UnitedHealthcare Insurance Company, Inc.

www.uhcfeds.com

Customer Service: 877-835-9861

UnitedHealthcare®

2023

Choice Open Access - Health Maintenance Organization

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

Serving: West (Arizona - Phoenix and Tucson, Colorado, Nevada, Oregon and Washington); Southeast (Alabama, Arkansas, Florida, Louisiana, Mississippi, North Carolina and Tennessee); Central (Iowa and Kentucky) and Northeast (District of Columbia, Maryland, Pennsylvania and Virginia)

IMPORTANT
- Rates: Back Cover
- Changes for 2023: Page 14
- Summary of Benefits: Page 90

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

Enrollment codes in AL, AR, FL, LA, MS, NC and TN:

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

Enrollment codes in IA and KY:

LJ1 Self Only, LJ3 Self Plus One, LJ2 Self and Family

Enrollment codes in DC, MD, PA, and VA:

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

Enrollment codes in AZ (Phoenix and Tucson), CO, NV, OR and WA:

KT1 Self Only, KT3 Self Plus One, KT2 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% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

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

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

Table of Contents

Introduction

This brochure describes the benefits of UnitedHealthcare Insurance Company, Inc. under contract (CS 2949) between UnitedHealthcare and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 1-877-835-9861 or through our website www.uhcfeds.com. The address for our administrative offices is:

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

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2023, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2023, and changes are summarized on page 14. Rates are shown at the end of this brochure.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee and each covered family member, "we" means 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 healthcare 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 healthcare 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 1-844-359-7736 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTHCARE FRAUD HOTLINE
1-877-499-7295
OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form

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

You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

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

  A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.
- If you have any questions about the eligibility of a 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

UnitedHealthcare 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 healthcare and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medications or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food and other allergies you have such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your 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 healthcare you need.

- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

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

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad 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 healthcare organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
- www.bemedwise.org The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

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

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error.

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

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage. 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, give you other plans' brochures and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

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

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

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

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

If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31-days before to 60-days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your carrier to add a family member when there is already family Coverage.

Contact your employing or retirement office if you are changing from Self to Self Plus One or Self and Family or to add a family member if you currently have a Self Only plan.

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 by another enrollee in another FEHB plan.

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

- **Family Member Coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by valid common-law marriage from a state that recognizes common-law marriages) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

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

Foster children
Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support
Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children
Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

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

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

- **Children's Equity Act**

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or

If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

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

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

- **When benefits and premiums start**

  The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1**. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2023 benefits of your prior plan or option. If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option.** However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2022 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, or if you are a covered child and you turn 26.

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

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

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

- **Converting to individual coverage**

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

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace guaranteed issue in your state. For assistance in finding coverage, please contact us at 877-835-9861.

- **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 a high option health maintenance organization (HMO) plan. 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 accreditations: National Committee for Quality Assurance (NCQA). To learn more about this plan's accreditation(s), please visit the following website:

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

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

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

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

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

General Features of our High Option Plan

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your Primary Care Provider (PCP) or by another participating provider in the network. We have a wide service area of participating providers you must use to access care. You will not have to routinely file claims for medical services and we have Customer Service Department available at 1-877-835-9861. We participate in FSAFEDS Paperless Reimbursement.

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).

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

The Plan’s provider directory lists primary care doctors with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. The directory is updated on a regular basis and is available at the time of enrollment or upon calling the Customer Service Department at 1-877-835-9861. When you enroll in this Plan, services (except for emergency benefits) are provided through the Plan’s delivery system; the continued availability and/or participation of any one doctor, hospital, or participation of any one doctor, hospital, or other provider, cannot be guaranteed.

The Plan will provide benefits for covered services only when the services are medically necessary to prevent, diagnose or treat your illness or condition. Payment of claims for prosthetic devices or durable medical equipment, when the item cost is more than $1,000 requires prior notification.

Your rights and responsibilities

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

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

You are also entitled to a 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 at www.myuhc.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. You may also visit our Web site at www.uhcfeds.com.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at www.myuhc.com. You can also contact us 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 is:

South East - Plan Code KK - Alabama, Arkansas, Florida, Louisiana, Mississippi, North Carolina and Tennessee

West - Plan Code KT - Phoenix, Arizona – Including the counties of: Maricopa and Pinal

Tucson, Arizona (Including the counties of: Santa Cruz, and portion of Pima county including the following zip codes : 85321,85341,85601,85602,85611,85614,85619, 85622, 85629, 85633, 85634, 85637,85639, 85641, 85646, 85652, 85653, 85654, 85658, 85701, 85702, 85703, 85704, 85705, 85706, 85707, 85708, 85709, 85710, 85711, 85712, 5713, 85714, 85715, 85716, 85717, 85718, 85719, 85720, 85721, 85722, 85723, 85724, 85725, 85726, 85728, 85730, 85731, 85732, 85733, 85734, 85735. 85736, 85737, 85738, 85739, 85740, 85741, 85742, 85743, 85744, 85745, 85746, 85747, 85748, 85749, 85750, 85751, 85752, 85754, 5755, 85756, 85757, 85775

Colorado, Nevada, Oregon and Washington

Central - Plan Code LJ - Iowa and Kentucky

Northeast - Plan Code LR - District of Columbia, Maryland, Pennsylvania and Virginia

Section 2. Changes for 2023

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

Program-Wide Changes

Changes to this plan

- Your share of the premium will increase for Self Only coverage and increase for Self Plus One and Self and Family, see rates page on the back of the brochure
- Your Emergency Room copay has changed from $250 to $275
- The Iatrogenic infertility benefit has been expanded to include a diagnosis of Gender Dysphoria
- Gender dysphoria - the following additional gender affirming surgery procedures will be covered: clitoroplasty, labiaplasty, laser or electrolysis hair removal in advance of genital reconstruction, metoidioplasty, penectomy, penile prosthesis, phalloplasty, scrotoplasty, testicular prosthesis, urethroplasty, vaginectomy, vaginoplasty, and vulvectomy

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 United Healthcare Insurance Company Inc., Federal Employees Health Benefits (FEHB) Program, at P.O. Box 30432, Salt Lake City, UT 84130-0432. You may also print temporary cards and request replacement cards through our web site www.myuhc.com.

Where you get covered care

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

Plan Providers

Plan providers are physicians and other healthcare 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 provider search tool is available on our Web sites at www.myuhc.com and www.uhcfeds.com.

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

This plan provides Care Coordinators for complex conditions and can be reached 877-835-9761 for assistance.

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 provider search tool is available from our Web sites www.myuhc.com and www.uhcfeds.com.

Balance Billing Protection

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

What you must do to get covered care

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

- **Primary care**

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

- **Specialty care**

You do not need to have a referral to see a participating specialist. If you need the care of a specialist, you may select a specialist from our provider directory, or call your PCP who will assist you in locating an appropriate participating provider.

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

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

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

Inpatient Hospital Admission

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

Other Services

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

- Applied Behavioral Analysis (ABA)
- Ambulance services for air and non-emergency ground
- Capsule endoscopy
- Clinical trials
- Congenital anomaly repair
- CT Scans (Computed tomography)
- Dialysis
- Discectomy/fusion
- Durable medical equipment over $1,000
- Electro-convulsive therapy
- Gender Affirming Surgical procedures
- Growth hormone therapy (GHT)
- Hysterectomy
- Inpatient Hospitalization
- Intensive Outpatient treatments
- Joint replacement
- Magnetic resonance angiogram (MRA)
- Magnetic resonance imaging (MRI)
- Morbid obesity surgery
- Nuclear medicine studies including nuclear cardiology.
- Orthopedic and prosthetic devices over $1,000
- Partial hospitalization
- PET scans
- Psychological, neurophysiological and extended developmental testing
- Reconstructive surgery
- Rhinoplasty/septo-rhinoplasty

- Sleep apnea - surgery and appliance (with sleep studies); sleep studies (polysomnograms) - attended
- Substance use disorder treatments
- Vein Ablation
- Virtual Colonoscopy
- Transplants

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

First, your physician, your hospital, you, or your representative, must call us at 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 planned days of confinement.

