

UnitedHealthcare Insurance Company, Inc.

www.uhcfeds.com

Customer Service: 877-835-9861

2025

Choice Plus Advanced - An Open Access Value Option

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 7 for details. This plan is accredited. See page 11.

Serving:

Chicago, Illinois

San Antonio, Texas

District of Columbia

Maryland

Northern Virginia

IMPORTANT

- Rates: Back Cover
- Changes for 2025: Page 14
- Summary of Benefits: Page 102

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See pages 12 and 13 for requirements.

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

Enrollment codes for this plan:

L91 -Self Only

L93 -Self Plus One

L92 - Self and Family

Authorized for distribution by the:



FEHB
Federal Employees
Health Benefits Program

**United States
Office of Personnel Management**

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

**Important Notice from UnitedHealthcare Insurance Company, Inc. About
Our Prescription Drug Coverage and Medicare**

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

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

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

Please be advised

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

Medicare's Low Income Benefits

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

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

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Introduction

This brochure describes the benefits of UnitedHealthcare Insurance Company, Inc. under contract (CS-2947) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer Service may be reached at 877-835-9861 or through our website: www.uhcfeds.com.

The address for administrative offices is:

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

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2025, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2025, and changes are summarized on page 15. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee and each covered family member, “we” means UnitedHealthcare Insurance Company.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

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

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

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

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

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

- Call the provider and ask for an explanation. There may be an error.

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

CALL THE HEALTHCARE FRAUD HOTLINE

877-499-7295

Or go to

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

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

You can also write to:

**United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100**

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

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

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

Discrimination is Against the Law

We comply with applicable Federal nondiscrimination laws and do not discriminate on the basis of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity).

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual's protected trait or traits, for example a member's gender identity or the fact that the covered benefit is sought in connection with gender-affirming care, will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined to be medically necessary.

Preventing Medical Mistakes

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

Take these simple steps:

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medications or give your doctor and pharmacist a list of all the 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 health care organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
- <https://psnet.ahrq.gov/issue/national-patient-safety-foundation>. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- www.bemedwise.org The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions (“Never Events”)

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

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

FEHB Facts

Coverage information

No pre-existing condition limitation

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

Minimum essential coverage (MEC)

Coverage under this plan qualifies as minimal 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 you and one eligible family member. Self and Family 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 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 are 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 a valid common law marriage and same sex domestic partners) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

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

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

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

Married children Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday. **Children with or eligible for employer provided health insurance Coverage:** Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay. You can find additional information at www.opm.gov/healthcare-insurance.

Children's Equity Act

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

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

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

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

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2025 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 2024 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

When you retire

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

When you lose benefits

When FEHB coverage ends

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

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

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

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

Upon divorce If you are an enrollee and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment.

You **must** contact us to let us know the date of the divorce or annulment and have us remove your ex-spouse. We may ask for a copy of the divorce decree as proof. In order to change enrollment type, you must contact your employing or retirement office. A change will not automatically be made.

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get information about your coverage choices. You can also visit OPM's website at <https://www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health>. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

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

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

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

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

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

Converting to individual coverage

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

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

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

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 866-546-0510 or visit our website at www.uhcfeds.com.

Health Insurance Marketplace

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

Section 1. How this Plan Works

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

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

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

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

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

We have Open Access benefits

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

We have Point of Service (POS) benefits

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

How we pay providers

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

Preventive care services

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

Annual deductible

The annual deductible must be met before Plan benefits are paid for many services other than preventive care services. Your deductible for this plan is \$500 for Self Only and \$1,000 for Self Plus One or Self and Family for In-Network and \$1,000 Self Only and \$2,000 Self Plus One or Self and Family Out-of-network. Information on how this deductible works can be found in Section 4 *Your Cost for Covered Services*.

Health education resources and accounts management tools:

myuhc.com gives you the the ability to:

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

myHealthcare Cost Estimator

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

Your rights and responsibilities

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

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

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

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

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

Your medical and claims records are confidential

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

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area is:

San Antonio, Texas including the following counties: Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall

Chicago, Illinois including the following counties: Boone, Cook, DeKalb, DuPage, Grundy, Iroquois, Kane, Kankakee, Kendall, Lake, LaSalle, McHenry, Will, and Winnebago.

District of Columbia

Maryland

Northern Virginia: Counties of:

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

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

Section 2. Changes for 2025

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.
- Emergency services – Emergency room copayment will increase from \$275 to \$350. See page 61
- Prescription drugs - Prescription drugs - Retail pharmacy up to 30-day supply will increase Tiers 2,3,4 from \$35/\$70/\$120 to \$45/\$85/\$170 and Mail order 90-day supply, increasing Tier's 2,3,4 drugs from \$87.50/\$175/\$300 to \$112.50/\$212.50/ \$425 . See page 68

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

Where you get covered care

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

UnitedHealth Tier 1 Premium Designated providers allow you to reduce your out-of-pocket expenses without compromising on quality. By using Premium Tier 1 physicians, you save on co-payments and coinsurance. UnitedHealth Premium Tier 1 physicians have received the Premium designation for either Quality and Cost Efficiency or Cost Efficiency and Not Enough Data to assess Quality. Look for the UnitedHealth Premium Tier 1 Symbol to quickly and easily find these physicians. You can find the physicians designation quickly and easily on www.myuhc.com or at www.UnitedHealthPremium.com.

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

This plan provides Care Coordinators for complex conditions and can be reached at 1-877-835-9761 for assistance.

UnitedHealth Tier 1 Premium doctors:

- Follow evidence-based guidelines for care
- Are more likely to be aware of the latest research and clinical trials

- May have lower surgery repeat rates

Quality guidelines are based on standards from organizations such as:

- American College of Cardiology
- Ambulatory Care Quality Alliance
- Agency for Healthcare Research and Quality (a division of the U.S. Department of Health & Human Services)

• Plan facilities

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

A freestanding facility is an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims as a freestanding entity and not as a hospital. You will have a lower out of pocket expenses when you use a freestanding facility instead of a hospital for outpatient services. Outpatient services are health services or treatments that do not require an overnight hospital stay. Outpatient care received in a hospital will typically cost you more. Talk to your doctor about the options available to you for these services.

• Non-network providers and facilities

You can access care from any licensed provider or facility. Providers and facilities not in the UnitedHealthcare Choice Plus network are considered non-network providers and facilities.

What you must do to get covered care

It depends on the type of care you need. You can go to any provider you choose to but it will cost you less to get care from our Premium designated providers and in network providers. We must approve some care in advance.

• Hospital care

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

• Primary care

Your primary care provider can be any primary care provider you choose. Your primary care provider will provide most of your healthcare, or give you a referral, although not required by the plan, to see a specialist.

If you want to change primary care providers or if your primary care provider leaves the Plan you can select a new one. We would be happy to assist you select a new one if needed.

• Specialty care

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

- If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care provider, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
 - terminate our contract with your specialist for other than cause;
 - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or
 - reduce our service area and you enroll in another FEHB plan;

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

If you are hospitalized when your enrollment begins

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.

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 877-835-9861. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

You need prior Plan approval for certain services

- **Inpatient hospital admission**
- **Other services**

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

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

- Angioma/Hemangioma (with pictures)
- Applied Behavioral Analysis
- Air Ambulance (non-emergent)
- Blepharoplasty (with pictures)
- Breast implant removal, breast reconstruction for non-cancer diagnosis, breast reduction
- Certain out of network services
- Dental procedures in a facility
- Certain Durable Medical Equipment supplies over \$1000
- Clinical trials
- Coronary artery bypass graft
- Congenital anomaly repair
- Computed Tomography (CT) scans (brain, chest, heart)
- Dialysis
- Discectomy/fusion
- Gender affirmation services
- Genetic testing
- Gynecomastia surgery
- Human Growth hormone

- Hysterectomy
- Iatrogenic Infertility services
- Infertility services
- Implanted spinal cord stimulators
- Inpatient hospitalization
- Intensive Outpatient Treatment
- Iatrogenic infertility services
- Joint replacement
- Morbid obesity surgery
- Magnetic resonance imaging (MRI) (brain, chest, heart, musculoskeletal)
- Magnetic resonance angiogram (MRA)
- Partial Hospitalization
- PET scans (non- cancer diagnosis)
- Pulmonary rehabilitation
- Radiation therapy
- Reconstructive surgery
- Sclerotherapy
- Sleep apnea (surgery & appliance) with sleep studies,(polysomnography) attended
- Temporomandibular Joint Dysfunction
- Transplants
- Therapeutic services: such as physical therapy, occupational therapy and speech therapy after the 8th visit
- Uvulopalatopharyngoplasty
- Vein Ablation
- Ventricular assist device

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

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

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

Next, provide the following information:

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

- **Non-urgent care claims**

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

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

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

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

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

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 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 877-835-9861. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).
- **Concurrent care claims**

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

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

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

- **Maternity Care**

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

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

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

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

If you fail to obtain authorization/precertification when using non-network facilities you can be responsible for 100% of the charges.

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

Circumstances beyond our control

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

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call 1-877-835-9761.

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

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

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

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

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

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

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

3. Write to you and maintain our denial.

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

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

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

Section 4. Your Costs for Covered Services

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

Cost-sharing

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

Copayments

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

Example: When you see your primary care provider you pay a copayment of \$25 per office visit.

Deductible

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

- The in-network individual calendar year deductible is \$500 for a Self Only and \$1,000 for a Self Plus One or Self and Family enrollment. The out-of-network deductible is \$1,000 for a Self Only enrollment and \$2,000 for a Self Plus One or Self and Family enrollment. Under a Self Only enrollment, the in-network deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach \$500. Under a Self Plus One or Self and Family enrollment, the in-network deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible reach \$1,000.
- Example: If you have services in network and the billed amount is \$80 and the provider has agreed through his contract with us to accept \$60 and you have not met your deductible you must pay \$60. We will apply this \$60 to your deductible. We will begin paying benefits once the remaining portion of your calendar year deductible has been satisfied.
- This benefit plan also contains a Per Occurrence Deductible that applies to certain Covered Health Services. This Per Occurrence Deductible must be met prior to and in addition to the Annual Deductible.
- 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.

Coinurance

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

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

Differences between our Plan allowance and the bill

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

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

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

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

What your plan pays (plan coinsurance): 80% in network/50% out of network for benefits with coinsurance.

What you pay (coinsurance): 20% in network / 50% out of network.

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

Your catastrophic protection out-of-pocket maximum

After your in-network out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance total \$6,000 for Self Only, or \$12,000 for a Self Plus One or Self and Family enrollment in any calendar year, or out-of network \$24,000 per Self Only or \$24,000 for Self Plus One or Self and Family you do not have to pay any more for covered services. ***The maximum annual limitation on cost sharing listed under Self Only of in network \$6,000 or out of network \$12,000 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.***

Example Scenario: Your plan has an in-network \$6,000 Self Only maximum out-of-pocket limit and a \$12,000 Self Plus One or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has in-network out-of-pocket qualified medical expenses of \$6,000 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment in-network out-of-pocket maximum of \$12,000, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of \$12,000 for the calendar year before their qualified medical expenses will begin to be covered in full.

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

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

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.

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

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

Section 5. Value Option Benefits

On page 102 is a benefits summary for this plan.

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Section 5. Value Options Benefit Overview

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

You can save money when you make more informed decisions about the providers you choose. Select Premium designated physicians that have been recognized for delivering quality, cost-efficient care as well as certain lower cost facilities. Since Choice Plus Advanced is an open-access product, you can seek care from many providers but may pay more out-of-pocket costs when you do not seek care from certain network providers and facilities.

All benefits are subject to the annual deductible unless stated: Not subject to deductible

Benefits	You pay
Medical Services provided by physicians: Diagnostic and treatment services provided in the office/telephonic	In-network: Office visit copay: \$25 primary care physician after deductible has been met In-network: Specialist: \$75 copay for a non-designated network provider or \$50 copay for Tier 1 premium-designated specialist after deductible has been met Out of network: 50% of the Plan allowance and any difference between our allowance and the billed amount after deductible has been met
Medical Services provided by physicians: Routine Preventive Care provided in-network	You pay nothing
Urgent Care	In-network: \$75 copayment after deductible has been met Out-of-network: 50% of the Plan allowance and any difference between the allowance and the billed amount, after deductible has been met.
Services provided by a hospital: Outpatient Surgical	In-network: 20% coinsurance after deductible has been met when services are in an ambulatory surgical center or physician's office In-network: 20% coinsurance and \$250 per occurrence deductible, after annual deductible has been met, when services are performed in an outpatient hospital based surgical center Out-of-network: 50% coinsurance of the Plan allowance and any difference between our allowance and the billed amount, when services are performed in an ambulatory surgical center after deductible has been met or Out-of-network: \$250 per occurrence deductible plus 50% coinsurance of the Plan allowance and any difference between our allowance and the billed amount when services are performed in an outpatient hospital based surgical center after deductible has been met
Inpatient	In-network: 20% coinsurance after deductible has been met Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount, after deductible has been met
Emergency benefits: Ambulance - emergency services	20% copay after deductible in-network or out-of-network.

