UnitedHealthcare Insurance Company, Inc.

www.uhcfeds.com

Customer Service: 877-835-9861

UnitedHealthcare®

2024

A High Deductible Health Plan with Health Savings Account

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

Serving all of the following states: Alabama, Arizona (Phoenix and Tucson), Arkansas, Colorado, District of Columbia, Florida, Louisiana, Maryland, Mississippi, Nevada, North Carolina, Oregon, Pennsylvania, Tennessee, Virginia, Washington

IMPORTANT
- Rates: Back Cover
- Changes for 2024: Page 15
- Summary of Benefits: Page 112

Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See page 15 for specific geographic information /requirements.

Enrollment codes for this Plan:

Southeast: Alabama, Arkansas, Florida, Louisiana, Mississippi, North Carolina, & Tennessee

LS1 Self Only, LS3 Self Plus One, LS2 Self and Family

West: Arizona (Phoenix and Tucson), Colorado, Nevada, Oregon, Washington State

LU1 Self Only, LU3 Self Plus One, LU2 Self and Family

Northeast - District of Columbia, Maryland, Pennsylvania, Virginia

V41 Self Only, V43 Self Plus One, V42 Self and Family

Special Notice: UnitedHealthcare Insurance Company, is Terminating Code N7 in its Central Area, Iowa and Kentucky service area for 2024

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

Important Notice from UnitedHealthcare Insurance Company About

Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the UnitedHealthcare Insurance Company 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 percent per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

Potential Additional Premium for Medicare's High Income Members

Income-Related Monthly Adjustment Amount (IRMAA)

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

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

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

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Introduction

This brochure describes the benefits of UnitedHealthcare Insurance Company, Inc. under contract (CS 2950) between UnitedHealthcare Insurance Company Inc. and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 1-877- 835-9861 or through our website at myuhc.com. The address for UnitedHealthcare Insurance Company Inc.'s administrative office is:

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

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

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

OPM negotiates benefits and rates for each plan annually. Benefit changes are effective January 1, 2024, and changes are summarized on page 3. 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.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your healthcare provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review Explanation of Benefits (EOBs) statements that you receive from us.
- Periodically review your claims 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
1-844-499-7295 or go to www.uhc.com/fraud
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); or
  - 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

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

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medications or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask your pharmacist about the medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

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

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

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

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

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

- "About how long will it take?"
- "What will happen after surgery?"
- "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

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

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients suffer from injuries or illnesses that could have been prevented if 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 preferred providers. Participating providers may not bill or collect payment from UnitedHealthcare members for any amounts not paid due to the application of this reimbursement policy. 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 that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

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

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

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

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

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

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

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

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

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

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB plan.

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

- **Family member coverage**

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

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

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

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

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

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

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

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

- **Children's Equity Act**

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest cost nationwide plan option as determined by OPM.
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest cost nationwide plan option as determined by OPM.

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

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

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2024 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2023 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

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

- **Upon divorce**

If you are an enrollee and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You **must** contact us to let us know the date of the divorce or annulment and have us remove your ex-spouse. We may ask for a copy of the divorce decree as proof. In order to change enrollment type, you must contact your employing or retirement office. A change will not automatically be made.

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

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

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

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

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

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

- **Converting to individual coverage**

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

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

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

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 1-877-835-9861.

- **Health Insurance Marketplace**

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

Section 1. How This Plan Works

This Plan is an individual practice plan offering you a high deductible health plan (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Account (HRA) for those who do not qualify for an HSA. HDHP's have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans. 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. To learn more about this plan's accreditation(s), please visit the following websites:

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

General Features of our High Deductible Health Plan

We have Point of Service (POS) benefits

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

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

How we pay providers

Network 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).

Out-of-Network providers - Because these providers are not contracted with us and do not participate in our networks, these providers are paid based on an out of network plan allowance. Members will be responsible for the difference between our allowance and the amount billed.

Preventive care services

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

Annual Deductible

The annual deductible in-network of $2,000 for Self Only enrollment or $4,000 for Self Plus One or Self and Family enrollment, must be met before benefits are paid for care other than preventive care services. The annual deductible out-of-network of $4,000 for Self Only enrollment or $8,000 for Self Plus One or $8,000 Self and Family enrollment must be met before out-of-network benefits are paid.

Health Savings Account

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, excluding specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), not enrolled in Medicare, have not received VA (except for veterans with a service-connected disability) or Indian Health Service (IHS) benefits within the last three months, are not covered by your own or your spouse's flexible spending account (FSA), and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by a High Deductible Health Plan.
- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.

- For each month that you are enrolled in an HDHP and eligible for an HSA, UnitedHealthcare will pass through (contribute) a portion of the health plan premium into your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. Your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable - you may take the HSA with you if you leave the Federal government or switch to another plan.
- Your HSA account fiduciary is Optum Financial Bank.
- Please refer to section 5 Savings - HSAs and HRAs for more complete information

Health Reimbursement Arrangement (HRA)

If you are not eligible for an HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an HSA, there are major differences.

- An HRA does not earn interest.
- An HRA is not portable if you leave the Federal government or switch to another plan.
- You will need to advise UnitedHealthcare if you are ineligible to allow us to move you into the HRA.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits annual out-of-pocket expenses for covered services, including deductibles and copayments, to no more than $7,000 for Self Only enrollment, and $14,000 for a Self Plus One or Self and Family. The out-of-pocket limit for this Plan may differ from the IRS limit, but cannot exceed that amount.

Health education resources and accounts management tools

myuhc.com provides you the ability to:

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

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

UnitedHealthcare Mobile App - allows you to obtain secure, on-the-go access to your personalized health information to help you better understand and use your health plan effectively. You can download this app from Apples ITunes Store or Google Play for Android. With the app you can:

- Find care and costs, including virtual care
- Review your plan information, including deductibles and copays/coinsurance
- Access your Optum Bank financial accounts

- Check on the status of claims
- Pay bills
- Access and View your Medical ID card
- Conduct a provider search (medical and behavioral)
- Find urgent care locations and hospital

Your rights and responsibilities

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

- UnitedHealthcare Insurance Company Inc. has been in existence since 1972
- UnitedHealthcare Insurance Company Inc. is a for profit corporation
- If you want more information about us, call 877-835-9861. You may also visit our website at www.uhcfeds.com.

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.

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

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. Our service area is:

South East - Plan code LS: Alabama, Arkansas, Florida, Louisiana, Mississippi, North Carolina and Tennessee.

West - Plan code LU: Colorado, Nevada, Oregon and Washington and:

Tucson, Arizona (Including the counties of: Santa Cruz, and portion of Pima county including the following zip codes : 85321, 85341, 85601, 85602, 85611, 85614, 85619, 85622, 85629, 85633, 85634, 85637, 85639, 85641, 85646, 85652, 85653, 85654, 85658, 85701, 85702, 85703, 85704, 85705, 85706, 85707, 85708, 85709, 85710, 85711, 85712, 85713, 85714, 85715, 85716, 85717, 85718, 85719, 85720, 85721, 85722, 85723, 85724, 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, 85755, 85756, 85757, 85775

Phoenix, Arizona - Including the counties of: Maricopa and Pinal

Northeast: Plan code V4: District of Columbia, Maryland, Pennsylvania, and Virginia

Section 2. Changes for 2024

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

Changes to this Plan

- Your share of the premium will increase for Self Only or increase for Self Plus One or increase for Self and Family. See rates page on the back of the brochure
- **Infertility services -** the Plan will cover intravaginal insemination (IVI), intracervical insemination (ICI), and intrauterine insemination (IUI) at 50% coinsurance of the Plan allowance. This is new coverage for contract year 2024. See page 46
- **Infertility drugs** - the Plan will now cover fertility drugs associated with artificial insemination procedures. The Plan will also provide three (3) cycles annually of fertility drugs associated with IVF. Preauthorization is required. The Plan will cover fertility drugs on all prescription drug tiers. See page 80
- **Gender Affirming Care and Services** - the Plan will expand coverage for medically necessary gender affirming care to include the following services for contract year 2024: breast enlargement including augmentation mammaplasty and breast implants, thyroid cartilage reduction/reduction thyroid chondroplasty, trachea shave (removal or reduction of the Adam's apple) and voice modification surgery (e.g., laryngoplasty, glottoplasty or shortening of vocal cords), facial gender affirming care surgery, and travel and lodging. The member cost share for these services is 20% coinsurance of the plan allowance. Preauthorization is required. There is a $2,000 maximum on travel and lodging. See page 59
- **COVID 19 Over The Counter (OTC) Test Kits** – The Plan will cover test kits (8 per member per month) at Tier 3 with a $12 cap cost share. See page 80
- **Telehealth services/virtual visits -** the Plan will eliminate the $5 member copayment for virtual visits and provide at no charge. Members must access these services through a Plan-designated virtual visit network provider. See page 44
- **Emergency services** - Emergency room copay changing to $275. See page 72
- **Revisional Bariatric surgery** - the Plan will now cover revisional bariatric surgery, a medical procedure used to correct problems with a previous weight loss operation. Members pay 20% coinsurance of the plan allowance. See page 57

Section 3. How You Get Care

Identification cards

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

If you do not receive your ID card within 30-days after the effective date of your enrollment, or if you need replacement cards, call us at 1-877-835-9861 or write to us at UnitedHealthcare's Federal Employees Health Benefits (FEHB) Program at P.O. Box 30432, Salt Lake City, UT 84130-0432. You may also request replacement cards and print temporary ID 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, deductibles, and/or coinsurance, if you use our network providers, if you use our point-of-service program, you can also get care from non-Plan providers for some services but it will cost you more. If you use our Open Access program you can receive covered services from a participating provider without a required referral from your primary care provider or by another participating provider in the network

Balance Billing Protection

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

- **Plan providers**

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

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

We list Plan providers in the provider directory, which we update periodically. The list is also on our website at www.uhc.com for members and www.uhcfeds.com for all.

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

This plan provides Care Coordinators for complex conditions and can be reached 877-835-9861 or myuhc.com 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 list is also on our web site at www.uhcfeds.com. You should also contact that provider to verify that they participate with the Plan.

What you must do to get covered care	**You do not need to select a primary care provider and you do not need written referrals to see a specialist for medical services**. The provider must be participating for services to be covered at an in-network level. Services provided out-of-network may need prior authorization to be covered and will cost more than in-network services. Call us at 1-877-835-9861 to determine if you need authorization for benefits as some services do require preauthorization. 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 provider will provide most of your healthcare or give you a referral to see a specialist. If you want to change primary care provider or if your primary care provider leaves the Plan, call us. We will help you select a new one.
• **Specialty care**	Here are some other things you should know about specialty care: • If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care provider will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. • Your physician will create your treatment plan. The physician may have to get an authorization or approval from us beforehand. If you have a chronic or disabling condition and lose access to your network specialist because we: • Terminate our contract with your specialist for other than cause; or • 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 and receive in-network benefits for up to 90 days after you receive notice of the change at in-network benefit level. 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 and receive the in-network benefit level.
• **Hospital Care**	Your Plan primary care provider or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.
• **If you are hospitalized when your enrollment begins**	We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-877-835-9861. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of 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; or • 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

Preauthorization is the process by which we evaluate the medical necessity of your hospital stay and the number of days required to treat your condition. In most cases, your Network physician will make necessary hospital arrangements and supervise your care. If you are using a non-network provider or facility, you are responsible for contacting the Plan at 1-877-835-9861 to obtain preauthorization. Failure to do may result in denial of services.

- **Inpatient hospital admission**

Your plan physician or specialist will make necessary hospital arrangements and supervisor your care. This includes admission to a skilled nursing or other type of facility. Because you are still responsible for ensuring that we are asked to precertify your care, you should always ask your physician or hospital whether they have contacted the Plan.

If you are using a non-network provider or facility, you are responsible for contacting the Plan at 1-877-835-9861.