Non-urgent care claims

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

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

Urgent care claims

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

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

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

	You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 1-877-835-9861. You may also call OPM's FEHB 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 1-877-835-9861. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).
Concurrent care claims	A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect. If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.
Emergency inpatient admission	If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must phone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital
Maternity Care	Your physician, your hospital, you or your representative, must call us at 1-877-835-9861 prior to admission. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for pre-certification of additional days for your baby. 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.
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 is an HMO and does not offer coverage for non-network facilities. If you use non-network faciltiies without written authorization from the plan, you will be responsible for 100% of charges.
Circumstances beyond our control	Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.
If you disagree with our pre-service claim decision	If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call 877-835-9861 If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

To reconsider a non-urgent care claim	Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure. In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to 1. Precertify your hospital stay or, if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply; or 2. Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision. 3. Write to you and maintain our denial.
To reconsider an urgent care claim	In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure. Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by phone, electronic mail, facsimile, or other expeditious methods.
To file an appeal with OPM	After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your Costs for Covered Services

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

Cost-Sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g. deductible, coinsurance, and copayments) for the covered care you receive.
Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. Example: When you see your primary care physician you pay a copayment of $25 per office visit and when you go in the hospital, you pay $150 per day up to a maximum of $750 per admission.
Deductible	We do not have a deductible.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Example: In our Plan, you pay 50% of our allowance for durable medical equipment
Differences between our Plan allowance and the bill	You should also see section Important Notice About Surprise Billing - Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.
Your catastrophic protection out-of-pocket maximum	After your out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance total $5,000 for Self Only, or $10,000 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. ***The maximum annual limitation on cost sharing listed under Self Only of $5,000 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.*** Example Scenario: Your plan has a $5,000 Self Only maximum out-of-pocket limit and a $10,000 Self Plus One or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of $5,000 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket maximum of $10,000, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of $10,000 for the calendar year before their qualified medical expenses will begin to be covered in full. However, copayments and coinsurance, if applicable for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services: • Copayments or coinsurance for chiropractic services • Expenses for services and supplies that exceed the stated maximum dollar or day limit • Expenses from utilizing out-of-network providers Be sure to keep accurate records and receipts of your copayments and coinsurance to ensure the plan's calculation of your out-of-pocket maximum is reflected accurately.

Carryover

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

When Government facilities bill us

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

Important Notice About Surprise Billing - Know your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" under certain circumstances. A surprise bill is an unexpected bill you receive from a nonparticipating health care provider, facility, or air ambulance service for healthcare. Surprise bills can happen when you receive emergency care – when you have little or no say in the facility or provider from whom you receive care. They can also happen when you receive non-emergency services at participating facilities, but you receive somecare from nonparticipating providers.

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

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

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

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

The Federal Flexible Spending Account Program – FSAFEDS

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

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

Section 5. High Option Benefits

See Page 14 for how our benefits changed this year.

Section 5. High Option Benefits Overview

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

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

Our benefit package offers the following unique features:

High Option Benefits	You pay
Medical services provided by physicians: Preventive Care Services	No copayments for preventive care services. This includes items such as, but not limited to, immunizations, physical examinations and screenings as appropriate and recommended by U.S. Preventive Services Task Force. Please refer to Section 5 of the brochure for more detail.
Medical services provided by physicians: Diagnostic and treatment services provided in the office	$25 per visit to your Primary Care Physician (PCP) for ages 18 and older, $0 per visit for children under 18 $5 per virtual visit through designated virtual visit providers $35 per visit to your specialist
Services provided by a hospital: Inpatient	$150 per day up to $750 per admission
Services provided by a hospital: Outpatient Surgical	$150 per visit at approved free standing surgical facility $300 per visit outpatient surgical facility charge at hospital
Emergency benefits: In or out-of-area	$275 per visit - waived if admitted
Mental health and substance use disorder treatment	Regular cost sharing
Prescription drugs: Plan retail pharmacy	Tier 1: $10; Tier 2: $40; Tier 3: $85; Tier 4: $175
Prescription drugs: Plan mail order for up to a 90-day fill	Tier 1: $25 Tier 2: $100 Tier 3: $212.50 Tier 4: $437.50
Specialty Pharmacy	Specialty pharmacy (30-day supply) Tier 1 $ 10 Tier 2 $150 Tier 3 $350 Tier 4 $500
Vision care	$35 specialist for eye refraction exam every year

	Note: Children have preventive eye examinations as described in the Bright Future Guidelines with 100% coverage

UnitedHealthcare Retiree Advantage Health Plan	You pay
Medical Benefit	
Deductible	Member Pays: No deductible; Brochure Section 9
Primary Care Physician Visit	
Preventive Care	
Specialist Visit	Member Pays: Nothing; Brochure Section 9
Virtual Visit	Member Pays: Nothing; Brochure Section 9
Urgent Care	Member Pays: Nothing; Brochure Section 9
Emergency Room	Member Pays: Nothing; Brochure Section 9
Medical Benefit: Pharmacy (30-day supply)	Member Pays: Tier 1 - $7, Tier 2 - $35, Tier 3 - $65, Tier 4 - $100; Brochure Section 9
	*Note: You must have Medicare Part A and Part B, and Medicare must be primary for you to enroll in the UnitedHealthcare Retiree Advantage Plan. This plan reduces your costs by eliminating your cost sharing for covered medical services. Please see Section 9 in this brochure for additional information on how to enroll in this plan and for details on a reimbursement of $150.00 of your Medicare Part B premium.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in a hospital, an ambulatory surgical center or the outpatient department of a hospital. See *Section 5(c) Services provided by a hospital or other facility, and ambulance services* for more information.
- We have no deductible.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with other coverage*, including with Medicare.
- If you enroll in UnitedHealthcare Choice Open Access are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a $150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.)
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SERVICES AND/OR PROCEDURES.** Please refer to the preauthorization information shown in Section 3 or call customer service to be sure which services require preauthorization.

Benefit Description	You pay
Diagnostic and treatment services	**High Option**
Professional services of physicians • In your physician's office/telehealth visit • Primary care / Optum Primary care • Office medical consultations • Second surgical opinion • Advanced care planning	$25 per primary care physician (PCP) visit for members 18 and older; $0 for children under 18 $35 per specialist visit
Second Opinion Benefit - You now have access to personalized second opinions by video or by phone through the Second Opinion Program. Second Opinion is powered by 2nd MD, a third-party-vendor, to assist you with more informed decision making. 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	Member pays nothing
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • At home	Nothing - facility fee applies

Benefit Description	You pay
Telehealth services/ Virtual visits	**High Option**
Use telehealth/virtual visits when : • Your doctor is not available • You become ill while traveling • Conditions such as: cold, flu, bladder infection, bronchitis, diarrhea, fever, pink eye, rash, sinus problem, sore throat, stomach ache Network Benefits 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.	$5 per visit
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 • Ultrasound • Electrocardiogram and EEG	$50 per visit
• CT Scans • MRI/MRA • PET Scans	$150 per visit
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
Preventive care, adult (cont.)	**High Option**
• Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women go to the Health and Human Services (HHS) website at https://www.healthcare.gov/preventive-care-women/ • To build your personalized list of preventive services go to to https://health.gov/myhealthfinder	Nothing
One annual biometric screening to include the following services if appropriate based upon age and frequency recommendation: • Body Mass Index (BMI) • Blood pressure • Lipid/cholesterol levels • Glucose/hemoglobin A1c measurement Note: Office visit and lab services must be rendered on the same day and coded by your doctor as preventive to be covered in-full Members can complete their HRA (Health Risk Assessment) on www.myuhc.com	Nothing
Routine mammogram - covered, including 3D mammograms	Nothing
Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC); based on the Advisory Committee on Immunization Practices (ACP) schedule	Nothing
BRCA genetic counseling and evaluation are covered as preventive services when a woman's family history is associated with an increased risk for deleterious mutations in *BRCA1* or *BRCA2* genes and medical necessity criteria has been met 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.	Nothing
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related expenses*	*All charges*