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Emergency Room	In-network or out-of-network : \$350 copay per visit in-network after deductible has been met (waived if admitted)
Mental Health and Substance Use Disorder Treatment	Regular cost sharing after deductible has been met
Prescription drugs:	<p>In network benefits only; costs are as follows: 30-day supply at Retail:</p> <p>Tier 1 \$10 Tier 2 \$45 Tier 3 \$85 Tier 4 \$170</p> <p>Up to 90-day supply at Mail Order:</p> <p>Tier 1 \$25 Tier 2 \$112.50 Tier 3 \$212.50 Tier 4 \$425</p>
Specialty Pharmacy 30-day supply at UHC designated specialty pharmacy	<p>Tier 1 - \$10 Tier 2 - \$150 Tier 3 - \$350 Tier 4 - \$500</p>

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

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

Retiree Advantage Medical Benefits	You pay
Deductible	No deductible - See Section 9
Primary Care Physician Visit	You pay nothing - See Section 9
Preventive Care	You pay nothing - See Section 9
Specialist Visit	You pay nothing - See Section 9
Virtual Visit	You pay nothing - see Section 9
Urgent Care	You pay nothing - See Section 9
Emergency Room	You pay nothing - See Section 9
Pharmacy (30-day supply)	<p>Tier 1 - \$6, Tier 2 - \$25, Tier 3 - \$60, Tier 4 - \$90</p> <p>See Section 9</p>

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

<p>Important things you should keep in mind about these benefits:</p> <ul style="list-style-type: none"> • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary. • A facility charge applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital. • The calendar year deductible is: \$500 Self only, \$1,000 Self Plus One and Self and Family in-network and \$1,000 Self only \$2,000, Self Plus One and Self and Family out-of-network. The calendar year deductible may apply to some benefits in this Section. We state: "Deductible does not apply" to show when the calendar year deductible does not apply. • Be sure to read Section 4, <i>Your Costs for Covered Services</i>, 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.). • If you enroll in UnitedHealthcare Choice Plus Advanced and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a \$150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.) <p>Be sure to read Section 4, <i>Your costs for covered services</i>, for valuable information about how cost-sharing works. Also, read Section 9, <i>Coordinating benefits with other coverage</i>, including with Medicare.</p>		
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Benefit Description	In-Network You pay after deductible	Out-of-Network You pay after deductible
Diagnostic and treatment services		
Professional services of Primary care provider (PCP) <ul style="list-style-type: none"> • In physician's office/telehealth/Optum primary care • Office medical consultation • Advanced care planning • At home 	\$25 copayment to Primary care provider (PCP)	50% of the Plan allowance and any difference between our allowance and the billed amount
Professional services of specialists <ul style="list-style-type: none"> • In physician's office/telehealth • Office medical consultation • Second Surgical opinion • Advanced care planning • At home 	Non premium-designated specialist \$75 copayment or Tier 1 premium-designated specialist \$50 copayment	50% of the Plan allowance and any difference between our allowance and the billed amount

Diagnostic and treatment services - continued on next page

Value Option

Benefit Description	Value Option	
Diagnostic and treatment services (cont.)	In-Network You pay after deductible	Out-of-Network You pay after deductible
2nd MD Second Opinion - 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	<i>All charges</i>
Professional services of physicians <ul style="list-style-type: none">• In an urgent care center• In an emergency room• During a hospital stay• In a skilled nursing facility	20% coinsurance of the plan allowance	50% of the Plan allowance and any difference between our allowance and the billed amount
Virtual visits	In-Network You pay after deductible	Out-of-Network You pay after deductible
Use virtual visits when : <ul style="list-style-type: none">• Your doctor is not available• You become ill while traveling• Conditions such as: cold, flu, bladder infection, bronchitis, diarrhea, fever, pink eye, rash, sinus problem, sore throat, stomachache Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at 877-835-9861. Access to Virtual Visits and prescription services may not be available in all states due to state regulations. You can pre-register with a group. After registering and requesting a visit you will pay your portion of service costs and then you enter a virtual waiting room.	\$0 copayment (deductible does not apply)	<i>All charges</i>
Lab, X-ray and other diagnostic tests	In-Network You pay after deductible	Out-of-Network You pay after deductible
Tests, such as: <ul style="list-style-type: none">• Blood tests• Urinalysis• Non-routine pap tests• Pathology• X-rays• Non-routine mammograms• Ultrasound• Electrocardiogram and EEG	20% coinsurance of the plan allowance	<i>All charges</i>

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

Value Option

Benefit Description		
Lab, X-ray and other diagnostic tests (cont.)	In-Network You pay after deductible	Out-of-Network You pay after deductible
Major Diagnostic tests <ul style="list-style-type: none"> • CT/CAT scans • PET Scans • Magnetic resonance imaging (MRI) • Magnetic resonance angiogram (MRA) • Nuclear Medicine pre-authorization is required 	Outpatient free-standing diagnostic center or in a physician's office you pay 20% coinsurance of the plan allowance or in a hospital-based diagnostic center you pay 20% of the plan allowance after per occurrence deductible of \$250	<i>All charges</i>
Preventive care, adult	In-Network You pay after deductible	Out-of-Network You pay after deductible
Routine physical every year: The following preventive services are covered at the time interval recommended at each of the links below: <ul style="list-style-type: none"> • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer . For a complete list of screenings go to the website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks • Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women please go to the Health and Human Services (HHS) website at http://www.hrsa.gov/womens-guidelines • To build your personalized list of preventive services go to https://health.gov/myhealthfinder 	\$0	<i>All charges</i>
Annual preventive biometric screening in your physician's office to include: <ul style="list-style-type: none"> • Body mass index (BMI) • Blood pressure • Lipid/cholesterol levels • Glucose/hemoglobin AIC measurement Services must be coded by your physician as preventive to be covered in full.	\$0	<i>All charges</i>
Routine mammogram	\$0	<i>All charges</i>

Preventive care, adult - continued on next page

Value Option

Benefit Description		
Preventive care, adult (cont.)	In-Network You pay after deductible	Out-of-Network You pay after deductible
BRCA genetic counseling and evaluation is covered as preventive when a woman's family history is associated with an increased risk for deleterious mutations in BRCA1 and BRCA2 genes and medical necessity criteria has been met. Preauthorization required	\$0	<i>All charges</i>
Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC) based on the Advisory Committee on Immunization Practices (ACIP) schedule. For a complete list of endorsed immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/	\$0	<i>All charges</i>
Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended list of services will be subject to the applicable member copayments, coinsurance and deductible.		
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.</i> • <i>Immunizations, boosters, and medications for travel or work-related exposure.</i> 	<i>All charges</i>	<i>All charges</i>
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: <ul style="list-style-type: none"> • Intensive nutrition and behavioral weight-loss counseling therapy, • Family centered programs when medically identified to support obesity prevention and management by an in-network provider. • When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) for cost share requirements for anti-obesity medications. • When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share. 	\$0	
Preventive care, children	In-Network You pay after deductible	Out-of-Network You pay after deductible
<ul style="list-style-type: none"> • Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org 	\$0	<i>All charges</i>

Preventive care, children - continued on next page

Value Option

Benefit Description	Value Option	
Preventive care, children (cont.)	In-Network You pay after deductible	Out-of-Network You pay after deductible
<ul style="list-style-type: none"> Children's immunizations endorsed by the Centers for Disease Control (CDC) including DTaP/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the website at https://www.cdc.gov/vaccines/schedules/index.html You can also find a complete list of U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations <p>Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.</p>	\$0	<i>All charges</i>
<i>Not covered: Physical examinations and immunizations required for attending camp, school or travel</i>	<i>All charges</i>	<i>All charges</i>
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: <ul style="list-style-type: none"> Intensive nutrition and behavioral weight-loss counseling therapy, Family centered programs when medically identified to support obesity prevention and management by an in-network provider. When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) for cost share requirements for anti-obesity medications. When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share. 	\$0	<i>All charges</i>
Maternity care	In-Network You pay after deductible	Out-of-Network You pay after deductible
Complete maternity (obstetrical) care, such as: <ul style="list-style-type: none"> Prenatal and Postpartum care Screening for gestational diabetes Delivery Screening and counseling for prenatal and postpartum depression <p>Note: Here are some things to keep in mind: You do not need to precertify your vaginal delivery; see page 56 for other circumstances, such as extended stays for you or your baby.</p>	Primary care physician (PCP) \$25 copayment - initial visit only; Non-designated specialist \$75 copayment - initial visit only; Tier 1 premium-designated specialist \$50 copayment - initial visit only	50% of the Plan allowance and any difference between our allowance and the billed amount

Maternity care - continued on next page

Value Option

Benefit Description		
Maternity care (cont.)	In-Network You pay after deductible	Out-of-Network You pay after deductible
<ul style="list-style-type: none"> • As part of your coverage, you have access to in-network certified nurse midwives, visits and board-certified lactation specialists during the prenatal and post-partum period. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Circumcisions are covered 100% during newborn stay. Note: Circumcisions following the newborn stay are covered under the surgical benefits at the applicable copayment or coinsurance. • Hospital services are covered under Section 5(c) and Surgical benefits section 5(b). <p>Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits.</p>	Primary care physician (PCP) \$25 copayment - initial visit only; Non-designated specialist \$75 copayment - initial visit only; Tier 1 premium-designated specialist \$50 copayment - initial visit only	50% of the Plan allowance and any difference between our allowance and the billed amount
Breastfeeding and lactation support, supplies and counseling for each birth	\$0	<i>All charges</i>
<i>Not covered:</i>	<i>All charges</i>	<i>All charges</i>
<i>Routine sonograms to determine fetal age, size or sex</i>		
Family planning	In-Network You pay after deductible	Out-of-Network You pay after deductible
Contraceptive counseling on an annual basis	\$0	<i>All charges</i>
A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories on the HRSA list. This list includes: <ul style="list-style-type: none"> • Voluntary female sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragms 	\$0	<i>All charges</i>
Note: See additional Family Planning and Prescription drug coverage Section 5(f).		

Family planning - continued on next page

Value Option

Benefit Description	In-Network You pay after deductible	Out-of-Network You pay after deductible
Family planning (cont.)		
<p>Note: Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below.</p> <p>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.</p> <p>To request an exemption, please call customer service at 887-835-9861</p> <p>If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov.</p>	\$0	<i>All charges</i>
Voluntary male sterilization	Non-designated specialist \$75 copayment or Tier 1 premium-designated specialist \$50 copayment	50% of the Plan allowance and any difference between our allowance and the billed amount
Genetic testing is covered when medically necessary for certain conditions such as pregnancy testing for cystic fibrosis, coverage of certain cancer drugs, certain autosomal recessive conditions, autosomal dominant less penetrant conditions, x-linked conditions and certain chromosome abnormalities.	Primary care provider (PCP) \$25 copayment; or Non-designated specialist \$75 copayment; Tier 1 premium-designated specialist \$50 copayment	50% of the Plan allowance and any difference between our plan allowance and the billed amount
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic testing and counseling unless medically necessary. Interruption of pregnancy unless the life of the mother is at risk</i> 	<i>All charges</i>	<i>All charges</i>

Value Option

Benefit Description		
Infertility services	In-Network You pay after deductible	Out-of-Network You pay after deductible
Diagnosis and treatment of infertility	20% coinsurance of the plan allowance	50% of the Plan allowance and any difference between our allowance and the billed amount
<p>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.</p> <p>Covered Services</p> <p>Diagnosis and treatment of infertility specific to:</p> <p>Artificial insemination:</p> <ul style="list-style-type: none"> • Intravaginal Insemination (IVI) • Intracervical Insemination (ICI) • Intrauterine Insemination (IUI) <p>Fertility drugs (see section 5f)</p> <ul style="list-style-type: none"> • Oral and injectable drugs associated with artificial insemination and IVF (3 cycles annually) procedures <p>Note: Prior Authorization required</p>	50% coinsurance of the plan allowance	50% coinsurance 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
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	Primary care provider (PCP) \$25 copayment; or Non-designated specialist \$75 copayment; or Tier 1 premium-designated specialist \$50 copayment	50% of the Plan allowance and any difference between our allowance and the billed amount
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Provocative food testing</i> • <i>Sublingual allergy desensitization</i> 	<i>All charges</i>	<i>All charges</i>

Value Option

Benefit Description		
Treatment therapies	In-Network You pay after deductible	Out-of-Network You pay after deductible
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 47.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy (pulmonary rehabilitation) is provided for up to 20 sessions • Cardiac rehabilitation following qualifying event/condition is provided for up to 36 sessions • Intravenous (IV)/Infusion Therapy - Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	20% coinsurance of the plan allowance	50% of the Plan allowance and any difference between our allowance and the billed amount
<ul style="list-style-type: none"> • Dialysis - hemodialysis and peritoneal dialysis 	20% coinsurance of the plan allowance	<i>All charges</i>
Applied Behavioral Analysis (ABA) - Children with autism spectrum disorder	Primary care provider (PCP) \$25 copayment; or Non-designated specialist \$75 copayment; or Tier 1 premium-designated specialist \$50 copayment	50% of the Plan allowance and any difference between our allowance and the billed amount
Habilitative/Rehabilitative Therapies	In-Network You pay after deductible	Out-of-Network You pay after deductible
Habilitative/Rehabilitative Services Outpatient Therapy when performed by qualified physical therapists and occupational therapists: <ul style="list-style-type: none"> • 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 <p>Note: We only cover therapy when a physician:</p>	\$25 copay per visit	50% of the Plan allowance and any difference between our allowance and the billed amount

Habilitative/Rehabilitative Therapies - continued on next page

Value Option

Benefit Description	Value Option	
Habilitative/Rehabilitative Therapies (cont.)	In-Network You pay after deductible	Out-of-Network You pay after deductible
<ul style="list-style-type: none"> • 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. 	\$25 copay per visit	50% of the Plan allowance and any difference between our allowance and the billed amount
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 	<i>All charges</i>	<i>All charges</i>
Speech therapy	In-Network You pay after deductible	Out-of-Network You pay after deductible
Up to 20 visits per year for speech therapy	\$25 copayment per visit	50% of the Plan allowance and any difference between our allowance and the billed amount
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Exercise programs, gyms or pool memberships</i> • <i>Work hardening/functional capacity programs or evaluations</i> • <i>Voice therapy</i> 	<i>All charges</i>	<i>All charges</i>
Hearing services (testing, treatment, and supplies)	In-Network You pay after deductible	Out-of-Network You pay after deductible
<ul style="list-style-type: none"> For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist <p>Routine hearing for children is covered as preventive services with no copayment</p>	20% coinsurance of the plan allowance	50% of the Plan allowance and any difference between our allowance and the billed amount
External Hearing Aids - A single purchase (including repair/replacement) per hearing impaired ear every three (3) years for enrolled dependent children up to age 18.	20% coinsurance	50% of the Plan allowance and any difference between our allowance and the billed amount
\$2,500 per ear and are limited to a single purchase (including repair/replacement) per hearing impaired ear every three (3) years for all other members.		
Implanted hearing related devices, such as bone anchored hearing aids (BAHA) and coclear implants	20% coinsurance	50% of the Plan allowance and any difference between our allowance and the billed amount
For therapy associated with cochlear implants please refer to the rehabilitative treatment therapy section of this brochure		
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>All other hearing testing</i> 	<i>All charges</i>	<i>All charges</i>