If the admission is a non-urgent admission or if you are being admitted to a non-network hospital, you must get the admission authorized by calling the Plan at 1-877-835-9861. This must be done at least 4 business days before the admission. If the admission is an emergency or an urgent admission, you, the person's provider, or the hospital must notify us by calling 1-877-835-9861 within one business day or the same day of admission, or as soon as reasonably possible.

Next, provide the following information:

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

NOTE: If you do not notify us, your benefits may be reduced $100 per admission for covered services.

- **Other Services**

Certain services require that you or your physician must obtain prior approval from us. We call this review and approval process prior authorization. You or your physician must obtain prior authorization for most out-of-network services as well as some network services such as, **but not limited** to the following:

- Accidental dental injury
- Ambulance Non Emergency or Air ambulance
- Applied Behavioral Analysis (ABA)
- Bariatric surgery - Morbid obesity surgery
- Capsule endoscopy
- Clinical trials
- Computed tomography (CT) scans
- Congenital anomaly repair
- Dialysis
- Discectomy/fusion
- Durable medical equipment over $1,000

- Electro-convulsive Therapy
- Gender Dysphoria treatment/gender affirming surgery
- Growth hormone therapy (GHT)
- Iatrogenic infertility services
- Infertility Services
- Inpatient admissions
- Intensive outpatient therapy
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiogram (MRA)
- Non emergency ambulance services
- 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
- Sleep apnea - surgery and appliance with sleep studies; sleep studies (polysomnograms) attended
- Substance Use Disorder treatment
- TMJ surgery
- Transplants
- Vein ablation

Please note this list is subject to change upon notification to Plan providers. Please call customer service 1-877-835-9861 to verify if your procedure/services do require prior authorization.

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

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

Next, provide the following information:

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

- **Non-urgent care claims**

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

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

- **Urgent care claims**

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

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide 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 Admissions**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must phone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

Maternity care

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

	Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. **NOTE:** Non-network benefits require that you notify us as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described above. If you do not notify us, your benefits will be reduced by $100 per admission.
• **If your treatment needs to be extended**	If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim
What happens when you do not follow the precertification rules when using non-network facilities	If you fail to obtain authorization/precertifications when using non-network facilities you can be responsible for a portion or all of the charges.
Circumstances beyond our control	Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.
If you disagree with our pre-service claim decision	If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call 877-835-9861. If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.
• **To reconsider a non-urgent 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. Write to you and maintain our denial.
• **To reconsider an urgent care claim**	In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure. Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by phone, electronic mail, facsimile, or other expeditious methods.

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

Section 4. Your Costs for Covered Services

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

Cost-sharing

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

Copayments

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

Example: When you see your primary care provider, you pay a copayment of $15 per office visit, and when you go in the hospital, you pay $500 per admission.

Deductible

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

- The calendar year deductible is $2,000 for Self Only or $4,000 for Self Plus One or Self and Family enrollment in-network. The deductible is $4,000 for Self Only or $8,000 for Self Plus One or Self and Family enrollment out-of-network. The full Self plus One or Self and Family deductible must be satisfied before the traditional medical plan benefits apply.

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

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

Coinsurance

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

Differences between our Plan allowance and the bill

Network providers and facilities have contracted with the Plan to accept our Plan allowance. If you use a network provider or facility, you do not have to pay the difference between our Plan allowance and the billed amount for covered services.

If you are using non-network providers you will have to pay the difference between our Plan allowance and the billed amount.

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

Your catastrophic protection out-of-pocket maximum

After your in-network (copayments and coinsurance) total $6,000 for a Self Only or $12,000 for Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. Your out-of-network limitation is $12,000 for Self Only enrollment or $24,000 for Self Plus One or Self and Family enrollment in any calendar year, then you do not have to pay any more for covered services.

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

- Expenses paid by the plan for your preventive care benefits
- Charges incurred by failure to obtain pre-certification when using non-network facilities and other amounts you pay because benefits have been reduced/denied for non compliance with the plans requirements
- The balance billing charges incurred when you see a non-network provider
- Copayments or coinsurance for chiropractic services

- Eyeglasses or contact lenses
- Expenses for services and supplies that exceed the stated maximum dollar or day limit

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

Carryover

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

When Government facilities bill us

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

Important Notice About Surprise Billing - Know Your Rights

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

A surprise bill is an unexpected bill you receive for:

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

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

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

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

- 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).

• The Federal Flexible Spending Account Program – FSAFEDS	• 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 Deductible Health Plan Benefits

See page 15 for how our benefits changed for this year. Page 112 provides a summary of benefits for your plan. Make sure that you review the benefits that are available to you.

Section 5. High Deductible Health Plan Benefits Overview

This Plan offers a High Deductible Health Plan (HDHP). The HDHP benefit package is described in this section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

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

Our HDHP option provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The Plan gives you greater control over how you use your healthcare benefits.

When you enroll in this HDHP, we provide you the documents for YOU to establish a Health Savings Account (HSA) either via mail or on line with Optum Bank who is the administrator of the HSA for UnitedHealthcare. We cannot fund our contribution until you have opened this account. If you do not qualify for a Health Savings Account, a Health Reimbursement Arrangement (HRA) will be opened for you through Optum Financial Bank once you notify us that you are not eligible. We automatically pass through a portion of the total health Plan premium to your HSA or credit an equal amount to your HRA based upon your eligibility. Timing of funding can be found within this section of the brochure. If you do not open your account by the last day of the current year, a new contract year will begin and you will forfeit any pass through funds from UnitedHealthcare for the prior year. It is important that you read and understand the terms of the HSA in Section 5. Savings - HSAs and HRAs.

With this Plan, preventive care is covered in full. As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits according to the benefits described in Section 5. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

This HDHP includes five key components: preventive care; traditional medical coverage healthcare that is subject to the deductible; savings; catastrophic protection for out-of-pocket expenses; and health education resources and account management tools

- **Preventive care**

  This Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), routine prenatal and well-child care, child and adult immunizations, tobacco cessation programs, obesity weight loss programs, disease management and wellness programs. These services are covered at 100% if you use a network provider and the services are described in Section 5 *Preventive care. You do not have to meet the deductible before using these services.*

- **Traditional medical coverage**

  After you have paid the Plan's deductible, we pay benefits under traditional medical coverage described in Section 5. Many of the benefits in this plan are subject to copayments when care is provided by an in-network plan provider. Benefits subject to coinsurance are paid at 80% by the plan. The Plan typically pays 70% of the allowed charges for out-of-network care.

  Covered services include:

  - Medical services and supplies provided by physicians and other healthcare professionals
  - Surgical and anesthesia services provided by physicians and other healthcare professionals
  - Hospital services; other facility or ambulance services
  - Emergency services/accidents
  - Mental health and substance use disorder benefits
  - Prescription drug benefits
  - Accidental dental injury benefits

- **Savings**

  Health Savings Accounts or Health Reimbursement Accounts provide a means to help you pay out-of-pocket expenses. (See page 31 for more details).

- **Health Savings Accounts (HSA)**

  By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else's tax return, have not received VA (except for veterans with a service-connected disability) and/or Indian Health Services (IHS) benefits within the last three months or do not have other health insurance coverage other than another High Deductible Health Plan. In 2024, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA $62.50 per month for a Self Only enrollment or $125 per month for a Self Plus One enrollment or Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions (the pass through as well as your own independent contributions) do not exceed the limit established by law, which is $4,150 for an individual and $8,300 for a family. See maximum contribution information on page 37. You can use funds in your HSA to help pay your health plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

  Federal tax tip: There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments are fully deductible on your Federal tax return. By fully funding your HSA early in the year, you have the flexibility of paying medical expenses from tax-free HSA dollars or after tax out-of-pocket dollars. If you don't deplete your HSA and you allow the contributions and the tax-free interest to accumulate, your HSA grows more quickly for future expenses.

  HSA features include:

  - Your HSA is administered by Optum Bank.
  - Your contributions to the HSA are tax deductible
  - You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.)
  - Your HSA earns tax-free interest
  - You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents (see IRS publication 502 for a complete list of eligible expenses)
  - Your unused HSA funds and interest accumulate from year to year
  - It's portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire
  - When you need it, funds up to the actual HSA balance are available.

  Important consideration if you want to participate in a Health Care Flexible Spending Account (HCFSA): If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a **HCFSA** health care flexible spending account (such as FSAFEDS offers) this plan cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA, we will establish an HRA for you.

- **Health Reimbursement Account (HRA)**

  If you are not eligible for an HSA, for example, you are enrolled in Medicare or have another health plan, we will administer and provide an HRA instead. You must notify us that you are ineligible for an HSA to allow us to set up the HRA for you.

  In 2024, we will give you an HRA credit of $750 per year for a Self Only enrollment or $1,500 per year for a Self Plus One Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don't count toward the deductible.

HRA features include:

- For our HDHP option, the HRA is administered by Optum Bank
- Entire HRA credit (prorated from your effective date to the end of the plan year) is available to cover claims from your effective date of enrollment. Claims with member responsibility are automatically paid from your HRA funds.
- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP.
- Unused credits carryover from year to year.
- HRA credit does not earn interest.
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans.
- An HRA does not affect your ability to participate in an FSAFEDS Health Care Flexible Spending Account (HCFSA). However, you must meet FSAFEDS eligibility requirements

- **Catastrophic protection for out-of-pocket expenses**

When you use network providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to $6,000 per person or $12,000 per Self Plus One or Self and Family enrollment. When you use out of network providers your annual maximum is limited to $12,000 Self Only or $24,000 per Self Plus One or Self and Family enrollment. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximum). Refer to Section 4 Your catastrophic protection out-of-pocket maximum and HDHP Section 5 *Traditional medical coverage subject to the deductible* for more details.

- **Health education resources and account management tools**

HDHP Section 5(i) describes the health education resources and account management tools available to you to help you manage your healthcare and your healthcare dollars.

Connect to www.uhcfeds.com to register for myuhc.com. On this site you can find health care at your fingertips, 24 hours a day. Keeping track of your benefits and claims, finding ways to save money, and learning more about how to stay healthy are easy at myuhc.com, your own secure personal member web site.

Section 5. Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Account (HRA): Provided only when you are ineligible for an HSA
Administrator	The Plan will provide you the documents required for you to establish a HSA with Optum Financial Bank, this HDHP's fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS). You will be responsible for opening the bank account -the Plan does not open the account for you.	UnitedHealthcare Insurance Company, Inc. is the HRA fiduciary for this Plan. We will begin funding your HRA once this account has been established by UnitedHealthcare. Please notify us if you are not eligible for the HSA to allow us to set this account up for you.
Fees	When you enroll in our HSA, you will automatically be enrolled in the Health eAccess HSA option. This account does not earn interest, but may be the right choice for you if you would like lower monthly fees and are an active spender. A letter will be mailed to you within approximately 90-days after you have opened your HSA explaining interest bearing options. These options have higher monthly fees. There is no fee to set up your account while you are enrolled in our High Deductible Health Plan, however there may be fees associated with your account. Your account may be subject to fees for services such as: • ATM transaction fees $2 • Transfer fees to transfer your HSA to another bank or custodian (all or portion of balance) $20 • Monthly maintenance fees $2.75 We are not charging fees for some routine charges. Information can be obtained at www.optumbank.com.	None
Eligibility	You must: • Enroll in the UnitedHealthcare Insurance Company, Inc. High Deductible Health Plan (HDHP) • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage)	You must enroll in the UnitedHealthcare Insurance Company, Inc. High Deductible Health Plan HDHP. Eligibility is determined on the day of enrollment and will be prorated for length of enrollment.