Benefit Description	You pay
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 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.	Nothing
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes • Bacteriuria screening • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your vaginal delivery; see page 18 for other circumstances, such as extended stays for you or your baby. • Routine care includes office visits, one office sonogram (as part of prenatal care) and laboratory work. Copays will continue to apply to specialized scanning, any specialist not the member's current OB/GYN, durable medical equipment, prescription drugs, chiropractic and acupuncture services, emergency room visits, urgent care visits, or inpatient hospital copayments as these services are not considered routine. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to a circumcision. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b) for applicable copayments.	Nothing for routine prenatal care or the first postpartum care visit $25 per primary care physician (PCP) visit $35 per specialist visit

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	**High Option**
Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.	Nothing for routine prenatal care or the first postpartum care visit $25 per primary care physician (PCP) visit $35 per specialist visit
Breastfeeding support, supplies and counseling for each birth	Nothing
Not covered: Routine sonograms to determine fetal age, size or sex after the first sonogram.	*All charges*
Family planning	**High Option**
Contraceptive counseling on an annual basis	Nothing
A range of voluntary family planning services, limited to: Surgically implanted contraceptives Injectable contraceptive drugs (such as Depo Provera) Intrauterine devices (IUDs) Diaphragms Tubal ligation Note: We cover oral contraceptives under the prescription drug benefit	Nothing
Voluntary sterilization (See Surgical procedures Section 5 (b))	$25 per primary care physician (PCP) visit $35 per specialist visit
Genetic testing is covered when medically necessary for certain conditions such as pregnancy testing for cystic fibrosis, certain autosomal recessive conditions and dominent less penetrant conditions, x-linked conditions and certain chromosome abnormalities.	$35 per specialist visit
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing not medically necessary*	*All charges*
Infertility services	**High Option**
Diagnosis and treatment of the cause of infertility	$25 per primary care physician (PCP) visit $35 per specialist visit
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)*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	**High Option**
- *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 unless part of the iatrogenic infertility benefit* • *Preimplantation diagnosis, testing, and/or screening, including the testing or screening of eggs, sperm, or embryos, unless part of the iatrogenic infertility benefit* • *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	$25 per primary care physician (PCP); visit for members 18 and older; $0 for children under 18 $35 per specialist visit
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 42. • Respiratory and inhalation therapy (Pulmonary rehabilitation) is provided for up to 20 visits per year • Cardiac rehabilitation following qualifying event/condition is provided for up to 36 visits per condition per year • Dialysis – hemodialysis and peritoneal dialysis • Cochlear therapy following cochlear implant up to 30 visits per year • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) **Note:** Growth hormone is covered under the prescription drug benefit.	$35 per specialist visit $50 per outpatient facility visit

Treatment therapies - continued on next page

Benefit Description	You pay
Treatment therapies (cont.)	**High Option**
Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services* on page 16. • Applied Behavior Analysis (ABA) - Children with autism spectrum disorder	$35 per specialist visit $50 per outpatient facility visit
Physical and occupational therapies	**High Option**
Up to 60 per year for rehabilitative/habilitative physical /occupational therapy in any combination of the following: • Qualified physical therapists • Occupational therapists • Physician • Licensed therapy provider Services must be performed by a physician or by a licensed therapy provider. Note: We only cover therapy when a 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. Benefits can be denied or shortened for covered persons who are not progressing in goal-directed rehabilitative services or if rehabilitation goals have not been met. We will pay benefits for up to 20 visits of cognitive rehabilitation therapy only when Medically Necessary following sudden External injuries such as car accidents or falls; or sudden internal injuries such as stroke (cerebral vascular accident), aneurysm, anoxia, encephalitis or brain tumors. All Therapies are subject to medical necessity.	$35 per specialist visit
Habilitative Services - for children under age 19 with congenital or genetic birth defects. Treatment is provided to enhance the child's ability to function. Services include: • Speech therapy • Occupational therapy; and • Physical therapy Includes medically necessary habilitative services coverage for children with Autism, an Autism Spectrum disorder, or Cerebral Palsy Note: No day or visits apply to these services. A congenital disorder means a significant structural or functional abnormality that was present from birth	$35 per specialist visit
Not covered: • *Long-term rehabilitative therapy*	*All charges*

Physical and occupational therapies - continued on next page

Benefit Description	You pay
Physical and occupational therapies (cont.)	**High Option**
• *Exercise programs*	*All charges*
Speech therapy	**High Option**
Up to 60 visits per calendar year for rehabilitative/habilitative speech therapy.	$35 per specialist visit
Not covered: • *Exercise programs* • *Voice therapy*	*All charges*
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. • First hearing aid and testing **only when necessitated by accidental injury**. Note: for routine hearing screening performed during a child's preventive care visit, see Section 5(a) Preventive care children • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: for benefits for the devices, see Section (a) *Orthopedic and prosthetic devices.*	$25 copayment per primary care (PCP) visit for members 18 and older; $0 for children under 18 $35 per specialist visit
Not covered: • *All other hearing aids and testing for them* • *Hearing services that are not shown as covered*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**
• Initial pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Annual eye refraction exams **Note:** Children examinations are covered at no charge as outlined in the Bright Future Guidelines provided by the American Academy of Pediatrics *Replacement glasses or contact lenses are not covered after the initial pair.*	$25 copayment per primary care (PCP) visit for members 18 and older; $0 for children under 18 $35 per specialist visit
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*

Benefit Description	You pay
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$25 copayment per primary care (PCP) visit for members 18 and older; $0 for children under 18 $35 per specialist visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	**High Option**
• Artificial limbs and eyes • Prosthetic sleeve or sock • Orthopedic devices such as braces, medical supplies including colostomy supplies, dressings, urinary catheters and related supplies • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy • A hair prosthesis for hair loss resulting from chemotherapy or radiation treatment for cancer. There is a limit of one hair prosthesis per lifetime with a maximum cost of $350. • Bone-anchored hearing aids (BAHA) are covered only when the member has either of the following: - Craniofacial anomalies in which abnormal or absent ear canals preclude the use of a wearable hearing aid; - Hearing loss of sufficient severity that it cannot be adequately remedied by a wearable hearing aid - Benefits limited to one bone anchored hearing aid per member, who meets the above coverage criteria, during the entire period of time the member is enrolled in the health plan. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services. Note**:** Plan prior authorization required for items that cost $1,000 or more.	50% of charges
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
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*	*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 • CPAP • Walkers • Blood glucose monitors • Insulin pumps **Note:** Plan prior authorization is required for items that cost $1,000 or more. Repairs and replacements are covered if needed due to a change in the member's medical condition. Call us at 877-835-9861 as soon as your Plan physician prescribes this equipment. We will arrange with a healthcare provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	50% of charges
Not covered: *Motorized wheelchairs* *Audible prescription reading devices* *Hearing aids* *Speech generating devices* *Talkers* *Story boards* *Scooters*	*All charges*

Benefit Description	You pay
Home health services	**High Option**
• Home healthcare ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true: - It must be delivered or supervised by a licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for safety of the patient - It is ordered by a physician - It is not delivered for the purpose of assisting with activities of daily living including dressing, feeding, bathing or transferring from a bed to a chair - It requires clinical training in order to be delivered safely and effectively - It is not custodial care • We will determine if benefits are available by reviewing both the skill nature of the service and the need for Physician directed medical management. A service will not be determined to be skilled simply because there is not an available caregiver. • Services include 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 liquid 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	$25 per visit $25 per prescription food delivery
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*

Benefit Description	You pay
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.	50% of charges
Alternative treatments	**High Option**
Acupuncture – by a doctor of medicine or osteopathy for 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	$35 per specialist visit
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback* • *Massage Therapy* • *Herbal medicine* • *Rolfing* • *Ayurveda* • *Homeopathy* • *Other alternative treatments unless specifically listed as covered*	*All charges*
Educational classes and programs	**High Option**
Coverage is provided for: Tobacco Cessation program 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
Childhood Obesity screening programs and treatment interventions	Nothing
• Outpatient self-management training for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin using diabetes and other designated chronic health conditions. • Must be prescribed by a licensed healthcare professional who has appropriate state licensing authority	$25 per Primary Care Physician (PCP) visit for members 18 and older; $0 for children under 18 $35 per specialist visit

Educational classes and programs - continued on next page

Benefit Description	You pay
Educational classes and programs (cont.)	**High Option**
• 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	$25 per Primary Care Physician (PCP) visit for members 18 and older; $0 for children under 18 $35 per specialist visit

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no deductible.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with other coverage,* including with Medicare.
- The amounts listed below are for the charges billed by a physician or other healthcare professional for your surgical care. Look in Section 5(a) for charges associated with an office visit and Section 5 (c) for charges associated with a facility (i.e. hospital, surgical center, etc.).
- If you enroll in UnitedHealthcare Choice Open Access are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a $150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.)
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SERVICES AND/OR PROCEDURES.** Please refer to the preauthorization information shown in Section 3 or call customer service to be sure which services require preauthorization.