Value Option

Benefit Description	Value Option	
Vision services (testing, treatment, and supplies)	In-Network You pay after deductible	Out-of-Network You pay after deductible
<ul style="list-style-type: none"> One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) 	20% coinsurance of the plan allowance	50% of the Plan allowance and any difference between our allowance and the billed amount
Diagnosis and treatment of diseases of the eye	\$25 per PCP visit; or \$75 copay for non-designated in-network specialist; or \$50 copay for premium-designated specialist	50% of the Plan allowance and any difference between our allowance and the billed amount
Routine Eye Examination - Eye refraction every two years examination to provide a written lens prescription Note: Eye examinations for children follow the Bright Futures Guidelines (American Academy of Pediatrics) at no charge (In-Network only)	\$25 copayment	50% of the Plan allowance and any difference between our allowance and the billed amount
<i>Not covered:</i> <ul style="list-style-type: none"> <i>Eyeglasses or contact lenses, except as shown above</i> <i>Eye exercises and orthoptics</i> <i>Radial keratotomy and other refractive surgery</i> 	<i>All charges</i>	<i>All charges</i>
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.	Primary care provider (PCP) \$25 copayment; or Non-designated specialist \$75 copayment; or Tier 1 premium-designated specialist \$50 copayment	50% of the Plan allowance and any difference between our allowance and the billed amount
<i>Not covered:</i> <ul style="list-style-type: none"> <i>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</i> <i>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)</i> 	<i>All charges</i>	<i>All charges</i>

Value Option

Benefit Description		
Orthopedic and prosthetic devices	In-Network You pay after deductible	Out-of-Network You pay after deductible
<ul style="list-style-type: none"> • Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Enteral equipment and supplies • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. • See Section 5(c) for payment information. Insertion of the device is paid as surgery • Ostomy supplies and urinary catheters • Orthotic braces and splints not available over the counter that straighten or change the shape of a body part • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome and/or Myofacial Pain Dysfunction (MDP). • Bone anchored hearing aids (BAHA) limited to one per member per lifetime, when the member has either of the following <ul style="list-style-type: none"> - Craniofacial anomalies in which abnormal or absent ear canals preclude the use of a wearable hearing aid - Hearing loss of sufficient severity that it cannot be adequately remedied by a wearable hearing aid • Single purchase of each type of prosthetic device every three (3) years (in-network). Prior authorization is required for prosthetic devices in excess of \$1,000. <p>Note: Most orthopedic and prosthetic devices must be preauthorized. Call us at 877-835-9861 if your plan physician prescribes this and you need assistance locating a health care physician or health care practitioner to sell or rent you orthopedic or prosthetic equipment. You may also call us to determine if certain devices are covered.</p> <p>Internal prosthetic devices are paid as hospital benefits. For information on the professional charges for the surgery to insert an implant please refer to Section 5(b) surgical procedures. For information on the hospital and/or ambulatory surgical center benefits see Section 5(c) Services provided by a hospital or other facility.</p>	20% coinsurance of the plan allowance	50% of the Plan allowance and any difference between our allowance and the billed amount
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Foot orthotics</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> 	<i>All charges</i>	<i>All charges</i>

Orthopedic and prosthetic devices - continued on next page

Value Option

Benefit Description		
Orthopedic and prosthetic devices (cont.)	In-Network You pay after deductible	Out-of-Network You pay after deductible
<ul style="list-style-type: none"> • Corsets, trusses, elastic stockings, support hose, and other supportive devices • Prosthetic replacements provided less than 5 years after the last one (except as needed to accommodate growth in children or socket replacement for members with significant residual limb volume or weight changes) • External penile devices • Speech prosthetics (except electrolarynx) • Carpal tunnel splints • Deodorants, filters, lubricants, tape, appliance cleansers, adhesive and adhesive removers related to ostomy supplies 	All charges	All charges
Durable medical equipment (DME)	In-Network You pay after deductible	Out-of-Network You pay after deductible
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <p>A single purchase of a type of durable medical equipment (including repair and replacement) every three (3) years. This limit does not apply to wound vacuums. Prior authorization is required for durable medical equipment in excess of \$1,000.</p> <ul style="list-style-type: none"> • Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks) • Dialysis equipment • Standard hospital beds • Wheelchairs • Crutches • CPAP • Walkers • Blood glucose monitors • Insulin pumps. and insulin pump supplies • Surgical dressings not available over-the-counter • Burn garments • Braces, including necessary adjustments to shoes to accommodate braces, which are used for the purpose of supporting a weak or deformed body part • Braces restricting or eliminating motion in a diseased or injured part of the body <p>Note: Many DME items must be preauthorized. Call us at 877-835-9861 if your plan physician prescribes this and you need assistance locating a healthcare physician or health care practitioner to sell or rent you equipment. You may also call us to determine if certain devices are covered.</p>	20% coinsurance of the plan allowance	All charges
<i>Not covered:</i>	All charges	All charges

Durable medical equipment (DME) - continued on next page

Value Option

Benefit Description		
Durable medical equipment (DME) (cont.)	In-Network You pay after deductible	Out-of-Network You pay after deductible
<ul style="list-style-type: none"> • Power operated vehicles unless medically necessary based upon diagnosis • Duplicate or back up equipment • Parts and labor costs for supplies and accessories replaced due to wear and tear such as tires and tubes • Educational, vocational or environmental equipment • Deluxe or upgraded equipment or supplies • Home or vehicle modifications; seat lifts • Over-the-counter medical supplies • Activities of daily living aids (such as grab bars and utensil holders) • Personal hygiene equipment • Paraffin baths, whirlpools and cold therapy • Augmentative communication devices • Physical fitness equipment • Continuous pulse oximetry unless skilled nursing is involved in home care and it is part of their medically necessary equipment 	All charges	All charges
Home health services	In-Network You pay after deductible	Out-of-Network You pay after deductible
<p>Medically necessary Homehealth care 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.</p> <p>Services include: oxygen therapy, intravenous therapy, medical foods and medications.</p> <p>Limited to 60 visits per year</p> <p>Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.</p>	20% coinsurance of the plan allowance	50% of the Plan allowance and any difference between our allowance and the billed amount coinsurance
<i>Not covered:</i> <ul style="list-style-type: none"> • Nursing care requested by, or for the convenience of, the patient or the patient's family • Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative • Private duty nursing • Foods that can be obtained over the counter (without a prescription) even if prescribed by your physician 	All charges	All charges

Value Option

Benefit Description		
Chiropractic	In-Network You pay after deductible	Out-of-Network You pay after deductible
<ul style="list-style-type: none"> • Manipulation of the spine and extremities up to 20 visits per year • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application 	\$25 copayment per visit	50% 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
<p>Acupuncture - by a doctor of medicine or osteopathy, or licensed or certified acupuncture practitioner for up to 12 visits per year</p> <ul style="list-style-type: none"> • Dry Needling – by a licensed or certified practitioner <p>Acupuncture services must be performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body.</p>	20% coinsurance of the plan allowance	50% of the Plan allowance and any difference between our allowance and the billed amount
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Naturopathic services</i> • <i>Hypnotherapy</i> • <i>Massage Therapy</i> • <i>Herbal medicine</i> • <i>Rolfing</i> • <i>Ayurveda</i> • <i>Homeopathy</i> • <i>Other alternative treatments unless specifically listed as covered</i> 	<i>All charges</i>	<i>All charges</i>
Educational classes and programs	In-Network You pay after deductible	Out-of-Network You pay after deductible
<p>Outpatient self-management training for the treatment of insulin-independent diabetes, insulin-using diabetes, gestational diabetes and non-insulin using diabetes as well as specified chronic conditions. Diabetes outpatient self-management training, education and medical nutrition therapy services must be prescribed by a licensed health care professional who has appropriate state licensing authority. Outpatient self-management training includes, but is not limited to, education and medical nutrition therapy. The training must be given by a certified registered or licensed health care professional trained in the care and management of diabetes.</p> <p>Coverage includes:</p>	Primary care provider (PCP) \$25 copayment; or Non-designated specialist \$75 copayment; or Tier 1 premium-designated specialist \$50 copayment	50% of the Plan allowance and any difference between our allowance and the billed amount

Educational classes and programs - continued on next page

Value Option		
Benefit Description	In-Network You pay after deductible	Out-of-Network You pay after deductible
Educational classes and programs (cont.)		
<ul style="list-style-type: none"> Initial training visit, up to 10 hours, after you are diagnosed with diabetes, for the care and management of diabetes, including but not limited to: Counseling in nutrition , the use of equipment and supplies, training and education, up to four hours, as a result of a subsequent diagnosis by a Physician of a significant change in your symptoms or condition which require modification of your program of self-management of diabetes. Also included is training and education, up to four hours, because of the development of new techniques and treatments. 	Primary care provider (PCP) \$25 copayment; or Non-designated specialist \$75 copayment; or Tier 1 premium-designated specialist \$50 copayment	50% of the Plan allowance and any difference between our allowance and the billed amount
Coverage is provided for: Tobacco and nicotine therapy 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. Diabetes self management	\$0 for members in the program	\$0

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

<p>Important things you should keep in mind about these benefits:</p> <ul style="list-style-type: none"> • 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. • Physicians must provide or arrange your care. • The calendar year deductible is: \$500 Self Only, \$1,000 Self Plus One and Self and Family in-network and \$1,000 Self Only, \$2,000 Self Plus One and Self and Family out-of-network. The calendar year deductible applies to almost all benefits in this Section. We indicate "Deductible does not apply" to show when the calendar year deductible does not apply. • Be sure to read Section 4, <i>Your Costs for Covered Services</i>, for valuable information about how cost sharing works. Also read Section 9, <i>Coordinating benefits with other coverage</i>, 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. • If you enroll in UnitedHealthcare Choice Plus Advanced and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a \$150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.) 		
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Benefit Description	In-Network You pay after deductible	Out-of-Network You pay after deductible
<p>Surgical procedures</p> <p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see <i>Reconstructive surgery</i>) • Insertion of internal prosthetic devices . See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information • Treatment of burns <p>Note: For female surgical family planning procedures see Family Planning Section 5(a)</p> <p>Note: For male surgical family planning procedures see Family Planning Section 5(a)</p>	20% coinsurance of the plan allowance	50% of the Plan allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Value option		
Benefit Description	In-Network You pay after deductible	Out-of-Network You pay after deductible
Surgical procedures (cont.) 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	50% of the Plan allowance and any difference between our allowance and the billed amount
Physician charges for Scopic Procedures such as: <ul style="list-style-type: none">• Endoscopy• Colonoscopy (Diagnostic)• Sigmoidscopy Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under <i>Surgery</i> . Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.	20% coinsurance of the plan allowance	50% of the Plan allowance and any difference between our allowance and the billed amount
<i>Not covered:</i> <ul style="list-style-type: none">• Reversal of voluntary sterilization• Routine treatment of conditions of the foot; see <i>Foot care</i>	<i>All charges</i>	<i>All charges</i>
Bariatric Surgery Surgical treatment of severe obesity (Bariatric surgery) when the following criteria has been met: <ul style="list-style-type: none">• 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:<ul style="list-style-type: none">- 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:<ul style="list-style-type: none">- One structured diet program for six consecutive months; or	In-Network You pay after deductible 20% coinsurance of the plan allowance	Out-of-Network You pay after deductible <i>All charges</i>

Bariatric Surgery - continued on next page

Value option		
Benefit Description	In-Network You pay after deductible	Out-of-Network You pay after deductible
Bariatric Surgery (cont.)		
<ul style="list-style-type: none"> - 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 • This benefit must be coordinated by UnitedHealthcare Bariatric and Bariatric Centers of Excellence Facility 	20% coinsurance of the plan allowance	<i>All charges</i>
<p>Revisonal Bariatric Surgery due to a technical failure or major complication from the initial procedure; potential failure/ complications include but are not limited to the following:</p> <ul style="list-style-type: none"> • Bowel perforation (including adjustable gastric band erosion) • Adjustable gastric band migration (slippage) that cannot be corrected with manipulation or adjustment (records must demonstrate that manipulation or adjustment to correct band slippage has been attempted) • Leak • Obstruction (confirmed by imaging studies) • Staple-line failure • Mechanical adjustable gastric band failure • Uncontrollable reflux related to sleeve gastrectomy when all the following criteria are met: <ul style="list-style-type: none"> - Maximum nonpharmacological medical management failure (e.g., positional, dietary modification and behavioral changes); and - Maximum pharmacological medical management failure (e.g., at least one month of double dose PPI, H2 blocker, and/or sucralfate); and - Severe esophagitis (grade C or D) confirmed by endoscopy despite maximum medical management <p>The individual must also meet the following criteria: Both of the following:</p> <p>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</p>	20% coinsurance of the plan allowance	<i>All charges</i>