	• Not be enrolled in Medicare • Not be claimed as a dependent on someone else's tax return • Not have received VA (except for veterans with a service-connected disability) and/or Indian Health Service (IHS) benefits in the last three months • Complete and submit to OptumBank all banking paperwork including the initial application to open your HSA with Optum Financial Bank • Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.	If you do not meet the requirements above to participate in the HSA please contact customer service at 1-877-835-9861 and we will have you moved to the HRA.
Funding	If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month when the premium is received. Premium pass through contributions are based on the effective date of your enrollment in the UnitedHealthcare Insurance Company Inc. High Deductible Health Plan. Note: If you are new to this Plan based on an Open Season change, your first premium pass-through will be made available in February, by the 25th of February as new enrollees and terminations from open season are still being received in January. Note: If your effective date in the HDHP is after the 1st of the month, the earliest your HSA will be funded is by the 25th of the following month as long as your account has been opened before the 20th of the month prior. Example: if you open your account by the 20th of April your first funding will occur in May. If your account does not open until April 25th your funding will not occur until June. We encourage you to open your account immediately upon enrollment into the plan and be sure to advise the bank of your group number and employer as Federal Employees Health Benefit Plan. This information is on the application provided to you or on line at uhcfeds.com.	Eligibility for the annual credit will be determined on the first day of the month and will be prorated for length of enrollment. The entire amount of your HRA will be available to you once you notify us that you are not eligible for the HSA.

	In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e. Employee Express, MyPay, etc.).	
• **Self Only enrollment**	For 2024, a monthly premium pass through of $62.50 will be made by the HDHP directly into your HSA each month upon receipt of premium.	For 2024, your HRA annual credit will be $750 which (prorated for mid-year enrollment).
• **Self Plus One enrollment**	For 2024, a monthly premium pass through of $125 will be made by the HDHP directly into your HSA each month upon receipt of premium.	For 2024, your HRA annual credit is $1,500 (prorated for mid-year enrollment).
• **Self and Family enrollment**	For 2024, a monthly premium pass through of $125 will be made by the HDHP directly into your HSA account each month upon receipt of premium.	For 2024, your HRA annual credit is $1,500 (prorated for mid-year enrollment)
Contributions/credits	The maximum that can be contributed to your HSA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of $4,150 for an individual and $8,300 for a family. If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution. You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year. If you do not meet the 12 month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.	The full HRA credit will be available, subject to proration, within 30-days of the effective date of enrollment (unless date is retroactive at which time the credit will be made available within 30-days of plan notification of enrollment). The HRA does not earn interest.

	You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP). HSAs earn tax-free interest (does not affect your annual maximum contribution). Additional contribution discussed on page 37.	
• **Self Only enrollment**	You may make an annual maximum contribution of $4,150.	You cannot contribute to the HRA.
• **Self Plus One enrollment**	You may make an annual maximum contribution of $8,300 (per family)	You cannot contribute to the HRA
• **Self and Family enrollment**	You may make an annual maximum contribution of $8,300 (per family)	You cannot contribute to the HRA.
Access funds	You can access your HSA by the following methods: UnitedHealthcare Health Savings Account MasterCard® Debit Card must be activated in order to have access to HSA funds On-line bill payment Checks (if you choose to purchase these) ATM Withdrawals	For qualified medical expenses under the UnitedHealthcare Insurance Company Inc. High Deductible Health Plan, you will be automatically reimbursed when claims are submitted through the UnitedHealthcare Insurance Company Inc. High Deductible Health Plan.
Distributions/withdrawals *(this section continues on the next page)* • **Medical**	You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not coverd by the HDHP) from the funds available in your HSA. See IRS Publication 502 for a list of eligible medical expenses. You may use the UnitedHealthcare Health Savings Account MasterCard® Debit Card or checks (optional) for all qualified expenses.	You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the UnitedHealthcare Insurance Company Inc. HDHP. Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan. See *Availability of funds* below for information on when funds are available in the HRA. See IRS Publication 502 for a list of eligible medical expenses. Physician prescribed over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.

• **Non-medical**	If you are under age 65, withdrawal of funds for non-medical expenses will create a 20% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds. When you turn age 65, distributions can be used for any reason without being subject to the 20% penalty, however they will be subject to ordinary income tax.	Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.
Availability of funds	Funds are not available for withdrawal until all the following steps are completed: • Your enrollment in the UnitedHealthcare Insurance Company Inc. High Deductible Health Plan is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • **You must complete and send the HSA application to Optum Financial Bank or complete the application on line. An application will be mailed to you however you may find the application as well as a link to the account for your plan code, on our web site, www.uhcfeds.com. You need to include your group number to ensure that your account is tied to the appropriate plan.** • The UnitedHealthcare Insurance Company Inc. High Deductible Health Plan's fiduciary (Optum Financial Bank) receives completed HSA application for your HSA Account either via fax or online. Optum bank will contact you via email if there are any items that need to be resolved to open your account. • In the event your enrollment is backdated (retro enrollment) your bank account, once active, will be funded back to the date your enrollment became effective within the current plan year.	The entire amount of your HRA will be available to you by month close of the month your enrollment in the UnitedHealthcare Insurance Company, Inc. High Deductible Health Plan is received, and verification received by the plan that you are not eligible for a Health Savings Account. (The amount of your HRA will be prorated based on the effective date of coverage.)

	• The fiduciary (Optum Financial Bank) receives the completed paperwork back from you and your HSA is completely established. Any information required by Optum Financial Bank from you will be sent directly to you. Communications to you with any questions occur via email to expedite the process. • The contribution to your HSA is prorated for partial months of enrollment. • Accounts opened by the 20th of the month will be funded the following month. Accounts opened after the 20th of the month will be funded the second month following. • Plan contributions are typically deposited by the 25th of the month. • Note: Annual premium pass through contributions will be forfeited if you do not open your HSA by December 31 of the current plan year.	
Account owner	FEHB enrollee	UnitedHealthcare Insurance Company Inc. High Deductible Health Plan
Portable	You can take this account with you when you change plans, separate or retire. If you do not enroll in another HDHP, you can no longer contribute to your HSA. See "HSA eligibility".	If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA. If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

If You Have an HSA

If you have an HSA

- **Contributions**

  All contributions are aggregated and cannot exceed the maximum contribution amount set by the IRS. You may contribute your own money to your account through payroll deductions, or you may make lump sum contributions at any time, in any amount not to exceed an annual maximum limit. If you contribute, you can claim the total amount you contributed for the year as a tax deduction when you file your income taxes. Your own HSA contributions are either tax-deductible or pre-tax (if made by payroll deduction). You receive tax advantages in any case. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum contribution amount set by the IRS. You have until April 15 of the following year to make HSA contributions for the current year.

  If you newly enroll in an HDHP during Open Season and your effective data is after January 1st or you otherwise have partial year coverage, you are eligible to fund your account up to the maximum contribution limit set by the IRS as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. If you do not meet this requirement, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.

- **Over age 55 additional contributions**

  If you are age 55 or older, the IRS permits you to make additional contributions to your HSA. The allowable additional contribution is $1,000. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the IRS website at www.irs.gov or request a copy of IRS Publication 969 by calling 1-800-829-3676.

- **If you die**

  If you have not named a beneficiary and you are married, your HSA becomes your spouse's; otherwise, your HSA becomes part of your taxable estate.

- **Qualified expenses**

  You can pay for "qualified medical expenses," as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, **physician prescribed** over-the-counter drugs, LASIK surgery, and some nursing services.

  When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are enrolled in Medicare.

  For a detailed list of IRS-allowable expenses, request a copy of IRS Publication 502 by calling 1-800-829-3676, or visit the IRS website at www.irs.gov and click on "Forms and Publications." Note: Although **physician prescribed** over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.

- **Non-qualified expenses**

  You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.

- **Tracking your HSA balance**

  You will be able to view your monthly statements from OptumHealth Bank online. This statement shows the "premium pass through deposits", withdrawals, and interest earned on your account . You may also request a paper statement.

- **Minimum reimbursements from your HSA**

  You may make payments to providers or reimbursements to yourself in any amount via your UnitedHealthcare Health Savings Account MasterCard® Debit Card, check, online bill pay, or ATM withdrawal.

If You Have an HRA

- **Why an HRA is established**

  If you do not qualify for an HSA when you enroll in this HDHP, or later become ineligible for an HSA, please advise us and we will establish an HRA for you. If you are enrolled in Medicare, you are ineligible for an HSA, advise us and we will establish an HRA for you. You must tell us if you become ineligible to contribute to an HSA.

- **How an HRA differs**

  Please review Section 5. Savings - HSAs and HRAs which details the differences between an HRA and an HSA. The major differences are:

  - you cannot make contributions to an HRA
  - funds are forfeited if you leave the HDHP
  - an HRA does not earn interest
  - HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP. FEHB law does not permit qualified medical expenses to include services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.

Section 5. Preventive Care

Important things you should keep in mind about these benefits:

- Preventive care services listed in this Section are not subject to the deductible.
- You must use providers that are part of our network in order to have the benefits paid.
- For all other covered expenses, please see Section 5 – *Traditional medical coverage subject to the deductible.*

Benefit Description		
Preventive care, adult	**In-Network You pay**	**Out-of-Network You pay**
• Routine physical every year The **following** preventive services are covered at the time interval recommended at each of the links below • Immunizations such as Pneumococcal, influenza, shingles, tetanus/Tdap, and human papillomavirus (HPV). For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ • Screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer screening. For a complete list of screenings go to the U. S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks • Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women 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 https://health.gov/myhealthfinder.	$0	*All charges*
• Routine mammogram- covered	$0	*All charges*
• Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule.	$0	*All charges*
• Routine exams limited to: - One routine eye exam every 12 months - One routine OB/GYN exam every 12 months including 1 Pap smear and related services - One routine hearing exam every 24 months	$0	*All charges*
• Medical Nutrition Therapy and Intensive Behavioral Therapy for the prevention of obesity related comorbidities as recommended under the U.S. Preventive Services Task Force (USPSTF) A and B recommendations.	$0	*All charges*
One annual biometric screening to include age appropriate screening such as: • Body Mass Index (BMI) • Blood Pressure • Lipid/cholesterol levels • Glucose/hemoglobin A1C measurement Note: services must be coded by your doctor as preventive to be covered in full Members can access the Health Risk Assessment on www.myuhc.com	$0	*All charges*

Preventive care, adult - continued on next page

Benefit Description		
Preventive care, adult (cont.)	**In-Network You pay**	**Out-of-Network You pay**
BRCA genetic counseling and evaluation is covered as preventive when a woman's family history is associated with an increased risk for deleterious mutations in BRCA1 and BRCA2 genes and medical necessity criteria has been met.	$0	*All charges*
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*	*All charges*
Preventive care, children	**In-Network You pay**	**Out-of-Network You pay**
Well-child visits examinations, and immunizations as described in the Bright Future Guidelines provided by the American Academy of Pediatrics 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 listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available (USPSTF) is available online at: www.uspreventiveservicestaskforce.org HHS: www.healthcare.gov/preventive-care-benefits/ ACIP recommendations on immunizations, please refer to the National Immunization Program Web site at: www.cdc.gov/vaccines/schedules/index.html CDC: www.cdc.gov/vaccines/schedules/index.html For additional information: healthfinder.gov/myhealthfinder/default.aspx Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to brightfutures.aap.org/Pages/default.aspx	$0	*All charges*
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams,or travel* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*	*All charges*

Section 5. Traditional Medical Coverage Subject to the Deductible

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.
- In-network preventive care is covered at 100% and is not subject to the calendar year deductible.
- The in-network deductible is $2,000 per Self Only enrollment, or $4,000 per Self Plus One or Self and Family enrollment. The out-of-network deductible is $4,000 per Self Only enrollment or $8,000 per Self Plus One or Self and Family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- Under Traditional medical coverage, you are responsible for your coinsurance and copayments for covered expenses.
- When you use in-network providers, you are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance, copayments and deductibles total $6,000 self only or $12,000 per Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services from network providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum,
- In-network benefits apply only when you use a network provider. When a network provider is not available, out-of-network benefits apply.
- When you use **out of network** providers you are protected by an annual catastrophic maximum on out-of-network expenses for covered services. After your coinsurance, copayments and deductibles total $12,000 Self Only or $24,000 per Self Plus One or Self and Family, you do not have to pay any more for covered services from network providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum, or amounts in excess of the Plan allowance).
- Be sure to read Section 4, Your Costs for Covered services, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description		
Deductible before Traditional medical coverage begins	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
The deductible applies to all benefits in this Section. In the **You pay** column, we say "No deductible" when it does not apply. When you receive covered services from network providers, you are responsible for paying the allowable charges until you meet the deductible.	100% of allowable charges until you meet the deductible of $2,000 Self Only, $4,000 for Self Plus One or Self and Family coverage.	100% of charges until you meet the deductible of $4,000 for Self Only, $8,000 Self Plus One and/or Self and Family coverage
After you meet the deductible, we pay the allowable charge (less your coinsurance or copayment) until you meet the annual catastrophic out-of-pocket maximum.	After you meet the deductible, you pay the indicated coinsurance or copayments for covered services. You may choose to pay the coinsurance and copayments from your HSA or HRA, or you can pay for them out-of-pocket	After you meet the deductible, you pay the indicated coinsurance based on our Plan allowance and any difference between our allowance and the billed amount