Benefit Description	You pay
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 men (vasectomy) • Treatment of burns	$35 per specialist visit
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)	$35 per specialist visit

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**High Option**
• 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 • have a 6-month physician supervised diet within the last 2 years • One surgery per lifetime unless complications	$35 per specialist visit
Voluntary sterilization women (tubal ligation)	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; (see Foot care)*	*All charges*
Iatrogenic infertility services	**High Option**
Coverage is available for fertility preservation for medical reasons that cause irreversible infertility such as surgery, including surgical treatment of gender dysphoria, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes. Covered benefits include the following procedures: • Collection of sperm • Cryo-preservation of sperm • Oocyte cryo-preservation • Embryo cryo-preservation • Ovarian stimulation, retrieval of eggs and fertilization Benefits are not available for: • Embryo transfer • Long-term storage costs (greater than 1 year) • Elective fertility preservation. **Benefits are further limited to one cycle of fertility preservation for iatrogenic infertility per covered person during the period of time he or she is enrolled for coverage under the policy.** There is a benefit limit of $20,000 for medical services and $5,000 for pharmacy benefits. The preimplantation genetic testing and fertility preservations are one combined maximum. Prior authorization is required.	$35 per specialist visit
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;	$35 per specialist visit

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	**High Option**
- treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see *Prosthetic devices*)	$35 per specialist visit
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.	
Gender Affirming Surgery Surgical treatment for Gender Dysphoria may be indicated for individuals who meet the medical criteria and persistent, well-documented diagnostic criteria A disorder characterized by the following diagnostic criteria (Diagnostic and Statistical Manual of Mental Disorders, 5th edition [DSM-5]). **Requirements:** • Must be 18 years of age or older • Must have documented evidence of persistent gender dysphoria • Favorable psychosocial-behavioral evaluation to provide screening and identification of risk factors or potential postoperative challenges • Persistent, well-documented Gender Dysphoria • Capacity to make a fully informed decision and to consent for treatment • Complete at least 12 months of successful continuous full-time real-life experience in the desired gender • Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated) • Treatment plan that includes ongoing follow-up and care by a Qualified Behavioral Health Provider experienced in treating Gender Dysphoria* **Gender reconstructive surgeries for (male to female) include:** • Laser or electrolysis hair removal in advance of genital reconstruction • Orchiectomy: removal of testicles • Penectomy: removal of penis • Vaginoplasty: creation of vagina • Clitoroplasty: creation of clitoris • Labiaplasty: creation of labia • Prostatectomy: removal of prostate • Urethroplasty: creation of urethra **Gender reconstructive surgeries for (female to male) include:** • Laser or electrolysis hair removal in advance of genital reconstruction • Salpingo-oophorectomy: removal of fallopian tubes and ovaries • Vaginectomy: removal of vagina • Vulvectomy: removal of vulva • Metoidioplasty: creation of micro-penis using the clitoris • Phalloplasty: creation of penis, with or without urethra • Hysterectomy: removal of uterus • Urethroplasty: creation of urethra within penis • Scrotoplasty: creation of scrotum • Testicular prosthesis: implantation of artificial testes • Mastectomy: removal of the breast • Penile prosthesis	

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	**High Option**
Not covered: • *Treatment received out-of-network :* • *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 if repair is initiated promptly or as soon as the member's condition permits* • *Transgender procedures not specifically listed above, such as: abdominoplasty, blepharoplasty, , breast enlargement including augmentation mammaplasty and breast implants, blow lift, calf implants, cheek Cheek, chin and nose implants, Injection of fillers, Face/forehead lift and/or neck tightening, Facial bone remodeling for facial feminization, Laser or electrolysis hair removal not related to genital reconstruction, Hair transplantation, Lip augmentation, Lip reduction, Liposuction, Mastoplexy, Pectoral implants for chest masculinization, Rhinoplasty, skin-resurfacing (e.g., dermabrasion, chemical peels, laser), thyroid cartilage reduction/ reduction thyroid chondroplasty/trachea shave (removal or reduction of the Adam's apple), Voice modification surgery (e.g., laryngoplasty, glottoplasty or shortening of the vocal cords)* • *Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics* • *Surgical procedures for members who do not meet the gender dysphoria criteria*	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; • Dental care necessary to release pain in treatment of temporomandibular joint pain dysfunction; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	$35 per specialist visit
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*

Benefit Description	You pay
Temporomandibular joint dysfunction (TMJ)	**High Option**
Services for the evaluation and treatment of TMJ and associated muscles • Diagnosis: Exam, radiographs and applicable imaging studies and consultation. • Non-surgical treatment including: Clinical exams, Oral appliances (orthotic splints), Arthrocentesis, Trigger-point injections Benefits are provided for surgical treatment if the following criteria are met: • There is radiographic evidence of joint abnormality • Non-surgical treatment has not resolved the symptoms • Pain or dysfunction is moderate or severe. Benefits for surgical services include: • Arthrocentesis • Arthroscopy • Arthroplasty • Arthrotomy • Open or closed reduction of dislocations Services are limited to $3,000 for all TMJ services - facility fees, durable medical and pharmacy fees will apply	$35 per specialist visit
Organ/tissue 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	$35 per specialist visit

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- AL Amyloidosis - Multiple myleoma (de novo and treated) - Recurrent gem cell tumors (including testicular cancer)	$35 per specialist visit
Blood or marrow stem cell transplants the plan extends coverage for the diagnoses as indicated below:. • Allogenic transplants for - 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, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome	$35 per specialist visit
• Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reccurrence (relapsed) - Amyloidosis - Breast cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma	$35 per specialist visit

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Medulloblastoma - Multiple myeloma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	$35 per specialist visit
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 reccurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with reccurrence (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 reccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reccurrence (relapsed) - Amyloidosis - Neuroblastoma	$35 per specialist visit
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 if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for	$35 per specialist visit

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- 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/Myelodysplactic Syndromes - Myeloproliferative disorders (MDDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle Cell anemia • Autulogous Transplants for - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin's lymphoma - Breast Cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/ SLL) - Chronic myelogenous leukemia	$35 per specialist visit

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial ovarian cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis National Transplant Program (NTP) - OptumHealth Care Solutions (URN) used for organ tissue transplants Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute - or National Institutes of Health - approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor. Transplants must be provided in a Plan designated Center for Transplants. These centers do a large volume of these procedures each year and have a comprehensive program of care. A listing of these centers can be found in the Plan Directory of Health Care Providers, at our member web site www.myuhc.com or call our Customer Service Department at 1-877-835-9861 to request an up-to-date listing.	$35 per specialist visit
Note: Donor testing for bone marrow/stem cell transplants for up to 4 potential donors whether family or non-family	You pay 50%
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered* • *All services related to non-covered transplants* • *All services associated with complications resulting from the removal of an organ from a non-member*	*All charges*
Anesthesia	**High Option**
Professional services provided in: • Hospital (inpatient) • Hospital (outpatient department) • Skilled nursing facility • Ambulatory surgical center • Office	$35 per specialist visit

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no deductible.
- Be sure to read Section 4, *Your Costs for Covered Services* for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with other coverage,* including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- If you enroll in UnitedHealthcare Choice Open Access are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a $150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.)
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SERVICES AND/OR PROCEDURES.** Please refer to the preauthorization information shown in Section 3 or call customer service to be sure which services require preauthorization.