Value option		
Benefit Description	In-Network You pay after deductible	Out-of-Network You pay after deductible
Iatrogenic infertility services <p>Iatrogenic infertility preservation</p> <p>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.</p> <p>Covered benefits include the following procedures:</p> <ul style="list-style-type: none"> • Collection of sperm • Cryo-preservation of sperm • Oocyte cryo-preservation • Embryo cryo-preservation • Ovarian stimulation, retrieval of eggs and fertilization <p>The following benefits are not covered</p> <ul style="list-style-type: none"> • Embryo transfer • Long-term storage costs (greater than 1 year) • Elective fertility preservation <p>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.</p> <p>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 combine maximum. Prior authorization is required.</p> <p>Note: If member changes their FEHB enrollment, UnitedHealthcare will not renew storage payment after yearly increment expires</p>	20% coinsurance of the plan allowance	50% of the Plan allowance and any difference between our allowance and the billed amount
Gender Affirming Surgery <p>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]).</p> <p>Requirements:</p> <ul style="list-style-type: none"> • Must be 18 years of age or older • Must have documented evidence of persistent gender dysphoria • Favorable psychosocial-behavioral evaluation to provide screening and identification of risk factors or potential postoperative challenges • Persistent, well-documented Gender Dysphoria. • Capacity to make a fully informed decision and to consent for treatment 	20% coinsurance of the plan allowance	50% of the Plan allowance and any difference between our allowance and the billed amount

Gender Affirming Surgery - continued on next page
Value Option Section 5(b)

Value option		
Benefit Description	In-Network You pay after deductible	Out-of-Network You pay after deductible
Gender Affirming Surgery (cont.) <ul style="list-style-type: none"> • 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* <p>Gender affirming surgeries include:</p> <ul style="list-style-type: none"> • 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 • 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) <p>Note: Prior Authorization is required</p>	20% coinsurance of the plan allowance	50% of the Plan allowance and any difference between our allowance and the billed amount

Value option		
Benefit Description	In-Network You pay after deductible	Out-of-Network You pay after deductible
Reconstructive surgery Physician charges for : <ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birthmarks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - Surgery to produce a symmetrical appearance of breasts; - Treatment of any physical complications, such as lymphedemas; - Breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>) <p>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.</p>	20% coinsurance of the plan allowance	50% of the Plan allowance and any difference between our allowance and the billed amount
Oral and maxillofacial surgery Oral surgical procedures, limited to: <ul style="list-style-type: none"> • 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 Services for the evaluation and treatment of TMJ and associated muscles <ul style="list-style-type: none"> • Diagnosis: Exam, radiographs and applicable imaging studies and consultation. • Non-surgical treatment including: Clinical exams, Oral appliances (orthotic splints), Arthrocentesis, Trigger-point injections 	In-Network You pay after deductible 20% coinsurance of the plan allowance 20% coinsurance of the plan allowance	Out-of-Network You pay after deductible 50% of the Plan allowance and any difference between our allowance and the billed amount 50% of the Plan allowance and any difference between our allowance and the billed amount

Oral and maxillofacial surgery - continued on next page

Value option		
Benefit Description	In-Network You pay after deductible	Out-of-Network You pay after deductible
Oral and maxillofacial surgery (cont.) <p>Benefits are provided for surgical treatment if the following criteria are met:</p> <ul style="list-style-type: none"> There is radiographic evidence of joint abnormality. <ul style="list-style-type: none"> - Non-surgical treatment has not resolved the symptoms. - Pain or dysfunction is moderate or severe. <p>Benefits for surgical services include:</p> <ul style="list-style-type: none"> Arthrocentesis. Arthroscopy. Arthroplasty. Arthrotomy. Open or closed reduction of dislocations. <p>\$3,000 limit for all services related to TMJ treatments</p>	20% coinsurance of the plan allowance	50% of the Plan allowance and any difference between our allowance and the billed amount
<i>Not covered:</i> <ul style="list-style-type: none"> <i>Oral implants and transplants</i> <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<i>All charges</i>	<i>All charges</i>
Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants) <p>These solid organ transplants are covered. Solid organ transplants are limited to:</p> <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Isolated small intestine Small intestine with the liver Small intestine with multiple organs, such as the liver, stomach, and pancreas Kidney Kidney-pancreas Liver Lung: single/bilateral/lobar Pancreas 	20% coinsurance of the plan allowance	<i>All charges</i>
<p>These tandem blood or marrow stem cell transplants for covered transplants are subject to medical necessity review by the Plan. Refer to <i>Other services</i> in Section 3 for prior authorization procedures.</p>	20% coinsurance of the plan allowance	<i>All charges</i>

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

Value option		
Benefit Description	In-Network You pay after deductible	Out-of-Network You pay after deductible
Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants) (cont.) <ul style="list-style-type: none"> Autologous tandem transplants for <ul style="list-style-type: none"> - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer) 	20% coinsurance of the plan allowance	<i>All charges</i>
Blood or marrow stem cell transplants The plan extends coverage for the diagnoses as indicated below. <ul style="list-style-type: none"> Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hematopoietic stem cell - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) 	20% coinsurance of the plan allowance	<i>All charges</i>

Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants) - continued on next page
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Value option		
Benefit Description	In-Network You pay after deductible	Out-of-Network You pay after deductible
Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants) (cont.) <ul style="list-style-type: none"> - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Hematopoietic stem cell - Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors 	20% coinsurance of the plan allowance	<i>All charges</i>
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 <i>Other services</i> in Section 3 for prior authorization procedures: <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MDPs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) 	20% coinsurance of the plan allowance	All charges

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

Value option		
Benefit Description	In-Network You pay after deductible	Out-of-Network You pay after deductible
Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants) (cont.) <ul style="list-style-type: none"> - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma 	20% coinsurance of the plan allowan	All charges
<p>These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health approved clinical trial or a Plan-designated center of excellence if approved by the Plan's medical director in accordance with the Plan's protocols.</p> <p>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.</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - 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 <ul style="list-style-type: none"> - 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) 	20% coinsurance of the plan allowan	<i>All charges</i>

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

Value option		
Benefit Description	In-Network You pay after deductible	Out-of-Network You pay after deductible
Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants) (cont.) <ul style="list-style-type: none"> - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for: <ul style="list-style-type: none"> - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis <p>National Transplant Program (NTP) - OptumHealth Care Solutions (URN) used for organ tissue transplants</p> <p>Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p> <p>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.</p>	20% coinsurance of the plan allowance	<i>All charges</i>
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	<i>All charges</i>
<i>Not covered:</i>	<i>All charges</i>	<i>All charges</i>

Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants) - continued on next page
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Value option			
Benefit Description	In-Network You pay after deductible	Out-of-Network You pay after deductible	
Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants) (cont.)	<ul style="list-style-type: none"> <i>Donor screening tests and donor search expenses, except those performed for the actual donor - except as listed above</i> <i>Implants of artificial organs</i> <i>Transplants not listed as covered</i> <i>All services related to non-covered transplants</i> <i>All services associated with complications resulting from the removal of an organ from a non-member</i> 	<i>All charges</i>	<i>All charges</i>
Anesthesia	In-Network You pay after deductible	Out-of-Network You pay after deductible	
Professional services provided in : <ul style="list-style-type: none"> Hospital (inpatient) Hospital (outpatient) Surgical center Skilled nursing center Office 	20% coinsurance of the plan allowance	50% of the Plan allowance and any difference between our allowance and the billed amount	

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

<p>Important things you should keep in mind about these benefits:</p> <ul style="list-style-type: none"> • 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 this Section when the deductible does not apply we state "Deductible does not apply". The calendar year deductible is: \$500 Self Only, \$1,000 Self Plus One and Self and Family in-network and \$1,000 Self Only, \$2,000 Self Plus One and Self and Family out-of-network. • Some benefits in this section are subject to a "per occurrence deductible". When this applies we will state "per occurrence deductible." When utilizing free-standing facilities you can reduce your out of pocket expenses. • Be sure to read Section 4, <i>Your Costs for Covered Services</i> for valuable information about how cost sharing works. Also read Section 9, <i>Coordinating benefits with other coverage</i>, including with Medicare. • The amounts listed below are for the charges billed by a facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge such as physician charges are in Sections 5(a) or (b). • YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SERVICES AND/OR PROCEDURES. Please refer to the preauthorization information shown in Section 3 or call customer service to be sure which services require preauthorization. • If you enroll in UnitedHealthcare Choice Plus Advanced and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a \$150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.) 		
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Benefit Description	In-Network You pay after deductible	Out-of-Network You pay after deductible
Inpatient hospital		
Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	20% coinsurance of the plan allowance	50% of the Plan allowance and any difference between our allowance and the billed amount
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays 	20% coinsurance of the plan allowance	50% of the Plan allowance and any difference between our allowance and the billed amount

Inpatient hospital - continued on next page

Value Option

Benefit Description	Value Option	
Inpatient hospital (cont.)	In-Network You pay after deductible	Out-of-Network You pay after deductible
<ul style="list-style-type: none"> • Administration of blood and blood products • Blood products, derivatives and components, artificial blood products and biological serum. Blood products include any product created from a component of blood such as, but not limited to, plasma, packed red blood cells, platelets, albumin, Factor VIII, immunoglobulin, and prolastin • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthesia services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	20% coinsurance of the plan all	50% of the Plan allowance and any difference between our allowance and the billed amount
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Non-covered facilities, such as nursing homes, schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> 	<i>All charges</i>	<i>All charges</i>
Outpatient hospital or ambulatory surgical center	In-Network You pay after deductible	Out-of-Network You pay after deductible
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>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.</p>	20% coinsurance for services in ambulatory surgical center or physician's office; and 20% coinsurance plus \$250 per occurrence deductible for services in outpatient hospital based surgical center	50% of the Plan allowance and any difference between our allowance and the billed amount in ambulatory surgical center or physician's office; and 50% of the Plan allowance and any difference between our allowance and the billed amount plus \$250 per occurrence deductible for services in outpatient hospital based surgical center
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	<i>All charges</i>	<i>All charges</i>

Value Option

Benefit Description	In-Network You pay after deductible	Out-of-Network You pay after deductible
Extended care benefits/Skilled nursing care facility benefits		
<p>Services and supplies provided during Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for up to 60-days per year when full-time nursing care is medically necessary as determined by the Plan.</p> <p>Services include:</p> <ul style="list-style-type: none"> • Room and board in a Semi-private Room (a room with two or more beds), and general nursing care • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a physician. 	20% coinsurance of the plan allowance	50% of the Plan allowance and any difference between our allowance and the billed amount
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Rest cures, domiciliary or convalescent care</i> • <i>Personal comfort items, such as phone, barber services, guest meals and beds</i> 	<i>All charges</i>	<i>All charges</i>
Hospice care	In-Network You pay after deductible	Out-of-Network You pay after deductible
<p>Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill.</p> <p>Hospice care includes:</p> <ul style="list-style-type: none"> • Physical • Psychological • Social • Spiritual • Respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care • Benefits are available when hospice care is received from a licensed hospice agency. 	20% coinsurance of the plan allowance	50% of the Plan allowance and any difference between our allowance and the billed amount
<i>Not covered: Independent and private duty nursing, homemaker services</i>	<i>All charges</i>	<i>All charges</i>
Ambulance	In-Network You pay after deductible	Out-of-Network You pay after deductible
<p>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:</p> <ul style="list-style-type: none"> • From an out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required. 	20% coinsurance of the plan allowance	20% coinsurance of the plan allowance

Ambulance - continued on next page

Value Option

Benefit Description	In-Network You pay after deductible	Out-of-Network You pay after deductible
<p>Ambulance (cont.)</p> <ul style="list-style-type: none"> • 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. <p>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.</p> <p>For the purpose of this Benefit the following terms have the following meanings:</p> <ul style="list-style-type: none"> • "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting. • "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness. • "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis. 	20% coinsurance of the plan allowance	20% coinsurance of the plan allowance
<i>Not Covered:</i> International Transportation	<i>All charges</i>	<i>All charges</i>

Section 5(d). Emergency Services/Accidents

	<p>Important things you should keep in mind about these benefits:</p> <ul style="list-style-type: none"> • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary. • The calendar year deductible is: \$500 Self Only, \$1,000 Self Plus One and Self and family in-network and \$1,000 Self Only, \$2,000 Self Plus One and Self and Family out-of-network. The calendar year deductible applies to almost all benefits in this Section. We state "not subject to deductible" for those services not subject to the deductible. • Be sure to read Section 4, <i>Your Costs for Covered Services</i>, for valuable information about how cost sharing works. Also read Section 9, <i>Coordinating benefits with other coverage</i>, including with Medicare. • If you enroll in UnitedHealthcare Choice Plus Advanced and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a \$150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.) 	
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What is a medical emergency?

