page 11 for a description of our service area.

- You are a United States citizen or are lawfully present in the United States
- You do NOT have End-Stage Renal Disease (ESRD), with limited exceptions
- You complete an application for enrollment in the UnitedHealthcare Medicare Advantage Value Plan.

Reimbursement of $50 per month toward your Part B premium will begin on the first of the month following approval of your application. As part of this process CMS will verify your Medicare Part B enrollment. During a calendar year, you may enroll in this Medicare Advantage Value Plan only once. If the FEHB subscriber and/or dependent enrolls in the Medicare Advantage Value Plan, each qualified family member will have to complete an application by calling into our Retiree Services team at (1-844-481-8821).

Members who are not eligible for Medicare Part A and B will remain on the FEHB active plan. If, for any reason, you do not meet the enrollment requirements, you will no longer be eligible to participate in the Medicare Advantage Value plan. Your contributions will end and your regular FEHB benefits will resume. You may be required to repay any reimbursements paid to you in error.

This plan is designed:

- To help members with their Medicare Part B premium costs
- To provide access to our national network of providers, (in-network or out-of-network) at the same cost share
- To cover eligible medical benefits with little to no out of pocket costs
- To provide coverage with a catastrophic benefit for prescriptions
- **Note: You MUST remain enrolled in this FEHB plan to enroll in this Retiree Advantage plan. Do not suspend or terminate this FEHB plan or your Medicare Retiree Advantage plan will also terminate and you will be left without coverage**

The UnitedHealthcare Medicare Advantage Value Plan provides a monthly reimbursement of $50 of your Medicare Part B monthly premium. CMS will process reimbursement directly to your Social Security each month you are covered in the UHCA plan. In addition, we cover benefits, including office visit copayments at ($0), urgent care and emergency care at ($0), plus additional coverage for hearing aids discounts and wellness programs. Note: If you do not receive a social security check please notify us immediately to assist us in making arrangements to reimburse you directly.

Please see the following chart for your benefits under our Medicare Advantage Value plan.

Benefit Description	Member Cost without Medicare	Member Cost with Medicare Part B	Member Cost with UnitedHealthcare Medicare Advantage Value Plan
Deductible	$,2000 Self Only/ $4,000 Self Plus One and Self and Family	$2,000 Self Only/ $4,000 Self Plus One and Self and Family	No plan deductible
Out-of-Pocket Maximum	$7,350 Self Only $14,700 Self Plus One and $14,700 Self and Family	$7,350 Self Only $14,700 Self Plus One and $14,700 Self and Family	You pay nothing for Medicare-covered service from any provider
Primary Care Physician	30% coinsurance	30% coinsurance	$0
Specialist	30% coinsurance	30% coinsurance	$0
Virtual Visits	30% coinsurance	30% coinsurance	$0
Urgent Care	30% coinsurance	30% coinsurance	$0
Emergency	30% coinsurance	30% coinsurance	$0
Inpatient Hospital	30% coinsurance)	30% coinsurance	$0
Outpatient Hospital	30% coinsurance	30% coinsurance	$0
Rx Retail 30-day supply	Tier 1-$15, Tier 2-$45, Tier 3-$85,Tier 4-$200	Tier 1-$15, Tier 2-$45, Tier 3-$85,Tier 4–$200	Tier 1-$7, Tier 2-$35, Tier 3-$65, Tier 4–$100
Rx – Mail Order 90-day supply	Tier 1-$45, Tier 2-$135, Tier 3-$255, Tier 4-$600	Tier 1-$45, Tier 2-$135, Tier 3-$255, Tier 4-$600	Tier 1-$14, Tier 2-$70, Tier 3-$130, Tier 4-$200

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers) but we will not waive any of our copayments or coinsurance. If you enroll in a Medicare Advantage 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 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.) **If you enroll in our Medicare Advantage Value plan above, do NOT suspend your FEHB plan as it is required to remain in place to enroll in our Medicare Advantage value plan. If you were to suspend or terminate your FEHB plan the Medicare Advantage plan will also terminate.** For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

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

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

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

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

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

Section 10. Definitions of Terms We Use in This Brochure

Calendar year

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

Clinical Trials Cost Categories

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

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

Coinsurance

See Section 4, page 20.