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.
- The in-network deductible is $2,000 Self Only enrollment and $4,000 for Self Plus One and Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The out-of-network deductible is $4,000 for Self Only enrollment and $8,000 for Self Plus One and Self and Family enrollment each calendar year.
- The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description		
Diagnostic and treatment services	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
Professional services of Primary care provider: • In office/teleheatlh/Optum primary care • Office medical consultation • Advanced care planning	$15 copayment per Primary care provider (PCP) visit in office/ telephonic	30% of the Plan allowance and any difference between our allowance and the billed amount.
Professional services of specialists: • In your physicians office/telehealth • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical opinion • Advanced care planning	$30 copayment per visit	30% of the Plan allowance and any difference between our allowance and the billed amount.
Second Opinion by 2nd MD	**In-network You pay after deductible**	**Out-of-network You pay after deductible**

Second Opinion by 2nd MD - continued on next page

Benefit Description		
Second Opinion by 2nd MD (cont.)	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
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.	$0	*All charges*
Telehealth services/Virtual visits	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
Use virtual visits with our UHC Designated virtual visit network provider groups when : • Your doctor is not available • You become ill while traveling • Conditions such as: cold, flu, bladder infection, bronchitis, diarrhea, fever, pink eye, rash, sinus problem, sore throat, stomach ache 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 877-835-9861. Access to Virtual Visits and prescription services may not be available in all states due to state regulations. Note: There may be state restrictions pertaining to telemedicine and prescribing therefore not all services may be available in all states.	$0 copayment per visit	*All charges*
Lab, X-ray and other diagnostic tests	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
Tests, received in your provider's office at the time of your visit such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG	PCP $15 specialist $30	*All charges*
Tests received at a facility: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays	$50 copayment per visit	*All charges*

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description		
Lab, X-ray and other diagnostic tests (cont.)	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
• Non-routine mammograms • Ultrasound • Electrocardiogram and EEG	$50 copayment per visit	*All charges*
Major Diagnostic tests: • CT scans/MRI • PET scans • Nuclear medicine Preauthorization may be required for these tests	$150 copayment per visit	*All charges*
Maternity care	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
Complete maternity (obstetrical) care, such as: • Prenatal and Postpartum care • Screening for gestational diabetes • Bacteriuria screening • Delivery • Screening and counseling for prenatal and postpartum depression • Breastfeeding support, supplies and counseling for each birth Note: Here are some things to keep in mind: • You do not need to precertify your vaginal delivery; see page 16 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury • Hospital services are covered under Section 5(c) and Surgical benefits in Section 5(b). 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.	$30 copayment per specialist visit (only applies to first prenatal visit for routine services)	30% of the Plan allowance and any difference between our allowance and the billed amount.

Benefit Description		
Family planning	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
Contraceptive counseling on an annual basis	$0	30% of the Plan allowance and any difference between our allowance and the billed amount
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 • Genetic testing is covered when medically necessary for certain conditions such as pregnancy testing for cystic fibrosis, certain autosomal recessive conditions and dominant less penetrant conditions, x-linked conditions and certain chromosome abnormalities Note: We cover oral and injectable contraceptives under the prescription drug benefit.	$0	30% of the Plan allowance and any difference between our allowance and the billed amount.
Voluntary sterilization (See Surgical Procedures Section 5(b)	$35 per specialist visit	30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing or counseling not medically necessary*	*All charges*	*All charges*
Infertility services	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
Diagnosis and treatment of the underlying cause of infertility	$30 copayment per specialist visit	30% of the Plan allowance and any difference between our allowance and the billed amount.
Infertility: A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. It is defined by the failure to achieve a successful pregnancy after 12 months or more of unprotected intercourse or artificial insemination for individuals under age 35. Earlier evaluation and treatment for those individuals actively looking to achieve a conception may be justified based on medical history and diagnostic testing and is warranted after six (6) months for individuals aged 35 years or older. Covered Services Diagnosis and treatment of infertility specific to:	50% of the plan allowance	50% of the Plan allowance and any difference between our allowance and the billed amount.

Infertility services - continued on next page

Benefit Description		
Infertility services (cont.)	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
Artificial insemination: • Intravaginal Insemination (IVI) • Intracervical Insemination (ICI) • Intrauterine Insemination (IUI) • Fertility drugs (see section 5f) • Oral and injectable drugs associated with artificial insemination and IVF (3 cycles annually) procedures Note: Prior Authorization required	50% of the plan allowance	50% of the Plan allowance and any difference between our allowance and the billed amount.
Allergy care	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
• Allergy services provided in a Providers office - Testing and treatment - Allergy injections - Allergy serum	$15 copayment per primary care visit $30 copayment per specialist visit	You pay 30% of the Plan allowance and any difference between our allowance and the billed amount.
Not covered: Provocative food testing and sublingual allergy desensitization	*All charges*	*All charges*
Treatment therapies	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
• 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 in Section 5(b). • Respiratory and inhalation therapy up to 36 visits per year (Pulmonary therapy) • Cardiac rehabilitation following qualifying event/condition in provided for up up 36 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. Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information and it has been approved. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	$15 copayment per PCP visit $30 copayment per specialist visit	30% of the Plan allowance and any difference between our allowance and the billed amount

Treatment therapies - continued on next page

Benefit Description		
Treatment therapies (cont.)	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
• Applied Behavioral Analysis (ABA) - Children with autism spectrum disorder - home visits not covered	$15 copayment per PCP visit $30 copayment per specialist visit	30% of the Plan allowance and any difference between our allowance and the billed amount
• Dialysis – hemodialysis and peritoneal dialysis	$30 copayment per specialist visit	*All charges*
Habilitative / Rehabilitative Therapies	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
Rehabilitative Services Outpatient Therapy when performed by qualified physical therapists and occupational therapists • Physical therapy- up to 20 visits per year • Occupational therapy- up to 20 visits per year • Cognitive rehabilitation - up to 20 visits per year • Post cochlear implant rehabilitation and aural therapy up to 30 visits per year Note: we only cover therapy when a physician: • orders the care, • identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • indicates the length of time the services are needed.	$30 copayment per specialist visit	30% of the Plan allowance and any difference between our allowance and the billed amount.
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	$30 copayment per specialist visit	30% of the Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*	*All charges*

Benefit Description		
Speech therapy	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
Speech therapy treatment for up to 20 visits per year	$30 copayment per specialist visit	30% of the Plan allowance and any difference between our allowance and the billed amount.
Not covered: *Exercise programs, gyms, or pool memberships, work hardening/ functional capacity programs or evaluations*	*All charges*	*All charges*
Hearing services (testing, treatment, and supplies)	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an MD; DO or audiologist. • External hearing aids are not covered • Refer to Non-FEHB page for discount coverage of hearing aids through UnitedHealthcare Hearing	$30 copayment per specialist visit	30% of the Plan allowance and any difference between our allowance and the billed amount
Hearing examinations for children through age 17 (refer to preventive care - children) • Routine hearing exams for children through age 17 are covered as preventive in accordance to the Bright Future Guidelines published by the American Academy of Pediatrics at no copayment when received at an in-network provider	$0	*All charges*
• Implanted hearing related devices such as bone anchored hearing aids (BAHA) and cochlear implants. Note: for benefits for the device, see Section 5(a) *Orthopedic and prosthetic devices*	$30 copayment per specialist visit	30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *All other hearing testing* • *Hearing aids*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
Diagnosis and treatment of diseases of the eye	$30 copayment per specialist visit	30% of the Plan allowance and any difference between our allowance and the billed amount
Initial pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	20% coinsurance of the plan allowance	30% of the Plan allowance and any difference between our allowance and the billed amount

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

Benefit Description		
Vision services (testing, treatment, and supplies) (cont.)	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
Routine eye examination - Basic eye refraction every two years to provide a written lens prescription *Note: Children eye exams are covered as preventive as described in the Bright Future Guidelines provided by the American Academy of Pediatrics*	$30 copayment per specialist visit	30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*	*All charges*
Foot care	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	$30 copayment per specialist visit	30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
• Artificial limbs and eyes • Prosthetic sleeve or sock • Enteral equipment and supplies • Covered ostomy supplies and urinary catheters • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • External hearing aids • Hair prosthesis for hair loss resulting from chemotherapy or radiation treatment for cancer. There is a limit of one per lifetime with a maximum cost of $350. • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants	20% coinsurance of the plan allowance	30% of the Plan allowance and any difference between our allowance and the billed amount

Orthopedic and prosthetic devices - continued on next page

Benefit Description **Orthopedic and prosthetic devices (cont.)**	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
• Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) *Surgical and anesthesia services.* 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*	20% coinsurance of the plan allowance	30% of the Plan allowance and any difference between our allowance and the billed amount
Prosthesis for a scalp hair prosthesis for hair loss suffered as a result of chemotherapy limited to a maximum of $350 per year	20% coinsurance of the plan allowance	30% of the Plan allowance and difference between allowance and the billed amount
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than 3 years after the last one we covered (except as needed to accommodate growth in chidren or socket replacement for members with significant residual limb volume or weight changes)* • *External penile devices* • *Speech prosthetics except electrolarynx* • *Carpal tunnel splints* • *Deodorants, filters, lubricants, tape, appliance cleansers, adhesive and adhesive removers related to ostomy supplies*	*All charges*	*All charges*
Durable medical equipment (DME)	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen and the rental of equipment to administer oxygen including tubing, connectors and masks • Dialysis equipment • Standard Hospital beds • Standard Wheelchairs • Crutches • CPAP • Walker	20% coinsurance of the plan allowance	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description **Durable medical equipment (DME) (cont.)**	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
• Blood glucose monitors/continuous glucose monitors • Insulin pumps and insulin pump supplies • Surgical dressings not available over the counter • Therapeutic shoes for diabetics • Braces including necessary adjustments to shoes to accommodate braces, which are used for the purpose of supporting a weak or deformed body part • Braces restricting or eliminating motion in a diseased or injured part of the body Note: Most DME items must be preauthorized. Call us at 877-835-9861 if your plan physician prescribes equipment and you need assistance locating a provider for the equipment. You may also call us to determine if certain devices are covered. We provide benefits only for a single purchase (including repair/ replacement) of durable medical equipment once every three years. We will decide if the equipment should be purchased or rented.	20% coinsurance of the plan allowance	*All charges*
Not covered: • *Motorized wheelchairs and other power operated vehicles unless meeting ACA requirements and medical necessity* • *Duplicate or backup equipment* • *Parts and labor costs for supplies and accessories replaced due to wear and tear such as wheelchair tires* • *Educational, vocational, or environmental equipment* • *Deluxe or upgraded equipment and supplies* • *Home or vehicle modifications, seat lifts* • *Activities of daily living aids (such as grab bars)* • *Paraffin baths, whirlpools, and cold therapy* • *Infertility monitors* • *Physical fitness equipment* • *Orthotic devices* • *Personal comfort or hygiene items* • *Air conditioners, air purifiers and filters* • *Batteries and battery chargers* • *Dehumidifiers and humidifiers* • *Augmentative communication devices* • *Continuous pulse oximetry unless skilled nursing is involved in home care and it is part of their medically necessary equipment*	*All charges*	*All charges*