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

What to do in case of emergency:

Emergencies within or outside our service area

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

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

Benefit Description	In-Network You pay after deductible	Out-of-Network You pay after deductible
Emergency Care		
<ul style="list-style-type: none"> • Emergency care at a doctor's office • Emergency care at an urgent care center 	Primary care provider (PCP) \$25 copayment; Non-designated specialist \$75 copayment, Tier 1 premium-designated specialist \$50 copayment \$75 copayment at Urgent Care center	50% of the Plan allowance and any difference between our allowance and the billed amount 50% of the Plan allowance and any difference between our allowance and the billed amount

Emergency Care - continued on next page

Value Option

Benefit Description	In-Network You pay after deductible	Out-of-Network You pay after deductible
Emergency Care (cont.) <ul style="list-style-type: none"> Emergency care as an outpatient at a hospital, including doctors' services <p><i>Not covered: Elective care or non-emergency care at Hospital emergency room</i></p>	\$350 copayment per visit at Hospital emergency room (waived if admitted)	Out-of-Network: You pay \$350 copayment per visit at Hospital emergency room (waived if admitted)
	<i>All charges</i>	<i>All charges</i>
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.	20% coinsurance of the plan allowance	20% coinsurance of the plan allowance
<i>Not Covered</i> <ul style="list-style-type: none"> <i>International Transportation</i> 	<i>All charges</i>	<i>All charges</i>

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

	<p>When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.</p> <p>Important things you should keep in mind about these benefits:</p> <ul style="list-style-type: none"> • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary. • The calendar year deductible applies to almost all benefits in this Section. We added "deductible does not apply" to show when a deductible does not apply. • The calendar year deductible is: \$500 Self Only, \$1,000 Self Plus One and Self and Family in-network and \$1,000 Self Only, \$2,000 Self Plus One and Self and family out-of-network. • Be sure to read Section 4, <i>Your Costs for Covered Services</i>, for valuable information about how cost sharing works. Also read Section 9 <i>Coordinating benefits with other coverage</i>, including with Medicare. • We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required. • YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SERVICES AND/OR PROCEDURES. Please refer to the preauthorization information shown in Section 3 or call customer service to be sure which services require preauthorization. • If you enroll in UnitedHealthcare Choice Plus Advanced and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a \$150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.) 	
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Benefit Description	In-Network You pay after deductible	Out-of-Network You pay after deductible
Professional Services <p>When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.</p> <p>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.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<p>Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include:</p> <ul style="list-style-type: none"> • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and medication management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) in office 	<p>\$50 copay per visit</p>	<p>50% of the Plan allowance and any difference between our allowance and the billed amount</p>

Professional Services - continued on next page

Value option		
Benefit Description	In-Network You pay after deductible	Out-of-Network You pay after deductible
Professional Services (cont.)		
<ul style="list-style-type: none"> Diagnosis and treatment of substance use disorders, including detoxification, treatment and counseling Professional charges for outpatient treatment in a provider's office or other professional setting Electroconvulsive therapy 	\$50 copay per visit	50% of the Plan allowance and any difference between our allowance and the billed amount
Autism Spectrum Disorder for children with autism spectrum disorder <ul style="list-style-type: none"> Assessments, evaluations, or tests by a licensed physician or licensed psychologist to diagnose whether an individual has an autism spectrum disorder; Treatment of autism spectrum disorders when it is determined by a licensed physician or licensed psychologist that the treatment is medically necessary health care. A licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity 	\$50 copayment for specialist	50% of the 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
<ul style="list-style-type: none"> 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 	Cost sharing responsibilities are no greater than for other illnesses or conditions	Cost sharing responsibilities are no greater than for other illnesses or conditions
Inpatient Hospital or other covered facility	In-Network You pay after deductible	Out-of-Network You pay after deductible
Inpatient services provided and billed by a hospital or other covered facility <ul style="list-style-type: none"> Room and board, such as semi-private or intensive accommodations, general nursing care, meals and special diets, and other hospital services. Prior authorization is required Partial day treatment Residential Treatment 	20% coinsurance of the plan allowance	50% of the 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
Diagnostic tests <ul style="list-style-type: none"> Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility Inpatient diagnostic tests provided and billed by a hospital or other covered facility 	20% coinsurance of the plan allowance	<i>All charges</i>

Value option		
Benefit Description	In-Network You pay after deductible	Out-of-Network You pay after deductible
Outpatient hospital	In-Network You pay after deductible	Out-of-Network You pay after deductible
Outpatient services provided by and billed by a covered facility such as: <ul style="list-style-type: none"> • Facility based intensive outpatient treatment programs 	20% coinsurance of the plan allowance	50% of the 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
<ul style="list-style-type: none"> • <i>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</i> • <i>Methadone Maintenance for substance use unless it is part of an approved treatment program</i> • <i>Services and supplies when paid for directly or indirectly by a local state or Federal Government agency</i> • <i>Room and board at a therapeutic boarding school</i> • <i>Services rendered or billed by schools</i> • <i>Services that are not medically necessary .</i> <p><i>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.</i></p>	<i>All charges</i>	<i>All charges</i>

Section 5(f). Prescription Drug Benefits

	<p>Important things you should keep in mind about these benefits:</p> <ul style="list-style-type: none"> • We cover prescribed drugs and medications, as described in the chart beginning on the next page. Some injectable medications may be covered under your medical benefit. • Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary. • Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically. • Be sure to read Section 4, <i>Your Costs for Covered Services</i>, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare. Be sure to read Section 4, <i>Your costs for covered services</i>, for valuable information about how cost sharing works. Also read Section 9, <i>Coordinating benefits with other coverage</i>, including with Medicare. • There are no out-of-network benefits for prescription drugs. • Federal law prevents the pharmacy from accepting unused medications. • Prescription drugs are not subject to deductible. • If you enroll in UnitedHealthcare Choice Plus Advanced and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a \$150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.) 	
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There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice.
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy. Retail or mail order Specialty Pharmacy drugs are only filled at our Specialty Pharmacy. Some drugs are only available at the retail pharmacy for safety or other reasons. To locate the name of a Plan pharmacy near you, refer to your Directory of Healthcare Professionals, call our Customer Service Department 877-835-9861 or visit our website, www.uhcfeds.com.
- **We use a Prescription Drug List (PDL).** Our PDL Management Committee creates this list that includes FDA approved prescription medications, products, or devices. Our Plan covers all prescription medications written in accordance with FDA guidelines for a particular therapeutic indication except for prescription medications or classes of medications listed under "Not Covered" in this section of the brochure. The PDL Management Committee decides the tier placement based upon clinical information from the UnitedHealthcare Pharmacy and Therapeutics (P&T) Committee as well economic and financial considerations. You will find important information about our PDL as well as other Plan information on our web site, www.uhcfeds.com. Your plan PDL is the Traditional PDL.
- **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 \$25.00 for up to a 90-day supply through mail order), and includes most generic medications, as well as select preferred brand medications. Brand medications in Tier 1 include select insulin products, select inhalers for asthma, and select medications for migraine headaches for which no generic alternative(s) are available. For the lowest out-of-pocket expense, you should always consider Tier 1 medications if you and your provider decide they are appropriate for your treatment.
- **Tier 2** is your **middle** copayment option (\$45 for up to a 30-day supply or \$112.50 for up to a 90-day supply through mail order), and contains most preferred brand medications not included in Tier 1. Preferred medications placed in Tiers 1 and 2 are those the PDL Management Committee has determined to provide better overall value than those in Tier 3. If you are currently taking a medication in Tier 2, ask your provider whether there are Tier 1 alternatives that may be appropriate for your treatment.

- **Tier 3** is your **higher** copayment option (\$85 for up to a 30-day supply or \$212.50 for up to a 90-day supply through mail order), and consists of non-preferred medications. Sometimes there are alternatives available in Tier 1 or Tier 2. If you are currently taking a medication in Tier 3, ask your provider whether there are Tier 1 or Tier 2 alternatives that may be appropriate for your treatment.
- **Tier 4** is your **highest** priced (**\$170** for up to a 30-day supply or **\$425** for up to a 90-day supply through mail order) non-preferred medications that do not add clinical value over their covered Tier 1, Tier 2, or Tier 3 alternatives. Some medications on Tier 4 may also have an over-the-counter alternative which can be purchased without a prescription.

Specialty Pharmacy Tiers (30-day supply)

- Tier 1 \$10
- Tier 2 \$150
- Tier 3 \$350
- Tier 4 \$500

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. 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

Changes to Tier level for all covered medications and supplies may occur January 1 and July 1 of each year. Throughout the year, if new generic medications come to market throughout the Plan year they will be placed on Tier 1 and the brand could move to a higher tier. Newly marketed brand medications will be evaluated by our PDL Management Committee and they will then be placed in the appropriate Tier. A prescription medication may be moved to the 4th tier of PDL at anytime if the medication changes to over-the-counter status, or removed from the PDL due to safety concerns declared by the Food and Drug Administration (FDA).

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

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

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

Step Therapy - 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 - Some injectable medications may be covered under the medical policy. Medications typically covered under the pharmacy benefit and received through a retail or mail order pharmacy are those that are self-administered by you or a non-skilled caregiver. However, injectable medications that are typically administered by a health care professional are covered under your medical benefit and need to be accessed through your provider or Specialty pharmacy. Contact the Health Plan at 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 877-835-9861 for additional information

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

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

Benefit Description	In-Network You pay	Out-of-Network You pay
<p>Preventive care medications</p> <p>Medications to promote better health as currently recommended by ACA.</p> <p>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.</p> <ul style="list-style-type: none"> • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 & 800 mcg • Liquid iron supplements for children age 0-1 year • Pre-natal vitamins for pregnant women • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 • Certain statins to treat cardiovascular disease for adults age 40 to 75 will be covered without a copayment as recommended by the United States Preventive Services Task force (USPSTF) when the following criteria is met: <ul style="list-style-type: none"> - one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); - and a calculated 10-year risk of a cardiovascular event of 10% or greater 	\$0	<i>All charges</i>

Preventive care medications - continued on next page

Value Option

Benefit Description		
Preventive care medications (cont.)	In-Network You pay	Out-of-Network You pay
Covered medications and supplies	In-Network You pay	Out-of-Network You pay
<p>Note: Preventive Medications with USPSTF A and B recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations</p>	\$0	<i>All charges</i>
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medications that by Federal law of the United States require a physician's prescription for their purchase, except those listed as <i>Not covered</i>. • 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* <ul style="list-style-type: none"> - Estradiol - testosterone - leuprolide • Oral and injectable drugs associated with artificial insemination and IVF (3 cycles annually) procedures <ul style="list-style-type: none"> - Saxenda - Wegovy - ZepboundMedications prescribed to treat obesity* <p>Prior Authorization is required</p> <p>*For a complete list of drugs and medications, visit www.uhcfeds.com or call our Customer Service Department 877-835-9861</p>	<p>Non-maintenance medications at a retail pharmacy:</p> <p>Up to a 30-day supply</p> <ul style="list-style-type: none"> • Tier 1: \$10 copayment • Tier 2: \$45 copayment • Tier 3: \$85 copayment • Tier 4: \$170 copayment <p>Maintenance medications from the Plan mail order pharmacy for up to a maximum of a 90-day supply</p> <ul style="list-style-type: none"> • Tier 1: \$25 copayment • Tier 2: \$112.50 copayment • Tier 3: \$212.50 copayment • Tier 4: \$425 copayment 	<i>All charges</i>
<p>Specialty Medications</p>	<p>In-Network: You pay</p> <p>Tier 1 \$10</p> <p>Tier 2 \$150</p> <p>Tier 3 \$350</p> <p>Tier 4 \$500</p>	<i>All charges</i>
<p>COVID-19 Over The Counter (OTC) Test Kits</p> <ul style="list-style-type: none"> • 8 Tests per member per month 	<p>Tier 3 -\$12 Capped</p>	<i>All charges</i>

Covered medications and supplies - continued on next page

Value Option

Benefit Description		
Covered medications and supplies (cont.)	In-Network You pay	Out-of-Network You pay
<p>Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below.</p> <ul style="list-style-type: none"> • Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy. • 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. If you have difficulty accessing contraceptive coverage or other reproductive healthcare you can contact contraception@opm.gov. • Reimbursement for over-the-counter contraceptives can be submitted submitted in accordance with Section 7. • Tier 1 hormonal contraceptives • The "morning after pill" (Tier 1) is provided at no cost if prescribed by a physician and purchased at the network pharmacy. Please contact customer service at 877-835-9861 if you have any questions regarding contraceptive coverage. <p>Note: For additional Family Planning benefits see Section 5(a)</p> <p>Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Educational Classes and Programs in Section 5(a)</p>	\$0 Not subject to deductible	<i>All charges</i>
Tobacco Cessation medications are covered as follows: <ul style="list-style-type: none"> • Prescription medications for smoking cessation • Over-the-counter smoking cessation medications with a prescription from physician - subject to age and frequency limitations 	\$0	<i>All charges</i>
<i>Not covered:</i> <ul style="list-style-type: none"> • Drugs and supplies used for cosmetic purposes • Medical Marijuana • 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 	<i>All charges</i>	<i>All charges</i>

Covered medications and supplies - continued on next page

Value Option

Benefit Description	In-Network You pay	Out-of-Network You pay
Covered medications and supplies (cont.) <ul style="list-style-type: none"> • Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed • Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them • Drugs for sexual performance for patients that have undergone genital reconstruction • Drugs available over-the-counter that do not require a prescription order by federal or state law before being dispensed • Alcohol swabs and bio-hazard disposable containers • Compound drugs that do not contain at least one covered ingredient that requires a prescription order to fill 	<i>All charges</i>	<i>All charges</i>
<p>Opioid rescue agents such as naloxone are covered under this Plan with no cost sharing when obtained from a network pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections.</p> <p>For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose</p> <p>Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/</p>	\$0	<i>All charges</i>

Section 5(g). Dental Benefits

- Important things you should keep in mind about these benefits:**
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
 - If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9, *Coordinating benefits with other coverage*.
 - The calendar year deductible is: \$500 Self Only, \$1,000 Self Plus One and Self and Family in-network and \$1,000 Self Only, \$2,000 Self Plus One and Self and Family out-of-network. The calendar year deductible applies to some benefits in this Section. We state "deductible does not apply" to show when the calendar year deductible does not apply.
 - We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
 - **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SERVICES AND/OR PROCEDURES.** Please refer to the preauthorization information shown in Section 3 or call customer service to be sure which services require preauthorization.
 - If you enroll in UnitedHealthcare Choice Plus Advanced and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a \$150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.)
 - Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with other coverage*, including with Medicare.