Copayment

See Section 4, page 20,

Cost-Sharing

See Section 4, page 20.

Covered services

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

Custodial care

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

Deductible

See Section 4, page 20.

Experimental or investigational service

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

- Not approved by the *S. Food and Drug Administration (FDA*) to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States American Hospital Pharmacopoeia Dispensing Information* as appropriate for the proposed use
- Not recognized, in accordance with generally accepted medical standards, as being safe and effective for your condition;
- Subject to review and approval by any institution review board for the proposed use. (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be

Experimental or Investigational).

The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight

Health care professional

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

Medical necessity

Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental illness, substance use disorder disease or its symptoms, that are all of the following as determined by us or our designee, within our discretion.

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

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

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

Plan Allowance

Allowable Expense (plan allowance) is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

Post-service claims

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

Pre-service claims

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

Reimbursement

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

Subrogation

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

Unproven services

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

You

You refers to the enrollee and each covered family member.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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Summary of Benefits for the High Option Plan of UnitedHealthcare Insurance Company - 2021

- **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.
- Below, an asterisk (*) means the item is subject to the $2,000 Self Only, $4,000 Self Plus One or $4,000 Self and Family calendar year deductible.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office *	Office visit copay: Primary Care Physician (PCP) - 30% coinsurance Specialist - 30% coinsurance	26
Services provided by a hospital:		
• Inpatient *	30% coinsurance	46
• Outpatient*	30% coinsurance	47
Emergency benefits:		
• In or out-of-area*	30% coinsurance	49
Mental health and substance use disorder treatment*:	Regular cost-sharing	51
Prescription drugs*:		53
• Retail pharmacy* (30-day supply)	Tier 1: $15; Tier 2: $45; Tier 3: $85; Tier 4: $200	55
• Mail order* (90-day supply)	Tier 1:$45; Tier 2: $135; Tier 3: $255; Tier 4: $600	55
Accidental Dental and Adjunct Dental Care*:	30% coinsurance	57
Vision care - for eye refraction examination	30% coinsurance	32
Special features: UnitedHealthcare® app, Quit for Life®, Maternity Support Program, Spine and Joint Program, UnitedHealth Premium, Real Appeal, Specialty Pharmacy, Flexible Benefits Option, Cancer Clinical Trials		59
Protection against catastrophic costs (out-of-pocket maximum**):**	Nothing after $7,350 Self Only; $14,700 Self plus One or $14,700 Self and Family Some costs do not count toward this protection	20
Non-FEHB Benefits	PPO Preventive dental plan provided at no charge to all members; resources for hearing aids and other financial options available for our members	64

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2021 Rate Information for UnitedHealthcare Insurance Company, Inc.

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

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

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, contact the agency that maintains your health benefits enrollment.

Postal rates apply to certain United States Postal Service employees as follows:

- **Postal Category 1** rates apply to career bargaining unit employees who are represented by the following agreement: NALC.
- **Postal Category 2 rates** apply to career bargaining unit employees who are represented by the following agreement: PPOA.

Non-Postal rates apply to all career non-bargaining unit Postal Service employees and career employees represented by the following agreements: APWU, IT/AS, NPMHU, NPPN, and NRLCA agreement. Postal rates do not apply to non-career Postal employees, Postal retirees, and associate members of any Postal employee organization who are not career Postal employees.

USPS Human Resources Shared Service Center: 1-877-477-3273, option 5, Federal Relay Service 1-800-877-8339

Premiums for Tribal employees are shown under the monthly non-Postal 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	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
48 contiguous US States plus District of Columbia							
High Option Self Only	Y51	$142.52	$47.51	$308.80	$102.93	$45.61	$39.43
High Option Self Plus One	Y53	$313.55	$104.51	$679.35	$226.45	$100.33	$86.75
High Option Self and Family	Y52	$377.68	$125.89	$818.30	$272.77	$120.86	$104.49