Benefit Description		
Home health services	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
• 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 additional pharmaceutical charges ma • Limit of 60 visits per year	$30 copayment per visit	30% of the Plan allowance and any difference between our allowance and the billed amount
Prescription foods covered as follows: • Amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases which are prescribed for the therapeutic treatment of inherited metabolic diseases and are administered under the direction of a physician • Specialized formulas for the treatment of a disease or condition and are administered under the direction of a Physician • Medical foods which are determined to be the sole source of nutrition and cannot be obtained without a physician's prescription	20% coinsurance of the plan allowance	30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Private duty nursing* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication* • *Foods that can be obtained over the counter (without a prescription) even if prescribed by a physician*	*All charges*	*All charges*

Benefit Description		
Chiropractic	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
• 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 24 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.	20% coinsurance of the plan allowance	30% of the Plan allowance and any difference between our allowance and the billed amount
Alternative treatments	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
Acupuncture – by a doctor of medicine or osteopathy, or licensed or certified acupuncture practitioner up to 12 visits per year for the following: • Dry Needling – by a licensed or certified practitioner	20% coinsurance of the plan allowance	30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback* • *Acupressure* • *Aroma therapy* • *Massage therapy* • *Rolfing*	*All charges*	*All charges*
Educational classes and programs	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
• Diabetes self management (must be prescribed by a licensed health care professional - Outpatient self-management training for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insuling using diabetes and other approved chronic conditions. Diabetes self management training, education and medical nutrition therapy services must be prescribed by a licensed healthcare professional who has appropriate state licensing authority. - Outpatient self management training includes, but is not limited to, education and medical nutrition therapy. The training must be provided by a certified registered or licensed healthcare professional trained in the care and management of diabetes. - Coverage includes: Initial training visit, up to 10 hours, after you are diagnosed with diabetes for the care and management of diabetes, including but not limited to: Counseling in nutrition, the use of equipment and supplies, training and education, up to 4 hours as a result of a subsequent diagnosis by a Physician of a significant change in your symptom or condition which require modification of your program of self-management of diabetes.	$15 per visit to PCP $30 per visit to specialist	30% of the Plan allowance and difference between allowance and billed amount

Educational classes and programs - continued on next page

Benefit Description Educational classes and programs (cont.)	In-network You pay after deductible	Out-of-network You pay after deductible
- Also included is the training and education, up to four hours, because of the development of new techniques and treatments.	$15 per visit to PCP $30 per visit to specialist	30% of the Plan allowance and difference between allowance and billed amount
Coverage is provided for: Tobacco Cessation program which includes online learning, Nicotine Replacement Therapy Coaching and over the counter and prescription drugs approved by the FDA (subject to age and treatment therapy recommendations) to quit smoking or other nicotine use. Learn more about this program in Section 5(h) Wellness and other Special Features.	$0	30% of the Plan allowance and any difference between our allowance and the billed amount
Multicomponent, family centered programs focused on childhood obesity that are part of intensivebehavioral interventions (behavior change counseling for healthy diet and physical activity)	$0	30% of the Plan allowance and any difference between our allowance and the billed amount

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The in-network deductible is $2,000 per Self Only enrollment, or $4,000 per Self Plus One or Self and Family enrollment. The out-of-network deductible is $4,000 per Self Only enrollment or $8,000 per Self Plus One or Self and Family enrollment. The family deductible can be satisfied by one or more family members
- The deductible applies to all benefits in this Section unless we indicate differently. After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other healthcare professional for your surgical care. Look in Section 5(c) for charges associated with a facility (i.e. hospital, surgical center, etc).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SERVICES AND/OR PROCEDURES.** Please refer to the preauthorization information shown in Section 3 or call customer service to be sure which services require preauthorization.

Benefit Description		
Surgical procedures	**In-network You pay after the deductible**	**Out-of-network You pay after the deductible**
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 • Insertion of internal prosthetic devices. See 5(a) *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., vasectomy) • Treatment of burns **Note:** Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	20% coinsurance of the plan allowance	30% of the Plan allowance and any difference between our allowance and the billed amount
Surgical treatment of severe morbid obesity (bariatric surgery)	20% coinsurance of the plan allowance	*All charges*

Surgical procedures - continued on next page

Benefit Description		
Surgical procedures (cont.)	**In-network You pay after the deductible**	**Out-of-network You pay after the deductible**
• Eligible members must be age 18 or older or for adolescents, have achieved greater than 95% of estimated adult height AND a minimum Tanner Stage of 4 • A Body Mass Index (BMI) above 40 kg/m2 without co-morbidity; or • A BMI of 35 kg/m2 or greater with obesity-related co-morbid medical conditions including: - Hypertension - Cardiopulmonary condition - Sleep apnea - Diabetes - Any life threatening or serious medical condition that is weight induced • must enroll in the Bariatric Resource Services Program (BRS) • must use a designated Bariatric Resource Services (BRS) provider and facility • Documentation that dietary attempts at weight control have been ineffective through completion of a structured diet program, such as Weight Watchers or Jenny Craig. Either of the following in the two-year period that immediately precedes the request for the surgical treatment of morbid obesity meets the indication: - a. One structured diet program for six consecutive months; or - b. Two structured diet programs for three consecutive months • A carrier or a private review agent acting on behalf of a carrier shall use flexibility with regard to defining a structured diet program • Completion of a psychological examination of the member's readiness and fitness for surgery and the necessary postoperative lifestyle changes	20% coinsurance of the plan allowance	*All charges*
Revisional Bariatric Surgery using one of the following procedures: • Type 2 diabetes; or • Cardiovascular disease [e.g., history of stroke and/or myocardial infarction, poorly controlled hypertension (systolic blood pressure greater than 140 mm Hg or diastolic blood pressure 90 mm Hg or greater, despite pharmacotherapy)]; or • History of coronary artery disease with a surgical intervention such as coronary artery bypass or percutaneous transluminal coronary angioplasty; or • History of cardiomyopathy; or • Obstructive Sleep Apnea (OSA) confirmed on polysomnography with an AHI or RDI of > 30 and The individual must also meet the following criteria: Both of the following:	20% coinsurance of the plan allowance	*All charges*

Surgical procedures - continued on next page

Benefit Description		
Surgical procedures (cont.)	**In-network You pay after the deductible**	**Out-of-network You pay after the deductible**
• Completion of a preoperative evaluation that includes a detailed weight history along with dietary and physical activity patterns; • Psychosocial-behavioral evaluation by an individual who is professionally recognized as part of a behavioral health discipline to provide screening and identification of risk factors or potential postoperative challenges that may contribute to a poor postoperative outcome	20% coinsurance of the plan allowance	*All charges*
Physician charges for Scopic Procedures such as : Endoscopy Colonscopy (diagnostic) Sigmoidscopy Please note that benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under Surgery. Examples of surgical scopic prcedures are arthroscopy, laparoscopy, brochoscopy and hysteroscopy.	20% coinsurance of the plan allowance	30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; (see Foot care)*	*All charges*	*All charges*
Iatrogenic infertility	**In-network You pay after the deductible**	**Out-of-network You pay after the deductible**
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 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.	20% coinsurance of the plan allowance	30% of the Plan allowance and any difference between our allowance and the billed amount

Iatrogenic infertility - continued on next page

Benefit Description		
Iatrogenic infertility (cont.)	**In-network You pay after the deductible**	**Out-of-network You pay after the deductible**
Benefits are further limited to one cycle of fertility preservation for iatrogenic infertility per covered person during the period of time he or she is enrolled for coverage under the policy. There is a benefit limit of $20,000 for medical services and $5,000 for pharmacy benefits. The preimplantation genetic testing and fertility preservations are one combined maximum. Prior authorization is required.	20% coinsurance of the plan allowance	30% of the Plan allowance and any difference between our allowance and the billed amount
Reconstructive surgery	**In-network You pay after the deductible**	**Out-of-network You pay after the deductible**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) **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	20% coinsurance of the plan allowance	30% of the Plan allowance and any difference between our allowance and the billed amount

Reconstructive surgery - continued on next page

Benefit Description **Reconstructive surgery (cont.)**	**In-network** **You pay after the deductible**	**Out-of-network** **You pay after the deductible**
• 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 affirming 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 affirming surgeries for (female to male) include: • Laser or electrolysis hair removal in advance of genital reconstruction • Salpingo-oophorectomy: removal of fallopian tubes and ovaries • Vaginectomy: removal of vagina • Vulvectomy: removal of vulva • Metoidioplasty: creation of micro-penis using the clitoris • Phalloplasty: creation of penis, with or without urethra • Hysterectomy: removal of uterus • Urethroplasty: creation of urethra within penis • Scrotoplasty: creation of scrotum • Testicular prosthesis: implantation of artificial testes • Mastectomy: removal of the breast • Penile prosthesis • Tracheal shave • Voice modification surgery • Voice modification lessons and therapy • Chest and breast surgery including bilateral mastectomy • Breast reduction and Breast augmentation • Gender Affirming Facial Surgeries • Travel and Lodging ($2000 maximum)	20% coinsurance of the plan allowance	30% of the Plan allowance and any difference between our allowance and the billed amount

Reconstructive surgery - continued on next page

Benefit Description		
Reconstructive surgery (cont.)	**In-network You pay after the deductible**	**Out-of-network You pay after the deductible**
Note: Prior Authorization is required Gender Dysphoria diagnosis must be well documented and follow diagnostic criteria outlined in UHC Clinical policy.	20% coinsurance of the plan allowance	30% of the Plan allowance and any difference between our allowance and the billed amount
Oral and maxillofacial surgery	**In-network You pay after the deductible**	**Out-of-network You pay after the deductible**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures	20% coinsurance of the plan allowance	30% of the plan allowance and any difference between our allowance and the billed amount
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*	*All charges*
Temporomandibular Joint Dysfunction (TMJ)	**In-network You pay after the deductible**	**Out-of-network You pay after the deductible**
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.	20% coinsurance for surgical services or $30 specialist copayment for non-surgical charges	30% of the Plan allowance and any difference between the our allowance and the billed amount

Temporomandibular Joint Dysfunction (TMJ) - continued on next page

Benefit Description		
Temporomandibular Joint Dysfunction (TMJ) (cont.)	**In-network You pay after the deductible**	**Out-of-network You pay after the deductible**
$3,000 limit for all services pertaining to TMJ	20% coinsurance for surgical services or $30 specialist copayment for non-surgical charges	30% of the Plan allowance and any difference between the our allowance and the billed amount
Organ/tissue transplants (Transplants must be provided in a Plan Designated Center of Excellence for Transplants)	**In-network You pay after the deductible**	**Out-of-network You pay after the deductible**
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 necessity review by the Plan. Refer to Other services in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	20% coinsurance of the plan allowance	*All charges*
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as listed below. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs	20% coinsurance of the plan allowance	*All charges*

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

Benefit Description		
Organ/tissue transplants (Transplants must be provided in a Plan Designated Center of Excellence for Transplants) (cont.)	**In-network You pay after the deductible**	**Out-of-network You pay after the deductible**
- Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hematopoietic stem cell - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia Myelodys plastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Hematopoietic stem cell - Medulloblastoma - Multiple myeloma - Neuroblastoma	20% coinsurance of the plan allowance	*All charges*

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

Benefit Description		
Organ/tissue transplants (Transplants must be provided in a Plan Designated Center of Excellence for Transplants) (cont.)	**In-network You pay after the deductible**	**Out-of-network You pay after the deductible**
- Pineoblastoma - Testicular, Mediastinal, Retroperitoneal and ovarian germ cell tumors	20% coinsurance of the plan allowance	*All charges*
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to Other services in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	20% coinsurance of the plan allowance	*All charges*
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated Center of Excellence for transplants if approved by the Plan's medical director in accordance with the Plan's protocols.	20% coinsurance of the plan allowance	All charges