Benefit Description	In-Network You Pay after deductible	Out-of-Network You Pay after deductible
Accidental injury benefit		
<p>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.</p> <p>A sound natural tooth is defined as a tooth that:</p> <ul style="list-style-type: none"> • 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. <p>Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry</p>	20% coinsurance of the plan allowance	50% of the Plan allowance and any difference between our allowance and the billed amount

Accidental injury benefit - continued on next page

Value Option

Benefit Description	Value Option	
	In-Network You Pay after deductible	Out-of-Network You Pay after deductible
Accidental injury benefit (cont.) <p>The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period provided you do so within 60 days of the injury and if extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wire from fracture care.)</p> <p>Benefits for treatment of accidental injury are limited to the following:</p> <ul style="list-style-type: none"> • Emergency examination • Necessary X-rays /periapical and panoral radiographs • Endodontic (root canal) treatment • Emergency, temporary splinting of teeth • Prefabricated post and core • Simple minimal restorative procedures (fillings) • Emergency extractions • Post-traumatic crowns are covered if it is the only clinical treatment available • Replacement of tooth due lost due to accidental injury 	20% coinsurance of the plan allowance	50% of the Plan allowance and any difference between our allowance and the billed amount
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Oral implants and related procedures, including bone grafts to support implants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva and alveolar bone)</i> 	<i>All charges</i>	<i>All charges</i>
Adjunctive dental services	In-Network You Pay after deductible	Out-of-Network You Pay after deductible
<p>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.</p> <p>Examples of adjunctive dental care are:</p> <ul style="list-style-type: none"> • 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 <p>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.</p>	20% coinsurance of the plan allowance	50% of the Plan allowance and any difference between our allowance and the billed amount

Section 5(h) Wellness and Other Special features

Feature	
Feature	Value
UnitedHealthcare's Digital Experience	<p>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</p> <p>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.</p> <p>Download the UnitedHealthcare app* for access to health plan ID cards, benefits information and help answering questions.</p> <p>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</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Download the UnitedHealthcare app from the App Store® or Google Play™</p> <p>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:</p> <p>Your personalized website, myuhc.com®, features tools designed to help you:</p> <ul style="list-style-type: none"> • Find, price and save on care — you can save with Virtual Visits and other tools. You can save an average of 36% * 1 when you compare costs for providers and services • Get care from anywhere with Virtual Visits. A doctor can diagnose common conditions by phone or video 24/7 • Understand your benefits and the financial impact of care decisions • Find tailored recommendations regarding providers, products and services. You can even generate an out-of-pocket estimate based on your specific health plan status • Access claim details, plan balances and your health plan ID card quickly • Follow through on clinical recommendations and access wellness programs • Order prescription refills, get estimates and compare medication pricing • Check your plan balances, access financial accounts and more • Find a quality doctor, clinic, hospital or lab that helps meet their needs. • Use multiple search options to filter results by location, specialty, quality, cost, services offered and more. • See provider ratings created by patients. • Review cost and care options before making an appointment to help control spending and choose the right level of service. • Access personalized cost and provider information specific to the benefit plan.

Feature - continued on next page

Feature	Value
Feature (cont.)	Value
<u>www.Myuhc.com Behavioral Health Resources</u>	<p>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.</p> <p>Find the right care for you Using the provider search tool, you can:</p> <ul style="list-style-type: none"> • 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 <p>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.</p> <p>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</p> <ul style="list-style-type: none"> • You'll get access to: • Articles • Podcasts • Videos • Other tools <p>To find behavioral health care, sign in or register on myuhc.com and then go to Find Care Behavioral Health Directory</p>
Sanvello/ Self Care by Able To	<p>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.</p> <ul style="list-style-type: none"> • Assessments and tracking • Mental health skills and tools – Cognitive Behavioral Therapy skills, meditations 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.
UHC Rewards and One Pass	<p>Your health plan comes with a new way to earn up to \$300. With UnitedHealthcare Rewards, you can earn up to \$300 for tracking your steps or sleep, getting an annual checkup and more. The activities you go for are up to you. When you activate UHC Rewards, you can also get started with One Pass Select™, a fitness program that gives you unlimited access to a nationwide network of thousands of fitness centers. Plus, you can use your earnings to help pay for a One Pass Select membership.</p> <p>Start earning with UHC Rewards by:</p> <ul style="list-style-type: none"> • Download the UnitedHealthcare® app and then: Sign in or register • Select UHC Rewards • Activate UHC Rewards

Feature - continued on next page

Feature	
Feature (cont.)	Value
	<ul style="list-style-type: none"> Select Redeem rewards to access One Pass Select <p>UnitedHealthcare Rewards is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you. If any fraudulent activity is detected (e.g., misrepresented physical activity), you may be suspended and/or terminated from the program. If you are unable to meet a standard related to health factor to receive a reward under this program, you might qualify for an opportunity to receive the reward by different means. You may call us toll-free at 1-866-230-2505 or at the number on your health plan ID card, and we will work with you (and, if necessary, your doctor) to find another way for you to earn the same reward. Rewards may be limited due to incentive limits under applicable law. Components subject to change. This program is not available for fully insured members in Hawaii, Vermont and Puerto Rico.</p> <p>One Pass Select is a voluntary program featuring a subscription-based nationwide gym network, digital fitness and grocery delivery service. The information provided under this program is for general informational purposes only and is not intended to be nor should it be construed as medical advice. Individuals should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for them. Purchasing discounted gym and fitness studio memberships, digital fitness or grocery delivery services may have tax implications. Employers and individuals should consult an appropriate tax professional to determine if they have any tax obligations with respect to the purchase of these discounted memberships or services under this program, as applicable. One Pass Select is a program offered by Optum. Subscription costs are payable to Optum.</p>
Real Appeal - A Lifestyle and Weight Management Program	<p>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.</p> <p>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.</p> <p>Real Appeal includes:</p> <p>Social community resources such as: Real Appeal LinkedIn community; Facebook community; YouTube videos including getting started, workouts and success stories</p> <p>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:</p> <ul style="list-style-type: none"> Balanced Portion plate Electronic food scale Digital weight scale Fitness guide <p>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.</p> <ul style="list-style-type: none"> Customizable food, activity, weight and goal trackers.

Feature - continued on next page

Value Option

Feature	
Feature (cont.)	Value
	<ul style="list-style-type: none"> • Unlimited access to digital content. • An online lifestyle program to help you learn new ways to be your healthiest self
Quit for Life®	<p>Quit for Life provides our members with resources and support for tobacco cessation. Included are:</p> <ul style="list-style-type: none"> • 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) <p>Get started today. Go to www.myuhc.com, visit the "Health Resources" tab on the top right, Choose the "Quit for Life" tile.</p>
Maternity Health Solutions	<p>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.</p> <ul style="list-style-type: none"> • Maternity-related courses available on myuhc.com regarding course topics such as: <ul style="list-style-type: none"> - 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	<p>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.</p> <p>The program evaluates physicians in various specialties using evidence-based medicine and national standardized measures to help you locate quality and cost-efficient providers. It's easy to find a UnitedHealth Premium Care Physician. Just go to www.myuhc.com® and click on Find a Doctor. Choose smart. Look for blue hearts.</p> <ul style="list-style-type: none"> • 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	
Feature (cont.)	Value
	<ul style="list-style-type: none"> • Not Evaluated for Premium Care physician's specialty is not evaluated and/or does not have enough claims data for program evaluation or the physician's program evaluation is in process
Specialty Pharmacy	<p>What are the benefits of using Optum Specialty Pharmacy?</p> <p>Optum Specialty Pharmacy provides personalized support and resources at no extra cost to help you manage your condition.</p> <p>How does Optum Specialty Pharmacy support you?</p> <ul style="list-style-type: none"> • 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 <p>Tips for working with our Optum Specialty Pharmacy care team.</p> <ul style="list-style-type: none"> • 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. <p>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.</p>
Flexible Benefits Option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claims process (See Section 8).

Value Option

Feature	
Feature (cont.)	Value
Cancer Clinical Trials	<p>To be a qualifying clinical trial, a trial must meet all of the following criteria:</p> <p>Be sponsored and provided by a cancer center that has been designated by the <i>National Cancer Institute (NCI)</i> as a <i>Clinical Cancer Center</i> or <i>Comprehensive Cancer Center</i> or be sponsored by any of the following:</p> <ul style="list-style-type: none"> • <i>National Institutes of Health (NIH)</i>. (Includes <i>National Cancer Institute (NCI)</i>) • <i>Centers for Disease Control and Prevention (CDC)</i> • <i>Agency for Healthcare Research and Quality (AHRQ)</i> • <i>Centers for Medicare and Medicaid Services (CMS)</i> • <i>Department of Defense (DOD)</i> • <i>Veterans Administration (VA)</i> • The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals. Benefits are not available for preventive clinical trials. • The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.
Medicare Part B Reimbursement for Retiree Advantage Members	<p><i>Receive reimbursement for your Medicare Part B Premium</i></p> <ul style="list-style-type: none"> • <i>\$150.00 will be paid on your behalf directly to Medicare</i> • <i>See a reduction in your quarterly Medicare bill, or an increase in your Social Security payment or annuity payment</i> • <i>Receive this benefit for every month you're enrolled in the plan</i>
Renew Active Fitness Program for Retiree Advantage Members	<p><i>Renew Active is a fitness benefit which is included in the Retiree Advantage plan which provides:</i></p> <ul style="list-style-type: none"> • <i>A free gym membership to participating facilities</i> <ul style="list-style-type: none"> - <i>To view participating facilities, please visit www.uhcrenewactive.com</i> • <i>Access to an extensive network of gyms and fitness locations</i> • <i>A personalized fitness plan</i> • <i>Access to a wide variety of fitness classes</i> • <i>An online brain health program, exclusively from AARP® Staying Sharp</i> • <i>Connecting with others at local health and wellness events, and through the Fitbit® Community for Renew Active</i>
First Line Essentials for Retiree Advantage Members	<p><i>Shop for hundreds of over-the-counter items such as toothpaste, vitamins, and personal care from the Health Products catalog.</i></p> <ul style="list-style-type: none"> • <i>Members will receive \$40 each quarter to spend on items from the provided catalog</i> • <i>Items are delivered directly to your door</i> • <i>Orders can be placed over the phone, by mail, or online</i>
House Calls for Retiree Advantage Members	<p><i>With the UnitedHealthcare® HouseCalls program, you get an annual in-home preventive care visit from one of our health care practitioners at no extra cost.</i></p> <p><i>What does HouseCalls include?</i></p> <ul style="list-style-type: none"> • <i>One 45 to 60-minute at-home visit from a health care practitioner, each year.</i>

Feature - continued on next page

Value Option

Feature	
Feature (cont.)	Value
	<ul style="list-style-type: none"> <i>A head-to-toe exam, health screenings and plenty of time to talk about your health questions.</i> <i>A custom care plan made just for you.</i> <i>Help connecting you with additional care you may need.</i>
Healthy at Home for Retiree Advantage Members	<p><i>Healthy at Home provides the following benefits up to 30 days following all inpatient and skilled nursing facility discharges when referred by a UnitedHealthcare Advocate:</i></p> <ul style="list-style-type: none"> <i>Home-Delivered Meals</i> <i>Receive 28 home-delivered meals provided by Mom's Meals</i> <i>Non-emergency transportation</i> <i>Receive 12 one-way rides to medically related appointments and to the pharmacy provided by ModviCare</i> <i>In-home Personal Care</i> <i>Receive 6 hours of in-home personal care through our exclusive national provider CareLinx</i>
Real Appeal for Retiree Advantage Members	<p>Real Appeal is a weight loss program that can help members feel and look better. The program provides everything they need to lose weight and keep it off. This program is a pilot for select members residing in Wisconsin.</p> <p>The online program includes:</p> <ul style="list-style-type: none"> Personalized diabetes prevention coaching 24/7 online support and mobile app Customizable food, activity, weight and goal trackers Success group support, which lets members chat with others who are doing the Real Appeal program The weekly Real Appeal All-Star Show featuring healthy tips from celebrities, athletes and health experts <p>Success Kit includes:</p> <ul style="list-style-type: none"> Program, nutrition, and fitness guides Tools to help cook healthier, tasty meals Delivered right to their front door after attending their first group coaching session
UnitedHealthcare Hearing for Retiree Advantage Members	<p><i>UnitedHealthcare Hearing provides members with greater technology, choice and convenience</i></p> <ul style="list-style-type: none"> <i>Rechargeable hearing aids, remote adjustments and other advanced feature devices are available at up to 80% less than standard industry prices through direct delivery, including top brands in multiple styles</i> <i>6,500+ locations nationwide</i> <i>Choose home delivery or in person options</i> <i>3-minute online hearing test to assess hearing loss/need for in-person test</i> <i>Members receive \$1500 allowance every 36 months towards the purchase of hearing aids</i> <i>You must use a UnitedHealthcare Hearing provider for the purchase of your hearing aids</i>
Quit For Life for Retiree Advantage Members	<p>Quit For Life has helped 3.5 million members quit smoking or using tobacco. It provides the tools and one-on-one support to help you quit your way.</p> <p>And for UnitedHealthcare members, it's offered at \$0 out of pocket.</p>

Feature - continued on next page

Value Option

Feature	Value
Feature (cont.)	Value
	<p>With a 95% satisfaction rate, Quit for Life provides</p> <ul style="list-style-type: none"> • Tools and support to help members quit cigarettes, e-cigarettes, vaping and tobacco • A personal, one-on-one Quit Coach to help you create a customized quit plan • The Quit for Life mobile app, which offers 24/7 urge management support • Text2Quit text messages for daily tips and encouragement • Quit medications – Such as nicotine gum or patches – for no charge, based on eligibility.
PERS (Personal Emergency Response System) for Retiree Advantage Members	<p>UnitedHealthcare® works with Lifeline to provide a personal emergency response system at no cost for Retiree Advantage plan members</p> <p>Lifeline personal emergency response system (PERS) allows you to ask for help whenever you need it, anytime of day or night – 365 days of the year, 24/7. All you need to do is press the help button, worn as a wristband or pendant, and a Trained Care Specialist will assist you to make sure you quickly get the help you need.</p> <p>Features include:</p> <ul style="list-style-type: none"> • Optional AutoAlert fall detection technology automatically provides access to help if it detects a fall – even if wearer is disoriented, immobilized or unconscious and cannot press their help button • Cellular or landline compatible, Lifeline works anywhere in the U.S., where current telephone service is provided • Lightweight, waterproof help button can be worn on the wrist or as a pendant

Non-FEHB Benefits Available to Plan Members

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

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

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

UHC Rewards and One Pass* - UnitedHealthcare Rewards, you can earn dollars for tracking your steps or sleep, getting an annual checkup and more. The activities you go for are up to you. When you activate UHC Rewards, you can also get started with One Pass Select™, a fitness program that gives you unlimited access to a nationwide network of thousands of fitness centers. You can use your earnings to help pay for a One Pass Select membership. 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 www.myuhc.com.**

Financial Wellness Options: United Health ONE helps with individual 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.uh one.uhc.com/federal> or call 1-844-620-4814 (worldwide 24-hour a day).