Benefit Description	You pay
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.	$150 per day up to $750 per admission
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and 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	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	**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 • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service **Note:** We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$150 per outpatient surgical charge at approved free standing surgical facility $300 per outpatient surgical charge at hospital
Not covered: Blood and blood derivatives not replaced by the member	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High Option**
• Room and board in a semi-private room • General nursing • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor • Benefits up to 60 days when full time skilled nursing care is necessary and confinement is medically appropriate.	Nothing when transferred directly from inpatient $150 per day for up to $750 per admission if not transferring from inpatient
Not covered: Custodial care	*All charges*
Hospice care	**High Option**
• Inpatient care • Outpatient care • Family counseling • Supportive and palliative care for a terminally ill member is covered in the home or hospice	Nothing when transferred directly from hospital $150 per day up to 5 days per admission to facility if not transferring from hospital
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	**High Option**
Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities only when the transport meets one of the following: • From an out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required.	Nothing

Ambulance - continued on next page

Benefit Description	You pay
Ambulance (cont.)	**High Option**
• To the closest Network Hospital that provides the required Covered Health Care Services that were not available at the original Hospital, including transportation costs of a newborn to the nearest appropriate facility to treat the newborn's condition. The Physician must certify that such transportation is necessary to protect the health and safety of the newborn. • From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility where the required Covered Health Care Services can be delivered. • **Prior Authorization Requirement** In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you **must** obtain authorization as soon as possible before transport. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid. For the purpose of this Benefit the following terms have the following meanings: • "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting. • "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness. • "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.	Nothing

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no deductible.
- If you enroll in UnitedHealthcare Choice Open Access are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a $150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.)
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with other coverage*, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within or outside our service area

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

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

Benefit Description	You pay
Emergency within or outside our service area	**High Option**
• Emergency care at a doctor's office	$25 per primary care physician (PCP) visit; $35 per specialist visit
• Emergency care at an urgent care center	$35 per visit
• Emergency care as an outpatient at a hospital, including doctors' services **Note:** We waive the ER copay if you are admitted to the hospital.	$275 per visit
Not covered:	*All charges*

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

Benefit Description	You pay
Emergency within or outside our service area (cont.)	**High Option**
• *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance - Emergency	**High Option**
Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance or water vehicle) to the nearest Hospital where the required Emergency Health Care Services can be performed.	$500 copayment for Air Ambulance

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

You need to get Plan approval (preauthorization) for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance use disorder benefits are no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with other coverage*, including with Medicare.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SERVICES AND/OR PROCEDURES.** Please refer to the preauthorization information shown in Section 3 or call customer service to be sure which services require preauthorization.
- If you enroll in UnitedHealthcare Choice Open Access are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a $150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.)

Benefit Description	You pay
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. 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 in office or telemedicine)	$25 per visit $150 per day up to 5 days per inpatient admission

Professional Services - continued on next page

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

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescription medications, as described in the chart beginning on the next page. Some injectable medications are provided by your medical benefit. Please see below for more information.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Some prescription medications have Quantity Level Limits (QLL) and Quantity per Duration Limits (QD). Please see below for more information.
- We have no deductible.
- Federal law prevents the pharmacy from accepting unused medications.
- If you enroll in UnitedHealthcare Choice Open Access are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a $150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.)

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

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 Pharmacy. Some drugs are only available at the retail pharmacy for safety or other reasons. To locate the name of a Plan pharmacy near you, call our Customer Service Department 877-835-9861 or visit our website, www.uhcfeds.com. The PDL consists of Tiers 1, 2, 3 and 4.
- **We use a Prescription Drug List (PDL) called the Advantage PDL.** Our PDL Management Committee creates this list that includes FDA approved prescription medications, products, or devices. Our Plan covers all prescription medications written in accordance with FDA guidelines for a particular therapeutic indication except for 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 www.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. Specialty drugs are on separate tiers described below.
- **The PDL consists of Tiers 1, 2, 3 and 4.**
  - **Tier 1** is your **lowest** co-payment option (**$10** for up to a 30-day supply or $25.00 for up to a 90-day supply through mail order), and includes **a number of generic medications,as well as select preferred brand medications**. Brand medications in Tier 1 include select insulin products, select inhalers for asthma, and select medications for migraine headaches for which no generic alternative(s) are available. For the lowest out-of-pocket expense, you should always consider Tier 1 medications if you and your provider decide they are appropriate for your treatment.
  - **Tier 2** is your **middle** co-payment option (**$40** for up to a 30-day supply or $100 for up to a 90-day supply through mail order), and contains a **preferred brand medications not included in Tier 1**. Preferred medications placed in Tiers 1 and 2 are those the PDL Management Committee has determined to provide better overall value than those in Tier 3. If you are currently taking a medication in Tier 2, ask your provider whether there are Tier 1 alternatives that may be appropriate for your treatment.

- **Tier 3** is your **higher** co-payment option (**$85** for up to a 30-day supply or $212.50 for up to a 90-day supply through mail order), and consists of non-preferred medications. Sometimes there are alternatives available in Tier 1 or Tier 2. If you are currently taking a medication in Tier 3, ask your provider whether there are Tier 1 or Tier 2 alternatives that may be appropriate for your treatment.
- **Tier 4** is your **highest** co-payment option (**$175** for up to a 30-day supply or $437.50 for up to a 90-day supply through mail order) non-preferred medications that do not add clinical value over their covered Tier 1, Tier 2, or Tier 3 alternatives. Some medications on Tier 4 may also have an over-the-counter alternative which can be purchased without a prescription.

- **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.** Prescriptions for specialty medications must be filled for a maximum of a 30-day supply. To locate a specialty pharmacy for your particular needs members can contact customer service at 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 supplies.
  - **Expert support** — Members get 24/7 telephone access to specially trained pharmacists who can provide answers, patient education materials, proactive refill monitoring, counseling on side effects and more.
  - **Individualized services** — experienced nurses and pharmacists trained in specialty medications and rare and complex conditions offer personalized therapy support that can lead to better health outcomes.
  - **Supplies, such as sharps containers, needles, syringes** and tubing necessary to administer an injectable specialty drug are provided at **no cost** to you by the specialty pharmacy. Talk with your specialty pharmacy to learn more.
  - **Costs for Specialty Drugs are as follows for 30-day supply**
    - **Tier 1 - $10**
    - **Tier 2 - $150**
    - **Tier 3 - $350**
    - **Tier 4 - $500**

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 then they will be placed in the appropriate Tier. A prescription medication may be moved to the 4th tier of PDL at anytime if the medication changes to over-the-counter status, or removed from the PDL due to safety concerns declared by the Food and Drug Administration (FDA).

These are the dispensing limitations.

- Some drugs may only be available at a retail pharmacy or through the designated Specialty Pharmacy. See the next page for details on Specialty Pharmacy drugs.
- Subject to your prescription's instructions, you may purchase up to a 90-day supply for most covered medications and supplies at a retail pharmacy for the applicable tier co-payment for each 30-day supply. Drugs available through mail order require the applicable tier co-payment.
- **Contraceptives:** You pay one copay for up to maximum of a 90-day supply of contraceptive medications, subject to QLL and QD limitations
- **Quantity Duration (QD):** Some medications have a limited amount that can be covered for a specific period of time.
- **Quantity Level Limits (QLL)**: Some medications have a limited amount that can be covered at one time.