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

Benefit Description		
Organ/tissue transplants (Transplants must be provided in a Plan Designated Center of Excellence for Transplants) (cont.)	**In-network You pay after the deductible**	**Out-of-network You pay after the deductible**
If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MDDs) - Myelodysplasia/Myelodysplastic Syndromes - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for - Advanced childhood kidney cancers	20% coinsurance of the plan allowance	All charges

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

Benefit Description		
Organ/tissue transplants (Transplants must be provided in a Plan Designated Center of Excellence for Transplants) (cont.)	**In-network You pay after the deductible**	**Out-of-network You pay after the deductible**
- Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis National Transplant Program (NTP) OptumHealth Care Solutions 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 for Transplants and if approved by the Plan's medical director in accordance with Plan protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient. **Transplants must be provided in a Plan Designated Center of Excellence for Transplants. These centers do a large volume of these procedures each year and have a comprehensive program of care. Call 877-835-9861 for information.**	20% coinsurance of the plan allowance	All charges
Donor testing for bone marrow /stem cell transplants for up to 4 potential donors whether family or non-family	20% coinsurance of the plan allowance	*All charges*
Not Covered: • *Donor screening tests and donor search expenses except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered - and all services related to these non-covered transplants* • *All services associated with complications resulting from the removal of an organ from a non-member*	*All charges*	*All charges*

Benefit Description		
Anesthesia	**In-network You pay after the deductible**	**Out-of-network You pay after the deductible**
Professional services provided in: • Hospital (inpatient) • Hospital (outpatient department) • Skilled nursing facility • Ambulatory surgical center • Office	In-network: You pay 20% coinsurance	Out-of-Network: You pay 30% of our Plan allowance and any difference between our allowance and the billed amount

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions , limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The in-network deductible is $2,000 per Self Only enrollment, or $4,000 per Self Plus One or Self and Family enrollment. The out-of-network deductible is $4,000 per Self Only enrollment or $8,000 per Self Plus One or Self and Family enrollment. The family deductible can be satisfied by one or more family members
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your Costs for Covered Services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET 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		
Inpatient hospital	**In-network You Pay after deductible**	**Out-of-network You Pay after deductible**
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. We will pay benefits for an inpatient stay of at least 48 hours following a mastectomy or lymph node dissections. If your hospital stay is elective, please notify us within five business days prior to your admission. For non-elective admissions, please notify us within one business day or the same day of admission. For emergency admissions, please notify us within one business, the same day of admission, or as soon as it is reasonably possible. If you fail to notify us in a timely manner, your benefits will be reduced by $100 per occurrence.	$500 copayment per admission	30% of our Plan allowance and any difference between our allowance and the billed amount
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services	$0	30% of our Plan allowance and any difference between our allowance and the billed amount.

Inpatient hospital - continued on next page

Benefit Description		
Inpatient hospital (cont.)	**In-network You Pay after deductible**	**Out-of-network You Pay after deductible**
• 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 (Note: calendar year deductible applies.)	$0	30% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as phone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**In-network You Pay after deductible**	**Out-of-network You Pay after deductible**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medication • 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.	$250 copayment per surgery	30% of our Plan allowance and any difference between our allowance and the billed amount
Not covered: Blood and blood derivatives not replaced by the member	*All charges*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**In-network You Pay after deductible**	**Out-of-network You Pay after deductible**
• 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 ordered by a Physician and delivered or supervised by a licensed technical or professional medical personnel in order to obtain the specific medical outcome, and provide for the safety of the patient • Benefits up to 60 days when full time skilled nursing care is necessary and confinement is medically appropriate	$0 if admitted from inpatient hospital setting, otherwise you pay $500 copayment per admission	30% of our Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Custodial care* • *Rest cures, domicillary or convalescent care*	*All charges*	*All charges*

Extended care benefits/Skilled nursing care facility benefits - continued on next page

Benefit Description		
Extended care benefits/Skilled nursing care facility benefits (cont.)	**In-network You Pay after deductible**	**Out-of-network You Pay after deductible**
• *Personal comfort items such as phone, barber services, guest meals and beds*	*All charges*	*All charges*
Hospice care	**In-network You Pay after deductible**	**Out-of-network You Pay after deductible**
Hospice care that is recommended by a physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for the immediate family members while the Covered person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency. • Outpatient care • Family counseling • Supportive and palliative care for a terminally ill member is covered in the home or hospice facility	20% coinsurance of the plan allowance	30% of our Plan allowance and any difference between our allowance and the billed amount
Not covered: Independent nursing, homemaker services	*All charges*	*All charges*
Ambulance	**In-network You Pay after deductible**	**Out-of-network You Pay after deductible**
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. • 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.	20% coinsurance of the plan allowance	30% of our Plan allowance and any difference between our allowance and the billed amount

Ambulance - continued on next page

Benefit Description		
Ambulance (cont.)	**In-network You Pay after deductible**	**Out-of-network You Pay after deductible**
• "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness. • "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.	20% coinsurance of the plan allowance	30% of our Plan allowance and any difference between our allowance and the billed amount

Section 5(d). Emergency Services/Accidents

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The in-network deductible is $2,000 per Self Only enrollment, or $4,000 per Self Plus One or Self and Family enrollment. The out-of-network deductible is $4,000 per Self Only enrollment or $8,000 per Self Plus One or Self and Family enrollment. The family deductible can be satisfied by one or more family members
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within or outside our service area:

If you are in an emergency situation, please call your doctor. In extreme emergencies, if you are unable to contact your doctor, contact your local emergency system (e.g. 911 phone system) or go to the nearest hospital emergency room. You or a family member must notify the Plan within 48 hours or as soon as possible after you receive outpatient emergency room.

If you need to be hospitalized, the Plan must be notified within 24 hours, the same day of admission, unless it was not reasonably possible to notify the Plan within that time. If you do not notify us, benefits will be reduced by $100 per occurrence. Benefits will not be reduced for the outpatient emergency room visit.

Benefit Description		
Emergency within or outside our service area	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
• Emergency care at a doctor's office	$15 copayment per Primary Care Visit or $30 copayment per Specialist office visit	30% of our Plan allowance and any difference between our allowance and the billed amount
• Emergency care at an urgent care center	$35 copayment per urgent care visit	30% of our Plan allowance and any difference between our allowance and the billed amount
Emergency care as an outpatient in a hospital including doctors' services Note: We waive the ER copay if you are admitted to the hospital	$275 copayment per visit (waived if admitted)	30% of our Plan allowance and any difference between our allowance and the billed amount
Not covered:	*All charges*	*All charges*

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

Benefit Description		
Emergency within or outside our service area (cont.)	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
• *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*	*All charges*
Ambulance	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
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.	$0 for ground ambulance or $500 copayment for air ambulance	30% of our Plan allowance and any difference between our allowance and the billed amount

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

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

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The in-network deductible is $2,000 per Self Only enrollment, or $4,000 per Self Plus One or Self and Family enrollment. The out-of-network deductible is $4,000 per Self Only enrollment or $8,000 per Self Plus One or Self and Family enrollment. The family deductible can be satisfied by one or more family members
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SERVICES AND/OR PROCEDURES.** Please refer to the preauthorization information shown in Section 3 or call customer service to be sure which services require preauthorization.

Benefit Description		
Professional Services	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
We cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions
Diagnosis and treatment of psychiatric conditions, mental illness or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Diagnosis and treatment of substance abuse disorders, including detoxification, treatment and counseling	$30 per specialist visit	30% of our Plan allowance and any difference between our allowance and the billed amount

Professional Services - continued on next page

Benefit Description		
Professional Services (cont.)	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
• Treatment and counseling (including individual or group therapy visits) with providers such as psychiatrists, psychologists, or clinical social workers • Professional charges for intensive outpatient treatment in a provider's office, telehealth or other non facility professional setting • Electroconvulsive therapy	$30 per specialist visit	30% of our Plan allowance and any difference between our allowance and the billed amount
Diagnostics	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
• 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	$50 copayment per visit for minor diagnostic tests	30% of our Plan allowance and any difference between our allowance and the billed amount
Inpatient hospital or other covered facility	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
Services provided by a hospital or other facility • Full day hospitalization • Room and board such as semi private or intensive accommodations, general nursing care, meals and special diets, and other hospital services	$500 copayment per admission	30% of our Plan allowance and any difference between our allowance and the billed amount
Outpatient hospital or other covered facility	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
Outpatient Services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full day hospitalization, or facility-based intensive outpatient treatment	$50 copayment per day	30% of our Plan allowance and any difference between our allowance and the billed amount
Not covered	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
Not covered: • *Psychiatric evaluation or therapy on court order or as a condition of parole or probation unless determined by the plan physician to be necessary and appropriate* • *Methadone maintenance that is not part of a treatment* • *Services and supplies when paid for directly or indirectly by a local State or Federal Government Agency* • *Room and board at a therapeutic boarding school* • *Services rendered or billed by schools*	*All charges*	*All charges*

Not covered - continued on next page

Benefit Description		
Not covered (cont.)	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
• *Services that are not medically necessary* *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*	*All charges*

Section 5(f). Prescription Drug Benefits

Here are some important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page. Some injectable medications 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.
- The in-network deductible is $2,000 per Self Only enrollment, or $4,000 per Self Plus One or Self and Family enrollment. The out-of-network deductible is $4,000 per Self Only enrollment or $8,000 per Self Plus One or Self and Family enrollment. The family deductible can be satisfied by one or more family members.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses or copayments for eligible prescriptions.
- Some prescription medications have Quantity Level Limits (QLL) and Quantity per Duration Limits (QD). Please see below for more information.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically. If your pharmacist tells you that your prescription medication requires approval, ask your pharmacist or prescriber to contact the Plan at the number on your Member ID card for further instructions.
- Federal law prevents the pharmacy from accepting unused medications.
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

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

• **Where you can obtain them.** You may fill the prescription at a Plan pharmacy. You may fill prescriptions for maintenance medications either by mail or at a retail pharmacy. Maintenance medications are those medications anticipated to be required for six months or longer to treat a chronic condition such as high blood pressure, asthma, or diabetes. To locate the name of a Plan pharmacy near you, refer to your Directory of Health Care Professionals, call our Customer Service Department 1-877-835-9861.

• **We have a managed Formulary/Prescription Drug List (PDL) called the Advantage PDL.** Our PDL Management Committee creates a list that includes FDA approved prescription medications, products, or devices. Our Plan covers all prescription medications written in accordance with FDA guidelines for a particular therapeutic indication except for prescription medications or classes of medications listed under “Not Covered” in this section of the brochure. The PDL Management Committee decides the tier placement upon clinical information from the UnitedHealthcare Pharmacy and Therapeutics (P www.uhcfeds.com.

The PDL consists of Tiers 1, 2, 3 and 4.

• **Tier 1** is your **lowest** copayment option ($10 for up to a 30-day supply or $25 for up to a 90-day supply through our mail order program) and includes some generic medications, as well as select preferred brand medications. Brand medications in Tier 1 include select insulin products, select inhalers for asthma, and select medications for migraine headaches for which no generic alternative(s) are available. For the lowest out-of-pocket expense, you should always consider Tier 1 medications if you and your provider decide they are appropriate for your treatment.

• **Tier 2** is your **middle** copayment option ($40 for up to a 30-day supply or $100 for up to a 90-day supply through our mail order program) and contains some generic and preferred brand medications not included in Tier 1. Preferred medications placed in Tiers 1 and 2 are those the PDL Management Committee has determined to provide better overall value than those in Tier 3. If you are currently taking a medication in Tier 2, ask your provider whether there are Tier 1 alternatives that may be appropriate for your treatment.

• **Tier 3** is your **higher** copayment option $85 for up to a 30-day supply or $212.50 for up to a 90-day supply through our mail order program) and consists of non-preferred brand medications. Sometimes there are alternatives available in Tier 1 or Tier 2. If you are currently taking a medication in Tier 3, ask your provider whether there are Tier 1 or Tier 2 alternatives that may be appropriate for your treatment.