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

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

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

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

We do not cover the following:

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

Section 7. Filing a Claim for Covered Services

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

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

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

Medical and hospital benefits	In most cases, providers and facilities file claims for you. Providers must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 877-835-9861.
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When you must file a claim – such as for services you received outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

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

Submit domestic medical claims to:

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

Submit international medical claims to:

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

Prescription drugs

Submit your claims to:

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

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

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

Other supplies or services

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

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

Section 8. The Disputed Claims Process

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

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

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

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

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

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

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

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

- a) Write to us within 6 months from the date of our decision; and
- b) Send your request to us at: UnitedHealthcare, Federal Employees Health Benefit Program (FEHB) Appeals, P.O. Box 30573, Salt Lake City, UT 84130-0573; and
- c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
- d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
- e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

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

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

- a) Pay the claim or
- b) Write to you and maintain our denial or.

c) Ask you or your provider for more information

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

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

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

You must write to OPM within:

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

Write to OPM at: United States Office of Personnel Management, 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 pre-certification or prior approval. This is the only deadline that may not be extended.

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

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

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

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

Section 9 Coordinating Benefits With 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 pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

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

- **TRICARE and CHAMPUS**

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

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

- **Workers' Compensation**

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

We do not cover services that:

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

- **Medicaid**

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

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

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

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

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on www.BENEFEDS.com or by phone 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)**

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

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

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

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

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

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

We 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.

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

Medicare

Benefit Description: Deductible

Value Option - You pay without Medicare - In-Network: \$500 Self Only; \$1,000 Self Plus One or Self and Family

Value Option - You pay with Medicare Part B - In-Network: \$500 Self only; \$1,000 Self Plus One or Self and Family

Benefit Description: Out-of-Pocket Maximum

Value Option - You pay without Medicare - In-Network: \$6,000 self Only/\$12,000 Self Plus One or Self and Family

Value Option - You pay with Medicare Part B - In-Network: \$6,000 self only/\$12,000 Self Plus One or Self and Family

Benefit Description: Part B Premium reimbursement offered?
Value Option - You pay without Medicare - In-Network: N/A
Value Option -You pay with Medicare Part B - In-Network: N/A

Benefit Description: Primary Care Provider
Value Option - You pay without Medicare - In-Network: \$25 copayment
Value Option -You pay with Medicare Part B - In-Network: \$25 copayment

Benefit Description: Specialist
Value Option - You pay without Medicare - In-Network: Tier 1 premium Designated \$50 copayment; Non-designated \$75; copayment
Value Option -You pay with Medicare Part B - In-Network: Tier 1 premium Designated \$50 copayment ; Non-designated \$75; copayment

Benefit Description: Inpatient Hospital
Value Option - You pay without Medicare - In-Network: 20% coinsurance
Value Option -You pay with Medicare Part B - In-Network: 20% coinsurance

Benefit Description: Outpatient Hospital
Value Option - You pay without Medicare - In-Network: 20% coinsurance
Value Option -You pay with Medicare Part B - In-Network: 20% coinsurance

Benefit Description: Incentives offered
Value Option - You pay without Medicare - In-Network: N/A
Value Option -You pay with Medicare Part B - In-Network: N/A

- **Tell us about your Medicare coverage**

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

Medicare Part B Premium Reimbursement

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

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

- **Medicare Advantage (Part C)**

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

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

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

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

You may enroll in the UnitedHealthcare Retiree Advantage Plan if:

- You are enrolled in this UnitedHealthcare FEHBP active plan and have both Medicare Part A & Part B

- You are retired and live in our geographic service area. See Section 1 which describes our service area.
- You are a United States citizen or are lawfully present in the United States
- You do NOT have End-Stage Renal Disease (ESRD), with limited exceptions
- You complete an application for enrollment in the UnitedHealthcare Retiree Advantage Plan.

As part of this process CMS will verify your Medicare Part B enrollment. If the FEHB subscriber and or dependent enrolls in the Retiree Advantage plan, each family member will have to complete an application by calling into our Retiree Solutions team (1-844-481-8821). Members who are not eligible for Medicare Part A and B will remain on this FEHB plan. If, for any reason, you do not meet the enrollment requirements, you will no longer be eligible to participate in the Retiree Advantage plan. Your contributions will end and your regular FEHB benefits will resume. You may be required to repay any reimbursements paid to you in error.

We offer a plan designed:

- To help members with their Medicare Part B premium costs
- To provide access to our national network of providers, (in-network or out-of-network) at the same cost share
- To cover eligible medical benefits with little to no out of pocket costs
- Medicare Part D prescription drug coverage with a low \$2,000 out of pocket max

The Retiree Advantage plan provides monthly reimbursement of \$150.00 of your Medicare Part B monthly premium. In addition, we cover benefits, including office visit copayments at (\$0), urgent care and emergency care at (\$0), plus additional coverage for hearing aids discounts and wellness programs. See the benefits below. If you elect to enroll in the UnitedHealthcare Retiree Advantage plan which includes Medicare part D, your FEHB plan will not coordinate benefits. The UnitedHealthcare Retiree Advantage plan will take over as the primary and only payer.

If you elect to enroll in the UnitedHealthcare Retiree Advantage Group Medicare Advantage plan you must retain your FEHB coverage. Do not suspend your FEHB coverage as this will make you ineligible for the Retiree Advantage plan.

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

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.

Benefit Description: Deductible

Member Cost without Medicare (In-Network): \$500 Self Only, \$1,000 Self Plus One and \$1,000 Self and Family

Member Cost with Medicare Part B (In-Network): \$500 Self Only, \$1,000 Self Plus One and \$1,000 Self and Family

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

Benefit Description: Out of Pocket Maximum

Member Cost without Medicare (In-Network): \$6,000 Self Only, \$12,000 Self Plus One and \$6,000 Self and Family

Member Cost with Medicare Part B (In-Network): \$6,000 Self Only, \$12,000 Self Plus One and \$6,000 Self and Family

Member Cost with UnitedHealthcare Retiree Advantage Health Plan: You pay nothing for Medicare-covered service from any provider

Benefit Description: Primary Care Provider

Member Cost without Medicare (In-Network): \$25

Member Cost with Medicare Part B (In-Network): \$25

Member Cost with UnitedHealthcare Retiree Advantage Health Plan: \$0

Benefit Description: Specialist (Non-Tier)

Member Cost without Medicare (In-Network): Non-Tier physician: \$75

Member Cost with Medicare Part B (In-Network): Non-Tier physician: \$75

Member Cost with UnitedHealthcare Retiree Advantage Health Plan: \$0

Benefit Description: Specialist (Tier 1)

Member Cost without Medicare (In-Network): Tier 1 physician: \$50

Member Cost with Medicare Part B (In-Network): Tier 1 physician: \$50

Member Cost with UnitedHealthcare Retiree Advantage Health Plan: \$0

Benefit Description: Virtual Visits

Member Cost without Medicare (In-Network): \$0

Member Cost with Medicare Part B (In-Network): \$5

Member Cost with UnitedHealthcare Retiree Advantage Health Plan: \$0

Benefit Description: Urgent Care

Member Cost without Medicare (In-Network): \$100

Member Cost with Medicare Part B (In-Network): \$100

Member Cost with UnitedHealthcare Retiree Advantage Health Plan: \$0

Benefit Description: Emergency

Member Cost without Medicare (In-Network): \$350

Member Cost with Medicare Part B (In-Network): \$250

Member Cost with UnitedHealthcare Retiree Advantage Health Plan: \$0

Benefit Description: Inpatient Hospital

Member Cost without Medicare (In-Network): 20% after annual deductible

Member Cost with Medicare Part B (In-Network): 20% after annual deductible

Member Cost with UnitedHealthcare Retiree Advantage Health Plan: \$0

Benefit Description: Outpatient Hospital (freestanding)

Member Cost without Medicare (In-Network): Freestanding: 20% after deductible

Member Cost with Medicare Part B (In-Network): Freestanding: 20% after deductible

Member Cost with UnitedHealthcare Retiree Advantage Health Plan: \$0

Benefit Description: Outpatient Hospital (hospital-based)

Member Cost without Medicare (In-Network): Hospital-based: 20% per occurrence deductible of \$250 & annual deductible

Member Cost with Medicare Part B (In-Network): Hospital-based: 20% per occurrence deductible of \$250 & annual deductible

Member Cost with UnitedHealthcare Retiree Advantage Health Plan: \$0

Benefit Description: Rx (30-day) supply at retail Tier 1

Member Cost without Medicare (In-Network): Tier 1- \$10

Member Cost with Medicare Part B (In-Network): Tier 1- \$10

Member Cost with UnitedHealthcare Retiree Advantage Health Plan: Tier 1- \$5

Benefit Description: Rx (30-day) supply at retail Tier 2

Member Cost without Medicare (In-Network): Tier 1- \$45

Member Cost with Medicare Part B (In-Network): Tier 1- \$35

Member Cost with UnitedHealthcare Retiree Advantage Health Plan: Tier 1- \$25

Benefit Description: Rx (30-day) supply at retail Tier 3

Member Cost without Medicare (In-Network): Tier 1- \$85

Member Cost with Medicare Part B (In-Network): Tier 1- \$70

Member Cost with UnitedHealthcare Retiree Advantage Health Plan: Tier 1- \$60

Benefit Description: Rx (30-day) supply at retail Tier 4

Member Cost without Medicare (In-Network): Tier 1- \$170

Member Cost with Medicare Part B (In-Network): Tier 1- \$120

Member Cost with UnitedHealthcare Retiree Advantage Health Plan: Tier 1- \$90

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

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

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

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

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

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

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

Section 10. Definitions of Terms We Use in This Brochure

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: <ul style="list-style-type: none">• We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.• Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.• OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.
Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Clinical trials cost categories	An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application. <ul style="list-style-type: none">• Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy• Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care• Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.
Coinsurance	See Section 4, page 22
Copayment	See Section 4, page 22
Cost Sharing	See Section 4, page 22
Covered services	Care we provide benefits for, as described in this brochure.
Deductible	See Section 4, page 22
Experimental or investigational service	Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States American Hospital Pharmacopoeia Dispensing Information* as appropriate for the proposed use
- Not recognized, in accordance with generally accepted medical standards, as being safe and effective for your condition;
- Subject to review and approval by any institution review board for the proposed use. (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

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

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

Medical necessity Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, Substance Use Disorder disease or its symptoms, that are all of the following as determined by us or our designee, within our discretion.

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

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

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

Plan allowance Allowable expense (plan allowance) is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid.

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

Post-service claims

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

Pre-service claims

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

Reimbursement

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

Subrogation

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

Surprise bill

An unexpected bill you receive for:

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

Unproven Service(s)

Unproven services, including medications, are services that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy). The comparison group must be nearly identical to the study treatment group.

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note: If you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion consider an otherwise unproven service to be a covered health service for that sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that sickness or condition.

Urgent care claims

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

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

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

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 1-877-835-9861. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We

Us and We refer to UnitedHealthcare

You

You refers to the enrollee and each covered family member.

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Summary of Benefits for the Value Option of UnitedHealthcare Insurance Company - 2025

- 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.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- All benefits are subject to the annual deductible unless we state "not subject to deductible".

Value Option Benefits	You Pay
Medical services provided by physicians : Diagnostic and treatment services provided in the office	In-network: Primary care provider (PCP) \$25 copayment Specialist: Non-designated specialist \$75 copayment Tier 1 premium-designated specialist \$50 copayment Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
Services provided by a hospital: Inpatient	In-network: 20% coinsurance of the plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
Services provided by a hospital: Outpatient (Non-surgical)	In-network: 20% coinsurance of the plan allowance Out-of-network: 50% of the plan allowance and any difference between our allowance and the billed amount
Emergency benefits: Emergency Room of Hospital	\$350 copayment per visit in-network (waived if admitted) \$350 copayment per visit out-of-network (waived if admitted)
Emergency benefits: Urgent Care Facility	In-network: \$75 copayment per visit Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
Mental health and substance use disorder treatment:	Regular cost sharing
Prescription drugs:	In-network benefits only
• Retail pharmacy	Up to 30-day supply at retail (in-network only) Tier 1: \$10 copayment Tier 2: \$45 copayment Tier 3: \$85 copayment Tier 4: \$170 copayment
• Mail order	Up to 90-days at Mail Order (in-network only) Tier 1: \$25 copayment

	Tier 2: \$112.50 copayment Tier 3: \$212.50 copayment Tier 4: \$425 copayment
Specialty Pharmacy (30-day supply)	Tier 1 \$10 Tier 2 \$150 Tier 3 \$350 Tier 4 \$500
Vision care:	Routine eye examination for children as described in the Bright Future Guidelines is covered at 100% (In-Network only - not subject to deductible) Routine Eye Examination for Adults In-network \$25 copayment Out-of-Network: 50% of the Plan allowance and any difference between our allowance and the billed amount
Annual Deductible	In-network <ul style="list-style-type: none">• \$500 Self Only• \$1,000 Self Plus One and Self and Family Out-of-network: <ul style="list-style-type: none">• \$1,000 Self Only• \$2,000 Self Plus One and Self and Family
Protection against catastrophic costs (out-of-pocket maximum):	You pay nothing after: In-network: <ul style="list-style-type: none">• \$6,000 Self Only• \$12,000 Self Plus One and Self and Family Out-of-Network: <ul style="list-style-type: none">• \$12,000 Self Only• \$24,000 Self Plus One and Self and Family Some costs do not count toward this protection.