- Changes to quantity duration and quantity level limits may occur on January 1 and July 1 of each year. We base these processes upon the manufacturer's package size, FDA-approved dosing guidelines as defined in the product package insert and/or the medical literature or guidelines that support the use of doses other than the FDA-recommended dosage. If your prescription written by your provider exceeds the allowed quantity, please refer to Section 8, to file an appeal with the Plan.
- **Day Supply:** "Day supply" means consecutive days within the period of prescription. Where a prescription regimen includes "on and off days" when the medication is taken, the off days are included in the count of the day supply.
- **Injectable medications**: Medications typically covered under the pharmacy benefit and received through a retail or mail order pharmacy are those that are self-administered by you or a non-skilled caregiver. However, injectable medications that are typically administered by a health care professional are covered under your Medical benefit and need to be accessed through your provider or Specialty pharmacy. Contact the Health Plan at 1-877-835-9861 for more information on these medications.
- **Special dispensing circumstances:**
  - The Plan will give special consideration to filling prescription medications for members covered under the FEHB if:
    - You are called to active duty, or
    - You are officially called off-site as a result of a national or other emergency, or
    - You are going to be on vacation for an extended period of time
- **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 www.uhcfeds.com or you may call customer service at 1-877-835-9861 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 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 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 co-payments 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 co-payment 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.
- **Why use Tier 1 drugs?** Medications in Tier 1 offer the best health care value and are available at the lowest co-payment. Tier 2 medications are available at a higher co-payment and Tier 3 and Tier 4 medications are available at the highest co-payment levels. This approach helps to assure access to a wide range of medications and control health care costs for you.

Benefit Description	You pay
Preventive care medications	**High Option**
Note: Note: Preventive Medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a health care professional and filled by a network pharmacy. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations The following drugs and supplements are covered without cost-share, even if over-the-counter, are prescribed by a healthcare professional and filled at a network pharmacy.	Nothing

Preventive care medications - continued on next page

Benefit Description	You pay
Preventive care medications (cont.)	**High Option**
• Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 & 800 mcg • Liquid iron supplements for children age 0-1 year • Pre-natal vitamins for pregnant women • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 • 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 greater. Note: To receive this benefit a prescription from a doctor must be presented to pharmacy. Benefits available at in-network pharmacy only.	Nothing
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. • Drugs to treat gender dysphoria • Oral and injectable contraceptive drugs • Drugs used for Gender Dysphoria - may require prior authorization and may be covered under the specialty drug benefits **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).* Specialty Medications (up to a 30-day supply)	Plan retail pharmacy up to a maximum of a 30-day supply: Tier 1- $10 Tier 2- $40 Tier 3- $85 Tier 4 -$175 Plan mail order pharmacy for up to a maximum of up to a 90-day supply: Tier 1- $25 Tier 2- $100 Tier 3- $212.50 Tier 4- $437.50 Tier 1 $10 Tier 2 $150 Tier 3 $350 Tier 4 $500
Contraceptive drugs and devices as listed in the ACA/HRSA site. Contraceptive coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in all methods of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below.	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
• Reimbursement for over-the-counter contraceptives can be submitted by completing a claim form and submitting the form with receipts to OptumRx, PO Box 29044, Hot Springs, AZ 71903. You can reach out to customer service at 877-835-9861 to obtain a prescription drug claim form. • Members may have a clinical review for contraceptives that are excluded. They should reach out to their prescribing provider. Contraceptive products that are not already available at $0 cost-share can be provided at $0 member cost-share if the provider determines that a particular contraceptive is medically necessary for that member. The cost-share waiver process requires that providers attest the product is needed for contraceptive purposes and this can be submitted electronically by the provider	Nothing
• Diabetic supplies limited to insulin syringes, needles, glucose test tape, Benedict's solution or equivalents and acetone test tablets. • Implanted contraceptive drugs and devices such as Norplant	50% of charges
Prescription tobacco cessation 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 used for cosmetic purposes* • *Any product dispensed for the purpose of appetite suppression and other weight loss products* • *Drugs to enhance athletic performance* • *Medical supplies such as dressings and antiseptics* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them* • *Drugs available over-the-counter that do not require a prescription order by federal or state law before being dispensed, and any drug that is therapeutically equivalent to an over- the-counter* • *Compound drugs that do not contain at least one covered ingredient that requires a Prescription Order or Refill* • *Alcohol swabs and bio-hazard disposable containers* • *Medical Marijuana* • *Drugs for sexual performance for patients that have undergone genital reconstruction* • *Nonprescription medications unless specifically indicated elsewhere* *Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation programs benefit. (See above)*	*All charges*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employees Dental Vision Insurance Program (FEDVIP) Dental Plan your FEHB Plan will be First Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- We have no deductible.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below**.**
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also read Section 9 *Coordinating benefits with other coverage,* including with Medicare.
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SERVICES AND/OR PROCEDURES.** Please refer to the preauthorization information shown in Section 3 or call customer service to be sure which services require preauthorization.
- If you enroll in UnitedHealthcare Choice Open Access are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a $150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.)

Benefit Description	You Pay
Accidental injury benefit	**High Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury and • 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	Nothing

Accidental injury benefit - continued on next page

Benefit Description	You Pay
Accidental injury benefit (cont.)	**High Option**
A sound natural tooth is defined as a tooth that: • has no active decay, has at least 50% bony support, • has no filling on more than two surfaces; • has no root canal treatment, is not an implant • is not in need of treatment except as a result of the accident, and • functions normally in chewing and speech. • Crowns, bridges, implants and dentures are not considered sound natural teeth	Nothing
Not covered: • *Oral implants and related procedures, including bone grafts to support implants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival and aveolar bone)*	*All charges*
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.	$35 per specialist visit

Section 5(h). Wellness and Other Special features

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

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

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

	A personalized Health Coach - Coaches guide members through the program step-by-step, customizing it to help fit their needs, personal preferences, goals and medical history. 24/7 online support and mobile app through our Rally Coach portal or directly through our Rally Coach mobile app. Staying accountable to goals may be easier than ever. • Customizable food, activity, weight and goal trackers. • Unlimited access to digital content. • An online lifestyle program to help you learn new ways to be your healthiest self
Smoking Cessation Program	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.
Maternity Health Solutions	Maternity Health Solutions is designed to help improve outcomes and lower costs by providing moms-to-be with personalized care for clinical, behavioral and other holistic needs. • Maternity-related courses available on myuhc.com regarding course topics such as: - Preconception: Preparing for a healthy pregnancy - Pregnancy in the first trimester - Pregnancy in the second trimester - Pregnancy in the third trimester - The fourth trimester after pregnancy: Postpartum - Pregnancy nutrition and exercise - Exploring breastfeeding • Maternity risk assessment on Myuhc.com • Additional support for high-risk cases
UnitedHealth Premium	Choosing a doctor is one of the most important health decisions you'll make. The UnitedHealth Premium® program can help you find doctors who are right for you and your family. You can find quality, cost-efficient care. Studies show that people who actively engage in their health care decisions have fewer Hospitalizations, fewer emergency visits, higher utilization of preventive care and overall lower medical costs. The program evaluates physicians in various specialties using evidence-based medicine and national standardized measures to help you locate quality and cost-efficient providers. It's easy to find a UnitedHealth Premium Care Physician. Just go to **myuhc.com**®and click on Find a Doctor. Choose smart. Look for blue hearts. • **Premium Care Physician** meets UnitedHealth Premium program quality & cost efficient care criteria.

	• **Quality Care Physician** meets UnitedHealth Premium program quality care criteria, but does not meet the program's cost efficient care criteria or is not evaluated for cost-efficient care. Physician is not eligible for a Premium designation. • **Not Evaluated for Premium Care p**hysician's specialty is not evaluated and/or does not have enough claims data for program evaluation or the physician's program evaluation is in process
Specialty Pharmacy	**What are the benefits of using Optum Specialty Pharmacy?** Optum Specialty Pharmacy provides personalized support and resources at no extra cost to help you manage your condition. **How does Optum Specialty Pharmacy support you?** • Pharmacists to answer questions 24/7 • A clinical care team to help you understand your medication • 1-on-1 video chats with your care team • Helpful videos from other specialty patients • Supplies you may need to take your medication at no extra cost • Refill reminders • Talk with a nurse about infusion services, if applicable **Tips for working with our Optum Specialty Pharmacy care team.** • Tell your pharmacist or nurse about any side effects or issues you may be facing with your care, such as forgetting to take your medication. • We're here to help with more than your medication. Our pharmacists and nurses can help you find resources to stay on track with your health. We're here to help. Call Optum Specialty Pharmacy at 1-855-427-4682 to learn more and transfer your prescriptions. Or, call the number on the back of your member ID card to find a designated specialty pharmacy near you.
Flexible Benefits Option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claims process (see Section 8).
Cancer Clinical Trials	To be a qualifying clinical trial, a trial must meet the following criteria: Be sponsored and provided by a cancer center that has been designated by the *National Cancer Institute (NCI)* as a *Clinical Cancer Center* or *Comprehensive Cancer Center* or be sponsored by any of the following: • *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI).*)