• **Tier 4** is your **highest** copayment option of $175 for up to a 30-day supply or $437.50 for up to a 90-day supply through our mail order program) and consists of only non-preferred medications which often are available over the counter without a prescription. The drugs on this tier do not add clinical value over those covered in the lower tiers. Ask your provider whether there are Tier 1 or Tier 2 alternatives that may be appropriate for your treatment.

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

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

Mandatory Specialty Pharmacy Program - Our Specialty Pharmacy Program includes medications for rare, unusual or complex diseases. Members must obtain these medications through our designated specialty pharmacy. You will pay the applicable Tier copay for your specialty medications and receive up to a maximum of a consecutive 30-day supply of your prescription medication. Our specialty pharmacy providers will give you superior assistance and support during your treatment.

Specialty pharmacy medications are included in a PDL. The specialty medication copayments for 30-day supply are as follows:

- Tier 1 $10; Tier 2 $150; Tier 3 $350 and Tier 4 $500.

This Program offers the following benefits to members:

- Expertise in storing, handling and distributing these unique medications
- Access to products and services that are not available through a traditional retail pharmacy
- Access to nurses and pharmacists with expertise in complex and high cost diseases
- Free supplies such as syringes and needles
- Educational materials as well as support and development of a necessary care plan

There are the dispensing limitations: These are the dispensing limitations. Some drugs may only be available at a retail pharmacy or through the designated Specialty Pharmacy. See the following section for details on Specialty Pharmacy drugs.

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

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 and alternatives may be found on myuhc.com or uhcfeds.com

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

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

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

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

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

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

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

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

Benefit Description		
Preventive care medications	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
We cover medications to promote better health currently recommended by ACA. Note: Preventive Medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a healthcare 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. • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age at risk for preclampsia	$0	*All charges*

Preventive care medications - continued on next page

Benefit Description		
Preventive care medications (cont.)	**In-network** **You pay after deductible**	**Out-of-network** **You pay after deductible**
• 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 - Tier 1 • 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 - 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 these benefits a prescription from a doctor must be presented to pharmacy	$0	*All charges*
Covered medications and supplies	**In-network** **You pay after deductible**	**Out-of-network** **You pay after deductible**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medications that by Federal law of the United States require a physician's prescription for their purchase, except those listed as Not covered • Insulin, with a copayment charge applied every 2 vials • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction are limited. Contact the plan for dosage limits. • Oral and injectable contraceptive drugs • Drugs to treat gender dysphoria (some may be covered under the specialty benefit) • Oral and injectable drugs associated with artificial insemination and IVF (3 cycles annually) procedures Prior Authorization is required **Note:** Intravenous fluids and medications for home use, implantable drugs, and some injectable drugs are covered under Section (5a) Medical services and supplies or Section (5b) Surgical and anesthesia services.	**Network retail pharmacy for up to a maximum of a 30-day supply:** Tier 1: $10 copayment Tier 2: $40 copayment Tier 3: $85 copayment Tier 4: $175 copayment **Plan mail order pharmacy for up to a 90-day supply:** Tier 1: $25 copayment Tier 2: $100 copayment Tier 3: $212.50 copayment Tier 4: $437.50 copayment	*All charges*
Specialty Pharmacy (30-day supply)	Tier 1: $10 copayment Tier 2: $150 copayment Tier 3: $350 copayment Tier 4: $500 copayment	*All charges*

Covered medications and supplies - continued on next page

Benefit Description Covered medications and supplies (cont.)	In-network You pay after deductible	Out-of-network You pay after deductible
• 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	20% coinsurance of the plan allowance	*All charges*
COVID-19 Over The Counter (OTC) Test Kits • 8 Tests per member per month	Tier 3 -$12 Capped	*All charges*
Contraceptive drugs and devices as listed in the ACA/ HRSA site. Contraceptive coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in all methods of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. Members 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. Reimbursement for over-the-counter contraceptives can be submitted by completing a prescription drug claim form and submitting it with the required documentation to: OptumRx at PO Box 29044, Hot Springs, AR 71903.	$0 (not subject to deductible)	*All charges*
Smoking cessation medications are covered as follows: • Prescription medications • Over the counter smoking cessation medications purchased with a prescription from a physician. Note may be subject to age and quantity limitations.	$0	*All charges*
Not covered: • *Drugs and supplies used for cosmetic purposes* • *Drugs to enhance athletic performance* • *Medical supplies such as dressings and antiseptics* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed*	*All charges*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description		
Covered medications and supplies (cont.)	**In-network You pay after deductible**	**Out-of-network You pay after deductible**
• *Nonprescription medications or 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 unless specifically indicated elsewhere* • *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* • *Drugs for sexual performance for patients that have undergone genital reconstruction* • *Medical marijuana* • *Nonprescription medications unless specifically indicated elsewhere* *Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco/nicotine dependence are covered under the Tobacco cessation programs benefit. (See above)*	*All charges*	*All charges*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHBP Plan. See Section 9 *Coordinating benefits with other coverage*.
- The in-network deductible is $2,000 per Self Only enrollment, or $4,000 per Self Plus One or Self and Family enrollment. The out-of-network deductible is $4,000 per Self Only enrollment or $8,000 per Self Plus One or Self and Family enrollment. The family deductible can be satisfied by one or more family members.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SERVICES AND/OR PROCEDURES.** Please refer to the preauthorization information shown in Section 3 or call customer service to be sure which services require preauthorization.
- Please refer to the non-FEHB page for a description of our non-FEHB dental benefits provided to you under this plan.

Benefit description		
Accidental injury benefit	**In-network You pay**	**Out-of-network You pay**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. A sound natural tooth is defined as a tooth that: • has no active decay, has at least 50% bony support, • has no filling on more than two surfaces; • has no root canal treatment, is not an implant • is not in need of treatment except as a result of the accident, and • functions normally in chewing and speech. • Crowns, bridges, implants and dentures are not considered sound natural teeth. Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry	20% coinsurance of the plan allowance	30% of our Plan allowance and any difference between our allowance and the billed amount

Accidental injury benefit - continued on next page

Benefit description		
Accidental injury benefit (cont.)	**In-network You pay**	**Out-of-network You pay**
• The dental coverage is severe enough that the 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 a fixation wire from fracture care.) • Benefits for treatment of the 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	20% coinsurance of the plan allowance	30% of our Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Oral implants and related procedures, including bone grafts to support implants.* • *Procedures that involve teeth or their supporting structures (such as periodontal membrane, gingival and aveolar bone).*	*All charges*	*All charges*
Adjunctive dental	**In-network You pay**	**Out-of-network You pay**
Benefits for dental care that is medically necessary and an integral part of the treatment of a sickness or condition for which covered health services are provided. Examples of adjunctive dental care are: • Extraction of teeth prior to radiation for oral cancer • Elimination of oral infection prior to transplant surgery • Removal of teeth in order to remove an extensive tumor	20% coinsurance of the plan allowance	30% of our Plan allowance and any difference between our allowance and the billed amount

Adjunctive dental - continued on next page

Benefit description		
Adjunctive dental (cont.)	**In-network You pay**	**Out-of-network You pay**
Note: When alternate methods may be used, we will authorize the least costly covered health service provided that the service and supplies are considered by the profession to be an appropriate method of treatment and meet broadly accepted national standards of dental practice. You and the provider may choose a more expensive level of care, but benefits will be payable according to these guidelines.	20% coinsurance of the plan allowance	30% of our Plan allowance and any difference between our allowance and the billed amount

Section 5(h). Wellness and Other Special Features

Feature	Description
Feature	
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.

Feature - continued on next page

Feature	Description
Feature (cont.)	
	• 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

Feature - continued on next page

Feature	Description
Feature (cont.)	
Specialist Management Solutions (SMS)	*Specialist Management Solutions (SMS) is part of your health plan and exists to simplify your path to affordable, quality surgery and specialty care. Think of SMS as a concierge service. In one phone call to SMS, you get instant access to a care advocate who will help you find a local surgeon who specializes in your condition, schedule an appointment for you, and talk to you about your options for where you can receive care for a surgery or other outpatient procedure. SMS will be available for you or your family member throughout the experience of getting surgery, available to answer questions and provide assistance at any time.* *Specialties include: Cardiovascular, ENT, Gastrointestinal, General Surgery, MSK/ Spine, Ophthalmology, Orthopedic, Pain Management, Podiatry, Urology, Women's Health* **Payment for medical appointments and treatments remain member's responsibility and are subject to plan benefits.*
The Second Opinion service through 2nd.MD	**Supporting informed decisions with access to personalized second opinions** The Second Opinion service through 2nd.MD helps our members with a diagnosis get an expert opinion from leading medical experts. This service is available at no additional charge and includes: • Virtual and phone consultations • A written summary within 24 hours • Chat and text capabilities with a dedicated nurse • Referrals and appointment scheduling for local peer-to-peer consults, if needed **Offering a concierge-like experience** You can request a consult online or by phone. After receiving the request, a care team nurse: 1. Performs triage and intake 2. Sends the employee's medical records and recommends a medical expert 3. Schedules the consultation; the employee meets with the expert and receives a written summary 4. Coordinates any follow-up needs within 9–14 days **Providing expert help throughout the care journey** The Second Opinion service provides second opinions for a variety of needs. Providers are hand-selected to help give you access to leading physicians who specialize in your condition. Consultations may cover: • New diagnoses • Changes in treatment • Chronic conditions • Potential surgeries 2nd.MD works with top physicians across the country who are world-class medical experts and have trained and worked at elite institutions such as Cleveland Clinic, Boston Children's Hospital, and Hospital for Special Surgery.

Feature - continued on next page

Feature	Description
Feature (cont.)	
Smoking Cessation	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.

Feature - continued on next page

Feature	Description
Feature (cont.)	
	• **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.
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
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

Feature - continued on next page

Feature	Description
Feature (cont.)	
	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 Benefit 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 under the OPM disputed claims process. (See Section 8).
Cancer Clinical Trials	To be a qualifying clinical trial, a trial must meet all of the following criteria: • Be sponsored and provided by a cancer center that has been designated by the *National Cancer Institute (NCI)* as a *Clinical Cancer Center* or *Comprehensive Cancer Center* or be sponsored by any of the following: - *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI).*) - *Centers for Disease Control and Prevention (CDC).* - *Agency for Healthcare Research and Quality (AHRQ).* - *Centers for Medicare and Medicaid Services (CMS).* - *Department of Defense (DOD).* - *Veterans Administration (VA).*

Feature - continued on next page

Feature	Description
Feature (cont.)	
	• 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.

Section 5(i). Health Education Resources and Account Management Tools

Special features	Description
Care Options and Costs	Understand Your Care Options and Costs. Before You Get Care. (visit myuhc.com) You can access step-by-step explanations for over 500 of the most common procedures, learn about doctors and hospitals from their quality and cost-efficiency ratings, and estimate the costs for office visits, treatments, lab tests and medications. And because the information is based on your individual benefits, there's less of a chance for surprises. • Learn about procedures and treatments • Know what questions to ask the doctor • Review hospital quality and safety data • See if there are lower-cost drug options • Find out how to use pharmacy options like mail order to reduce your out-of-pocket costs • Locate providers and pharmacies near home or work • Access maps and get driving directions
Track your care costs and payments	IT'S A FACT: Many consumers receive care without knowing the costs beforehand. Now you can compare your estimated treatment costs before seeing the doctor and, after the treatment, view detailed graphic explanations of how each claim was processed, what was billed, what your health plan paid, what you owe and why. • See which of your claims have been processed • Note claims you want to watch or follow up on • Add personalized notes • Pay health care providers online or with the UnitedHealthcare Health4Me® mobile app when the claim is final
www.uhc.com/health-and-wellness	Health and Wellness articles on topics including: • Preventive Care • Free Online Seminars • Nutrition • Family Health • Quizzes and Calculators • Slideshows • Booklets to download

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* - As a UHC Specialty member, you and your family have access to savings on a wide selection of name-brand and private-labeled hearing aids as well as professional care through the UnitedHealthcare Hearing provider network.