	• *Centers for Disease Control and Prevention (CDC).* • Agency for Healthcare Research and Quality (AHRQ). • Centers for Medicare and Medicaid Services (CMS). • Department of Defense (DOD). • Veterans Administration (VA). • The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals. Benefits are not available for preventive clinical trials. • The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.
Medicare Part B Reimbursement for Retire Advantage Members	*Receive reimbursement for your Medicare Part B Premium* • *$150.00 will be paid on your behalf directly to Medicare* • *See a reduction in your quarterly Medicare bill, or an increase in your Social Security payment or annuity payment* *Receive this benefit for every month you're enrolled in the plan*
Renew Active Fitness Program for Retiree Advantage Members:	Renew Active is a fitness benefit which is included in the Medicare Advantage plan which provides: • A free gym membership to participating facilities - To view participating facilities, please visit www.uhcrenewactive.com • Access to an extensive network of gyms and fitness locations near members • A personalized fitness plan • Access to a wide variety of fitness classes • An online brain health program, exclusively from AARP® Staying Sharp • Connecting with others at local health and wellness events, and through the Fitbit® Community for Renew Active
First Line Essentials for Retiree Advantage Members	*Shop for hundreds of over-the-counter items such as toothpaste, vitamins, and personal care from the Health Products catalog.* • *Members will receive $40 allowance each quarter to spend on items from the provided catalog* • *Items are delivered directly to your door* • *Orders can be place over the phone, by mail, or online*
House Calls for Retiree Advantage Members	With the UnitedHealthcare® HouseCalls program, you get an annual in-home preventive care visit from one of our health care practitioners at no extra cost. What does HouseCalls include? • One 45 to 60-minute at-home visit from a health care practitioner, each year. • A head-to-toe exam, health screenings and plenty of time to talk about your health questions. • A custom care plan made just for you. • Help connecting you with additional care you may need.
Healthy at Home for Retiree Advantage Members	*Healthy at Home provides the following benefits up to 30 days following all inpatient and skilled nursing facility discharges when referred by a UnitedHealthcare Advocate:* • *Home-Delivered Meals* *Receive 28 home-delivered meals provided by Mom's Meals*

	• *Non-emergency transportation* *Receive 12 one-way rides to medically related appointments and to the pharmacy provided by ModviCare* • *In-home Personal Care* • *Receive 6 hours of in-home personal care through our exclusive national provider CareLinx*
Real Appeal for Retiree Advantage Members	Real Appeal is a weight loss program that can help members feel and look better. The program provides everything they need to lose weight and keep it off. This program is a pilot for select members residing in Wisconsin. The online program includes: • Personalized diabetes prevention coaching • 24/7 online support and mobile app • Customizable food, activity, weight and goal trackers • Success group support, which lets members chat with others who are doing the Real Appeal program • The weekly Real Appeal All-Star Show featuring healthy tips from celebrities, athletes and health experts Success Kit includes: • Program, nutrition, and fitness guides • Tools to help cook healthier, tasty meals • Delivered right to their front door after attending their first group coaching session
UnitedHealthcare Hearing for Retiree Advantage Members	*UnitedHealthcare Hearing provides members with greater technology, choice and convenience* • *Rechargeable hearing aids, remote adjustments and other advanced feature devices are available at up to 80% less than standard industry prices through direct delivery, including top brands in multiple styles* • *6,500+ locations nationwide* • *Chose home delivery or in person options* • *3-minute online hearing test to assess hearing loss/need for in-person test* • *Members receive $1500 allowance every 36 months towards the purchase of hearing aids* • *Members must use a UHC hearing provider to use their hearing aid benefit*
Quit For Life for Retiree Advantage Members	Quit For Life has helped 3.5 million members quit smoking or using tobacco. It provides the tools and one-on-one support to help you quit your way. And for UnitedHealthcare members, it's offered at $0 out of pocket. With a 95% satisfaction rate, Quit for Life provides • Tools and support to help members quit cigarettes, e-cigarettes, vaping and tobacco • A personal, one-on-one Quit Coach to help you create a customized quit plan • The Quit for Life mobile app, which offers 24/7 urge management support • Text2Quit text messages for daily tips and encouragement • Quit medications – Such as nicotine gum or patches – for no charge, based on eligibility.

Feature	Description
PERS (Personal Emergency Response System) for Retiree Advantage Members	**UnitedHealthcare®** works with Lifeline to provide a personal emergency response system at no cost for Retiree Advantage plan members Lifeline personal emergency response system (PERS) allows you to ask for help whenever you need it, anytime of day or night – 365 days of the year, 24/7. All you need to do is press the help button, worn as a wristband or pendant, and a Trained Care Specialist will assist you to make sure you quickly get the help you need. **Features include:** Optional AutoAlert fall detection technology automatically provides access to help if it detects a fall – even if wearer is disoriented, immobilized or unconscious and cannot press their help button Cellular or landline compatible, Lifeline works anywhere in the U.S., where current telephone service is provided Lightweight, waterproof help button can be worn on the wrist or as a pendant

Non-FEHB Benefits Available to Plan Members

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

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

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

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

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

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

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

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

For details and plan cost and availability in your area.

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

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

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

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

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

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see *Emergencyservices/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental, investigational or unproven procedures, treatments, drugs or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, fetal reduction or non-surgical or drug induced pregnancy terminations except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Surrogate parenting
- Fetal reduction surgery
- Reversal of voluntary sterilization
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.
- Extra care costs or research costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- 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, call 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 the claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review as long as we notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected. If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

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

Authorized Representative

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

Notice Requirements

If you live in a county where at least 10% of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as phone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The Disputed Claims Process

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

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

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

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

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

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

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

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, Healthcare and Insurance, FEHB 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

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

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

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

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

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

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

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

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 877-835-9861. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's 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 family member is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation 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 healthcare expenses without regard to fault. This is called "double coverage."

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

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

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

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

We do not cover services that:

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

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

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

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

Some FEHB plans already cover some dental and vision services. When you are covered by more than one 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

What is 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 877-835-9861 or see our Web site at www.uhcfeds.com.

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

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

Medicare Part B Premium Reimbursement

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

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

Medicare

Benefit Description: Deductible
High Option You Pay **Without** Medicare: No deductible
High Option You Pay **With** Medicare Part B: No deductible

Benefit Description: Out-of-Pocket Maximum
High Option You Pay **Without** Medicare: $5,000 self only/$10,000 family
High Option You Pay **With** Medicare Part B: $5,000 self only/$10,000 family

Benefit Description: Part B Premium Reimbursement Offered
High Option You Pay **Without** Medicare: N/A
High Option You Pay **With** Medicare Part B: N/A

Benefit Description: Primary Care Physician
High Option You Pay **Without** Medicare: $25
High Option You Pay **With** Medicare Part B: $25

Benefit Description: Specialist
High Option You Pay **Without** Medicare: $35
High Option You Pay **With** Medicare Part B: $35

Benefit Description: Inpatient Hospital
High Option You Pay **Without** Medicare: $150 per day up to $750 per admission
High Option You Pay **With** Medicare Part B: $150 per day up to $750 per admission

Benefit Description: Outpatient Hospital
High Option You Pay **Without** Medicare: $150 free standing; $300 hospital based
High Option You Pay **With** Medicare Part B: $150 free standing; $300 hospital based

Benefit Description: Incentives offered
High Option You Pay **Without** Medicare: N/A
High Option You Pay **With** Medicare Part B: N/A

- **Tell us about your Medicare Coverage**

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

- **Medicare Advantage (Part C)**

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

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

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

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

You may enroll in the UnitedHealthcare Retiree Advantage Plan if:

- You are enrolled in this UnitedHealthcare FEHBP plan and have both Medicare Part A and Part B
- You are retired and live in our geographic service area. See page 12 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 Retiree Advantage Plan.

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

We offer a plan designed:

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

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

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

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

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

Benefit Description: Deductible
Member Cost **without** Medicare: No plan deductible
Member Cost **with** Medicare Part B: No plan deductible
Member Cost **with** UnitedHealthcare Retiree Advantage Health Plan: No plan deductible

Benefit Description: Out-of-Pocket Maximum
Member Cost **without** Medicare: $5,000 Self Only, $10,000 Self Plus One, and $10,000 Self and Family
Member Cost **with** Medicare Part B: $5,000 Self Only, $10,000 Self Plus One, and $10,000 Self and Family
Member Cost **with** UnitedHealthcare Retiree Advantage Health Plan: You pay nothing for Medicare-covered service from any provider

Benefit Description: Primary Care Physician
Member Cost **without** Medicare: $25 per visit
Member Cost **with** Medicare Part B: $25 per visit
Member Cost **with** UnitedHealthcare Retiree Advantage Health Plan: $0

Benefit Description: Specialist
Member Cost **without** Medicare: $35 per visit
Member Cost **with** Medicare Part B: $35 per visit
Member Cost **with** UnitedHealthcare Retiree Advantage Health Plan: $0

Benefit Description: Virtual Visits
Member Cost **without** Medicare: $5 per visit
Member Cost **with** Medicare Part B: $5 per visit
Member Cost **with** UnitedHealthcare Retiree Advantage Health Plan: $0

Benefit Description: Urgent Care
Member Cost **without** Medicare: $35 per visit
Member Cost **with** Medicare Part B: $35 per visit
Member Cost **with** UnitedHealthcare Retiree Advantage Health Plan: $0

Benefit Description: Emergency
Member Cost **without** Medicare: $250 per visit (waived if admitted)
Member Cost **with** Medicare Part B: $250 per visit (waived if admitted)
Member Cost **with** UnitedHealthcare Retiree Advantage Health Plan: $0

Benefit Description: Inpatient Hospital
Member Cost **without** Medicare: $150 per day (up to $750 per admission)
Member Cost **with** Medicare Part B: $150 per day (up to $750 per admission)
Member Cost **with** UnitedHealthcare Retiree Advantage Health Plan: $0

Benefit Description: Outpatient Hospital
Member Cost **without** Medicare: Freestanding: $150, Hospital-based: $300
Member Cost **with** Medicare Part B: Freestanding: $150, Hospital-based: $300
Member Cost **with** UnitedHealthcare Retiree Advantage Health Plan: $0

Benefit Description: Rx - (30-day at retail)
Member Cost **without** Medicare: Tier 1-$10, Tier 2-$40, Tier 3-$85, Tier 4-$175
Member Cost **with** Medicare Part B: Tier 1-$10, Tier 2-$40, Tier 3-$85, Tier 4–$175
Member Cost **with** UnitedHealthcare Retiree Advantage Health Plan: Tier 1-$6, Tier 2-$25, Tier 3-$60, Tier 4–$90

Benefit Description: Rx – Mail Order (90-day supply)
Member Cost **without** Medicare: 2.5 x retail copay
Member Cost **with** Medicare Part B: 2.5 x retail copay
Member Cost **with** UnitedHealthcare Retiree Advantage Health Plan: 2 x retail copay

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

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

  When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan. If you elect to enroll in the UnitedHealthcare Retiree Advantage plan which includes Medicare part D, your FEHB plan will not coordinate benefits. The UnitedHealthcare Retiree Advantage plan will take over as the primary and only payer.

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

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

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

Section 10. Definitions of Terms We Use in This Brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Clinical Trials Cost Categories	An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application. Routine care costs- costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy • Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. • Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.
Coinsurance	See Section 4, page 21
Copayment	See Section 4, page 21
Cost-Sharing	See Section 4, page 21
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 21
Experimental or investigational service	Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case are determined to be any of the following: • Not approved by the *U.S. Food and Drug Administration (FDA*) to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States American Hospital Pharmacopoeia Dispensing Information* as appropriate for the proposed use • Not recognized, in accordance with generally accepted medical standards, as being safe and effective for your condition; • Subject to review and approval by any institution review board for the proposed use. (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational). • The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight
Healthcare professional	A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.

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

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

Post-service claims

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

Pre-service claims

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

Reimbursement

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

Subrogation

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

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 1-877-835-9861. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We

Us and We refer to UnitedHealthcare Insurance Company, Inc.

You

You refers to the enrollee and each covered family member.

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Summary of Benefits for the High Option Plan of UnitedHealthcare Insurance Company - 2023

- **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 obtain a copy of our Summary of Benefits as required by the Affordable Care Act at www.uhcfeds.com.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies..

High Option Benefits	You pay	Page
Medical services provided by physicians: Preventive Care	No copayments for preventive care services. This includes items such as, but not limited to, immunizations, physical examinations and screenings as appropriate and recommended by U.S. Preventive Services Task Force. Please refer to Section 5.	28
Medical services provided by physicians: Diagnostic and treatment services provided in the office	$25 per primary care physician (PCP) visit for ages 18 and older, $0 for children under 18 visits to PCP $35 per specialist visit	25
Urgent Care	$35 copayment per visit	
Services provided by a hospital: Outpatient Services	$50 per outpatient non-surgical visit	49
Services provided by a hospital: Outpatient Surgical	$150 per outpatient surgical visit for services performed at approved free standing surgical facility $300 per outpatient hospital surgical visit	49
Inpatient	$150 per day up to 5 days per admission	48
Emergency benefits: In or out-of-area	$275 per emergency room visit (waived if admitted)	51
Mental health and substance use disorder treatment:	Regular cost-sharing	53
Prescription drugs: Plan Retail pharmacy and Specialty Pharmaceuticals	Tier 1: $10 Tier 2: $40 Tier 3: $85 Tier 4: $175	58
Prescription drugs: Plan mail order for up to a 90-day fill	Tier 1: $25 Tier 2: $100 Tier 3: $212.50 Tier 4: $437.50	58
Specialty Pharmacy (30-day supply)	Tier 1 $10 Tier 2 $150 Tier 3 $350 Tier 4 $500	56

High Option Benefits	You pay	Page
Vision care:	$35 specialist copayment for eye refraction exam every other year for adults	34
Wellness and Other Special features:	UnitedHealthcare mobile app, Smoking cessation program, Maternity Health Solutions, Orthopedic Health Support UnitedHealth Premium, Real Appeal, Specialty Pharmacy, Flexible Benefits Option, Cancer Clinical Trials	63
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $5,000 for Self Only enrollment or $10,000 for Self Plus One and Self and Family enrollment per year. Some costs do not count toward this protection	20
Non-FEHB Benefits	PPO Preventive dental plan at no charge to all members; Resoures for hearing aids and other financial options available for our members	71

Notes

Notes

2023 Rate Information for UnitedHealthcare Insurance Company, Inc.

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

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

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

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
District of Columbia, Maryland, Pennsylvania and Virginia					
High Option Self Only	LR1	$259.72	$159.36	$562.73	$345.28
High Option Self Plus One	LR3	$560.52	$340.48	$1,214.46	$737.71
High Option Self and Family	LR2	$611.42	$381.78	$1,324.74	$827.19
Alabama, Arkansas, Florida, Louisiana, Mississippi, North Carolina and Tennessee					
High Option Self Only	KK1	$259.72	$174.58	$562.73	$378.25
High Option Self Plus One	KK3	$560.52	$373.25	$1,214.46	$808.71
High Option Self and Family	KK2	$611.42	$474.36	$1,324.74	$1,027.78
Arizona (Phoenix and Tucson), Colorado, Nevada, Oregon and Washington					
High Option Self Only	KT1	$259.72	$184.95	$562.73	$400.72
High Option Self Plus One	KT3	$560.52	$395.51	$1,214.46	$856.94
High Option Self and Family	KT2	$611.42	$500.25	$1,324.74	$1,083.88
Iowa and Kentucky					
High Option Self Only	LJ1	$259.72	$190.49	$562.73	$412.73
High Option Self Plus One	LJ3	$560.52	$407.42	$1,214.46	$882.74
High Option Self and Family	LJ2	$611.42	$514.10	$1,324.74	$1,113.89