- 30-50% off MSRP on hundreds of name-brand and private-labeled hearing aids from major manufacturers, including Beltone™, Oticon, Phonak, ReSound, Signia, Starkey®, Unitron™ and Widex®.
- 7000+ credentialed hearing provider locations nationwide that provide hearing tests, hearing aid evaluations and follow-up support.
- Convenient ordering options that allow you to order hearing aids in person through your chosen provider or through home delivery, receiving them right to your doorstep within 5-10 business days.
- Extended 3-year warranty, trial-period and free batteries with each hearing aid purchased.
- Professional, nationwide support plus online tutorials, hearing health tips and more to help you stay connected and get the most out of your hearing aids.

To register, please visit www.uhchearing.com or call 1-855-523-9355, Monday through Friday, 8:00 am to 8:00 pm CT.

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.

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 per**sonal 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 services contact the Plan at 1-877-835-9861.**

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental, investigational or unproven procedures, treatments, drugs or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Surrogate parenting
- Fetal reduction
- Extra care costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care;
- Research costs related to conducting a clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.
- Services or supplies we are prohibited from covering under the Federal law.

Section 7. Filing a Claim for Covered Services

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

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

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Providers must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, 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 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); and
- Receipts, if you paid for your services.

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

Submit your international claims to: UnitedHealthcare Insurance Company, PO Box 30555, Salt Lake City, UT 84130-0555.

Prescription drugs

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

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

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

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

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

Authorized Representative	You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a healthcare professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.
Notice Requirements	If you live in a county where at least 10% of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as phone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language. Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes

Section 8. The Disputed Claims Process

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

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service 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 initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

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

Disagreements between you and the HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

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 atUnitedHealthcare’s Federal Employee Health Benefits (FEHB) Program Appeals, P.O. Box 30573, Salt Lake City, UT 84130-0573 ; and:

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

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

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

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

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

a) Pay the claim or

b) Write to you and maintain our denial or.

c) Ask you or your provider for more information

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

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

3

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

You must write to OPM within:

- 90-days after the date of our letter upholding our initial decision; or
- 120-days after you first wrote to us -- if we did not answer that request in some way within 30 days; or
- 120-days after we asked for additional information

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, FEHB 3, 1900 E Street, NW, Washington, DC 20415-3630

Send OPM the following information:

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

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

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

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

4

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

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

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

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

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 1-877-835-9861. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's FEHB 3 at 202-606-0755 between 8 a.m. and 5 p.m. Eastern Time.

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

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

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

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

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

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

- **TRICARE and CHAMPVA**

TRICARE is the 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 vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone 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, this health plan will provide related care as follows, if it is not provided by the clinical trial:

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

When you have Medicare

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

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

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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. See our example below:

Date of Service 02/10/21 billed $10,000

$10,000

Medicare allowance $9,000

$9,000

Medicare payment $7,200 (80% of allowance)

$7,200 (80% of allowance)

Balance after Medicare payment $1,800

$1,800

Member responsibility $1,800 x 20% = $360

$1,800 x 20% = $360

Plan pays $1,800 x 80% - $1,440

$1,800 x 80% = $1,440

To find out if you need to do something to file your claim, call us at 1-877-835-9861 or see our website at www.myuhc.com.

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

Please review the following examples which 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	**Benefit Description: Deductible** **HDHP Option - You pay without Medicare (In network) after deductible:** $2,000 Self Only, $4,000 Self Plus One and Self and Family **HDHP Option - You pay with Medicare Part B (In network) after deductible:** $2,000 Self Only, $4,000 Self Plus One and Self and Family **Benefit Description: Out-of-Pocket Maximum** **HDHP Option - You pay without Medicare (In network) after deductible:** $6,000 Self Only, $12,000 Self Plus One and Self Plus Family **HDHP Option - You pay with Medicare Part B (In network) after deductible:** $6,000 Self Only, $12,000 Self Plus One and Self and family **Benefit Description: Part B Premium Reimbursement offered** **HDHP Option - You pay without Medicare (In network) after deductible:** N/A **HDHP Option - You pay with Medicare Part B (In network) after deductible:** N/A **Benefit Description: Primary Care Provider** **HDHP Option - You pay without Medicare (In network) after deductible:** $15 copayment per visit **HDHP Option - You pay with Medicare Part B (In network) after deductible:** $15 copayment per visit **Benefit Description: Specialist** **HDHP Option - You pay without Medicare (In network) after deductible:** $30 copayment per visit **HDHP Option - You pay with Medicare Part B (In network) after deductible:** $30 copayment per visit **Benefit Description: Inpatient Hospital** **HDHP Option - You pay without Medicare (In network) after deductible:** $500 copayment per admission **HDHP Option - You pay with Medicare Part B (In network) after deductible:** $500 copayment per admission **Benefit Description: Outpatient Hospital** **HDHP Option - You pay without Medicare (In network) after deductible:** $250 copayment for surgery **HDHP Option - You pay with Medicare Part B (In network) after deductible:** $250 copayment for surgery **Benefit Description: Incentives Offered** **HDHP Option - You pay without Medicare (In network) after deductible:** N/A **HDHP Option - You pay with Medicare Part B (In network) after deductible:** 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 (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

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

This Plan and our Medicare Advantage plan: You may enroll in our 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).

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers).

However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

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

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

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

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

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

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

Section 10. Definitions of Terms We Use in This Brochure

Assignment

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

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

Calendar year

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

Clinical Trials Cost Categories

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

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

Coinsurance

See Section 4, page 23

Copayment

See Section 4, page 23

Cost-sharing

See Section 4, page 23

Covered services

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

Deductible

See Section 4, page 23

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.

Health Reimbursement Account (HRA)

A HRA is a tax-sheltered account designed to reimburse medical expenses. The funds in this type of account can best be described as "credits". These credits are applied toward your medical expenses until they are exhausted at which time you must pay your member responsibility (deductible) and coinsurance amounts up to the catastrophic limit.

Health Savings Account (HSA)

A HSA is consumer-oriented tax-advantaged savings account. HSAs allow for tax deductible contributions as well as tax free earnings and withdrawals for qualified medical expenses.

Infertility

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

Medical necessity

Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental illness, substance use disorder 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 misuse 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.

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.

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.
Premium contributions to HSA/HRA	The amount of money we contribute to your HSA or HRA.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
Surprise bill	An unexpected bill you receive for: • emergency care – when you have little or no say in the facility or provider from whom you receive care, or for • non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for • air ambulance services furnished by nonparticipating providers of air ambulance services
Unproven Services	Unproven services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature. • Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.) • Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group. We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com . Please note: If you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise unproven service to be a covered health service for that sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that sickness or condition.
Urgent Care Claims	A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will determine whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at **877-835-9861**. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We Us and We refer to UnitedHealthcare Insurance Company, Inc.

You You refers to the enrollee and each covered family member.

Index

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

Summary of Benefits for the HDHP of the UnitedHealthcare Insurance Company Inc. - 2024

- 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 and Coverage as required by the Affordable Care Act at www.uhcfeds.com.
- On this page we summarize specific expenses we cover; for more detail, look inside. If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- In 2023 for each month you are eligible for the Health Savings Account (HSA [Plan] will deposit $62.50 per month for Self Only enrollment, $125.00 for Self Plus One enrollment or $125 per month for Self and Family enrollment to your HSA.
- For the HSA you may use your HSA or pay out of pocket to satisfy your calendar year in-network deductible of $2,000 for Self Only, $4,000 for Self Plus One and $4,000 for Self and Family, out-of-network deductible of $4,000 for Self Only enrollment, $8,000 for Self Plus One and $8,000 for self and family. Once you satisfy your calendar year deductible, Traditional medical coverage begins.
- For the Health Reimbursement Arrangement (HRA), your health charges are applied to your annual HRA Fund of $750 for Self Only, $1,500 for Self Plus One, and $1,500 for Self and Family. Funds are prorated for partial year enrollments. Once your HRA is exhausted, you must satisfy your calendar year deductible. Once your calendar year deductible is satisfied, Traditional medical coverage begins.Unless noted, all benefits are subject to deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

HDHP Benefits	You Pay	Page
Medical services provided by physicians : In-network medical preventive care (not subject to deductible)	In-network: $0; Out-of-network: *All charges*	Page 39
Medical services provided by physicians (subject to deductible): Diagnostic and treatment services provided in the office:	In-network you pay: $15 copayment for PCP visit or $30 copayment for specialist visit Out-of-network: You pay 30% of our Plan allowance and any difference between our allowance and the billed amount	Page 42
Services provided by a hospital: Inpatient	In-network: You pay $500 copayment per admission Out-of-network: You pay 30% of our Plan allowance and any difference between our allowance and the billed amount	Page 67
Services provided by a hospital: Outpatient Services	In-network: You pay $50 copayment per visit non-surgical or $250 copayment per visit for outpatient surgery Out-of-network: You pay 30% of our Plan allowance and any difference between our allowance and the billed amount	Page 68
Emergency benefits: In-area or Out-of-area	In-Network: You pay $275 copayment per visit Out-of-network: You pay 30% of our Plan allowance and any difference between our allowance and the billed amount	Page 71
Mental health and substance use disorder treatment:	Regular cost-sharing	Page 73

HDHP Benefits	You Pay	Page
Prescription drugs: Retail pharmacy (30-day supply) Note: In Network Pharmacy Benefits Only	In-network: you pay Tier 1:$10 copayment Tier 2: $40 copayment Tier 3: $85 copayment Tier 4: $175 copayment	Page 79
Prescription drugs: UHC designated mail order (up to a 90-day supply) (subject to deductible)	In-network: You pay: Tier 1: $25 copayment Tier 2: $100 copayment Tier 3: $212.50 copayment Tier 4: $437.50 copayment	74
Specialty Pharmacy (30-day) supply at UHC designated specialty pharmacy (subject to deductible)	In-network you pay: Tier 1 $10 Tier 2 $150 Tier 3 $350 Tier 4 $500	78
Dental care	Emergency dental benefits are located in section 5(g). Our Non-FEHB benefits page provides detail on our non-FEHB dental benefit - this benefit is not subject to deductible.	Page 82
Vision care adults - One routine refraction eye exam every other calendar year	In-network: You pay $30 per specialist visit Out-of-network: You pay 30% of our Plan allowance and any difference between our plan allowance and the billed amount	Page 48
Wellness and Other Special features	Health4Me, Quit for Life, Pelaton, Maternity Health Solutions, UnitedHealth Premium, Real Appeal, Specialty Pharmacy, Flexible Benefit Option, Cancer Clinical Trials	Page 85
Protection against catastrophic costs (out-of-pocket maximum)**:** Note: Some costs do not count against the out of pocket maximum	In-network: Nothing after $6,000 Self Only or $12,000 Self Plus One and Self and Family per year. Out-of-network: Nothing after $12,000 Self Only or $24,000 Self Plus One and Self and Family per year.	Page 23

Notes

2024 Rate Information for UnitedHealthcare Insurance Company Inc.
High Deductible Health Plan

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

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

Premiums for Tribal employees are shown under the Monthly Premium Rate column. The amount shown under employee 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					
HDHP Option Self Only	V41	$240.08	$80.02	$520.16	$173.39
HDHP Option Self Plus One	V43	$516.18	$172.06	$1,118.39	$372.80
HDHP Option Self and Family	V42	$549.62	$183.21	$1,190.85	$396.95
Alabama, Arkansas, Florida, Louisiana, Mississippi, North Carolina and Tennessee					
HDHP Option Self Only	LS1	$265.51	$88.50	$575.27	$191.75
HDHP Option Self Plus One	LS3	$570.80	$190.27	$1,236.74	$412.25
HDHP Option Self and Family	LS2	$610.63	$203.54	$1,323.03	$441.01
Arizona (Phoenix and Tucson), Colorado, Nevada, Oregon, Washington					
HDHP Option Self Only	LU1	$270.84	$90.28	$586.82	$195.61
HDHP Option Self Plus One	LU3	$582.29	$194.09	$1,261.62	$420.54
HDHP Option Self and Family	LU2	$622.92	$207.64	$1,349.66	$449.89