Notes

2025 Rate Information for UnitedHealthcare Insurance Company, Inc.

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

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

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

Premiums for Tribal employees are shown under the Monthly 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, Northern Virginia, San Antonio, Texas and Chicago, Illinois

Value Option Self Only	L91	\$287.44	\$95.81	\$622.79	\$207.59
Value Option Self Plus One	L93	\$610.52	\$203.51	\$1,322.80	\$440.93
Value Option Self and Family	L92	\$689.55	\$229.85	\$1,494.02	\$498.01

UnitedHealthcare Insurance Company, Inc.

www.uhcfeds.com

Customer Service: 877-835-9861

2025

Choice Open Access - Health Maintenance Organization

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

Serving: District of Columbia, Maryland, Pennsylvania and Virginia

IMPORTANT

- Rates: Back Cover
- Changes for 2025: Page 14
- Summary of Benefits: Page 92

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

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

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

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

Special Notice: UnitedHealthcare Insurance Company, is Terminating Codes KK (Southeast), KT (West Region) and LJ (Central Region) service areas for 2025

Authorized for distribution by the:



**United States
Office of Personnel Management**

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

Important Notice from UnitedHealthcare Insurance Company, Inc.

About

Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

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

Medicare's Low Income Benefits

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

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

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

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2025, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates for each plan annually. Benefit changes are effective January 1, 2025, and changes are summarized on page 14. Rates are shown at the end of this brochure.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee and each covered family member, “we” means UnitedHealthcare Insurance Company, Inc.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

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

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

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

Do not give your plan identification (ID) number over the phone or to people you do not know, except for your healthcare providers, authorized health benefits plan, or OPM representative.

- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 1-844-359-7736 and explain the situation.
 - If we do not resolve the issue:

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

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

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

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

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

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

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

Discrimination is Against the Law

We comply with applicable Federal nondiscrimination laws and do not discriminate on the basis of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity).

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual's protected trait or traits, for example a member's gender identity or the fact that the covered benefit is sought in connection with gender-affirming care, will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined to be medically necessary.

Preventing Medical Mistakes

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

1. Ask questions if you have doubts or concerns.
 - Ask questions and make sure you understand the answers.
 - Choose a doctor with whom you feel comfortable talking.
 - Take a relative or friend with you to help you take notes, ask questions and understand answers.
2. Keep and bring a list of all the medications you take.
 - Bring the actual medications or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
 - Tell your doctor and pharmacist about any drug, food and other allergies you have such as to latex.
 - Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
 - Make sure your medications what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
 - Read the label and patient package insert when you get your medication, including all warnings and instructions.
 - Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
 - Contact your doctor or pharmacist if you have any questions.
 - Understand both the generic and the brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.
3. Get the results of any test or procedure.
 - Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
 - Don't assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
 - Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.
 - Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.
 - Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.
5. Make sure you understand what will happen if you need surgery.
 - Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
 - Ask your doctor, "Who will manage my care when I am in the hospital?"
 - Ask your surgeon:
 - "Exactly what will you be doing?"
 - "About how long will it take?"
 - "What will happen after surgery?"
 - "How can I expect to feel during recovery?"
 - Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

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

Preventable Healthcare Acquired Conditions ("Never Events")

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

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

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

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.
- **Minimum essential coverage (MEC)**

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

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

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

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

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

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

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

Once enrolled in your FEHB Program Plan, you should contact your carrier directly for address updates and questions about your benefit coverage.
- **Enrollment types available for you and your family**

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

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

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

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

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

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

- **Family Member Coverage**

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

Natural children, adopted children, and stepchildren

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

Foster children

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

Children incapable of self-support

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

Married children

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

Children with or eligible for employer-provided health insurance

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

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

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

- **Children's Equity Act**

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

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

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

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

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

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

- **When benefits and premiums start**

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2025 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 2024 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

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

- **Upon divorce**

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

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get information about your coverage choices. You can also visit OPM's Web site, <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**

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

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

- **Health Insurance Market Place**

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

Section 1. How This Plan Works

This Plan is a high option health maintenance organization (HMO) plan. OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. UnitedHealthcare Insurance Company, Inc. holds the following accreditations: National Committee for Quality Assurance (NCQA). To learn more about this plan's accreditation(s), please visit the following website:

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

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

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

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

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

General Features of our High Option Plan

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

We have Open Access benefits

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

How we pay providers

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

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

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

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

Your rights and responsibilities

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

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

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

If you want more information about us, call 1-877-835-9861. You may also visit our Web site at www.uhcfeds.com.

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

Your medical and claims records are confidential

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

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area is:

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

Section 2. Changes for 2025

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
- Emergency services – Emergency room copayment will increase from \$275 to \$350. See page 61
- Prescription drugs - Retail pharmacy up to 30-day supply increasing Tier's 2,3,4 drugs from \$40/\$85/\$175 to \$50/\$100/\$200 and Mail order 90-day supply increasing Tier's 2,3,4 drugs from \$100/\$212.50/\$437.50 to \$125/\$250/\$500. See page 68

Section 3. How You Get Care

Identification cards

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

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

Where you get covered care

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

- **Plan Providers**

Plan providers are physicians and other healthcare professionals in our service area that we contract with to provide covered services to our members. 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 provider search tool is available on our Web sites at www.myuhc.com and www.uhcfeds.com.

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

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

- **Plan Facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The provider search tool is available from our Web sites www.myuhc.com and www.uhcfeds.com.

Balance Billing Protection

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

What you must do to get covered care

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

- **Primary care**

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

- **Specialty care**

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

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

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

If you have a chronic and disabling condition and lose access to your specialist because we:

- terminate our contract with your specialist for other than cause;
- drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or
- reduce our service area and you enroll in another FEHB plan,

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

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

- **Hospital care**

Your Plan primary care 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;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

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

You need prior Plan approval for certain services

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

Inpatient Hospital Admission

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

Other Services

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

- Applied Behavioral Analysis (ABA)
- Air Ambulance (non-emergent)
- Capsule endoscopy
- Clinical trials
- Congenital anomaly repair
- CT Scans (Computed tomography)
- Dialysis
- Discectomy/fusion
- Durable medical equipment over \$1,000
- Electro-convulsive therapy
- Gender Affirming Surgical procedures
- Growth hormone therapy (GHT)
- Hysterectomy
- Iatrogenic Infertility Services
- Infertility Services
- Inpatient Hospitalization
- Intensive Outpatient treatments
- Joint replacement
- Magnetic resonance angiogram (MRA)

- Magnetic resonance imaging (MRI)
- Morbid obesity surgery
- Nuclear medicine studies including nuclear cardiology.
- Orthopedic and prosthetic devices over \$1,000
- Partial hospitalization
- PET scans
- Psychological, neurophysiological and extended developmental testing
- Reconstructive surgery
- Rhinoplasty/septo-rhinoplasty
- Sleep apnea - surgery and appliance (with sleep studies); sleep studies (polysomnograms) - attended
- Substance use disorder treatments
- Vein Ablation
- Virtual Colonoscopy
- Transplants

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

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

Next, provide the following information:

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

Non-urgent care claims

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

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

Urgent care claims

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

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

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

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 1-877-835-9861. You may also call OPM's FEHB 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 1-877-835-9861. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

Concurrent care claims

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

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

Emergency inpatient admission

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

Maternity Care

Your physician, your hospital, you or your representative, must call us at 1-877-835-9861 prior to admission.

Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for pre-certification of additional days for your baby.

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

If your treatment needs to be extended

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

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

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

Circumstances beyond our control

If you disagree with our pre-service claim decision

To reconsider a non-urgent care claim

To reconsider an urgent care claim

To file an appeal with OPM

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 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.

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

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

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

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

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

3. Write to you and maintain our denial.

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

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

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

Section 4. Your Costs for Covered Services

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

Cost-Sharing

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

Copayments

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

Example: When you see your primary care provider you pay a copayment of \$25 per office visit and when you go in the hospital, you pay \$150 per day up to a maximum of \$750 per admission.

Deductible

We do not have a deductible.

Coinsurance

Coinurance is the percentage of our allowance that you must pay for your care.

Example: In our Plan, you pay 50% of our allowance for durable medical equipment

Differences between our Plan allowance and the bill

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

Your catastrophic protection out-of-pocket maximum

After your out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance total \$5,000 for Self Only, or \$10,000 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services.

The maximum annual limitation on cost sharing listed under Self Only of \$5,000 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.

Example Scenario: Your plan has a \$5,000 Self Only maximum out-of-pocket limit and a \$10,000 Self Plus One or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of \$5,000 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket maximum of \$10,000, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of \$10,000 for the calendar year before their qualified medical expenses will begin to be covered in full.

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

- Copayments or coinsurance for chiropractic services
- Expenses for services and supplies that exceed the stated maximum dollar or day limit
- Expenses from utilizing out-of-network providers

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.

• The Federal Flexible Spending Account Program – FSAFEDS

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

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

Section 5. High Option Benefits

See Page 14 for how our benefits changed this year.

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Section 5. High Option Benefits Overview

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

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

Our benefit package offers the following unique features:

High Option Benefits	You pay
Medical services provided by physicians: Preventive Care Services	No copayments for preventive care services. This includes items such as, but not limited to, immunizations, physical examinations and screenings as appropriate and recommended by U.S. Preventive Services Task Force. Please refer to Section 5 of the brochure for more detail.
Medical services provided by physicians: Diagnostic and treatment services provided in the office	\$25 per visit to your Primary Care Provider (PCP) for ages 18 and older, \$0 per visit for children under 18 \$0 per virtual visit through designated virtual visit providers \$35 per visit to your specialist
Services provided by a hospital: Inpatient	\$150 per day up to \$750 per admission
Services provided by a hospital: Outpatient Surgical	\$150 per visit at approved free standing surgical facility \$300 per visit outpatient surgical facility charge at hospital
Emergency benefits: In or out-of-area	\$350 per visit - waived if admitted
Mental health and substance use disorder treatment	Regular cost sharing
Prescription drugs: Plan retail pharmacy	Tier 1: \$10; Tier 2: \$50; Tier 3: \$100; Tier 4: \$200
Prescription drugs: Plan mail order for up to a 90-day fill	Tier 1: \$25 Tier 2: \$125 Tier 3: \$250 Tier 4: \$500
Specialty Pharmacy	Specialty pharmacy (30-day supply) Tier 1 \$ 10 Tier 2 \$150 Tier 3 \$350 Tier 4 \$500
Vision care	\$35 specialist for eye refraction exam every year

Section 5. High Option

	Note: Children have preventive eye examinations as described in the Bright Future Guidelines with 100% coverage
UnitedHealthcare Retiree Advantage Health Plan	You pay
Medical Benefit	
Deductible	Member Pays: No deductible; Brochure Section 9
Primary Care Physician Visit	Member Pays: No deductible; Brochure Section 9
Preventive Care	Member Pays: No deductible; Brochure Section 9
Specialist Visit	Member Pays: Nothing; Brochure Section 9
Virtual Visit	Member Pays: Nothing; Brochure Section 9
Urgent Care	Member Pays: Nothing; Brochure Section 9
Emergency Room	Member Pays: Nothing; Brochure Section 9
Medical Benefit: Pharmacy (30-day supply)	Member Pays: Tier 1 - \$5, Tier 2 - \$35, Tier 3 - \$65, Tier 4 - \$100; Brochure Section 9
	*Note: You must have Medicare Part A and Part B, and Medicare must be primary for you to enroll in the UnitedHealthcare Retiree Advantage Plan. This plan reduces your costs by eliminating your cost sharing for covered medical services. Please see Section 9 in this brochure for additional information on how to enroll in this plan and for details on a reimbursement of \$150.00 of your Medicare Part B premium.

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

	<p>Important things you should keep in mind about these benefits:</p> <ul style="list-style-type: none"> • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary. • Plan physicians must provide or arrange your care. • A facility copay applies to services that appear in this section but are performed in a hospital, an ambulatory surgical center or the outpatient department of a hospital. See <i>Section 5(c) Services provided by a hospital or other facility, and ambulance services</i> for more information. • We have no deductible. • Be sure to read Section 4, <i>Your Costs for Covered Services</i>, for valuable information about how cost-sharing works. Also, read Section 9, <i>Coordinating benefits with other coverage</i>, including with Medicare. • If you enroll in UnitedHealthcare Choice Open Access are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a \$150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.) • The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.). • YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SERVICES AND/OR PROCEDURES. Please refer to the preauthorization information shown in Section 3 or call customer service to be sure which services require preauthorization. 	
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Benefit Description	
Diagnostic and treatment services	You pay
Professional services of physicians <ul style="list-style-type: none"> • In your physician's office/telehealth visit • Primary care / Optum Primary care • Office medical consultations • Second surgical opinion • Advanced care planning 	\$25 per primary care provider (PCP) visit for members 18 and older; \$0 for children under 18 \$35 per specialist visit
Second Opinion Benefit - You now have access to personalized second opinions by video or by phone through the Second Opinion Program. Second Opinion is powered by 2nd MD, a third-party-vendor, to assist you with more informed decision making. The plan pays 100% for this program when the 2nd MD is the provider. This is an in-network only option. It does not change your cost sharing costs for your second opinion benefit when utilized through other providers	\$0
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • In a skilled nursing facility • At home 	\$0 - facility fee applies

Benefit Description	You pay
Virtual visits	You pay
<p>Virtual visits when :</p> <ul style="list-style-type: none"> • 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 <p>Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider.</p> <p>Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at 1-877-835-9861. Virtual Visits and prescription services are subject to state regulations.</p>	\$0 per visit
Lab, X-ray and other diagnostic tests	You pay
<p>Tests, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG 	\$50 per visit
<ul style="list-style-type: none"> • CT Scans • MRI/MRA • PET Scans 	\$150 per visit
Preventive care, adult	You pay
<p>Routine physical every year:</p> <p>The following preventive services are covered at the time interval recommended at each of the links below:</p> <ul style="list-style-type: none"> • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. For a complete list of screenings go to the website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks • 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.hrsa.gov/womens-guidelines 	\$0

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.) <ul style="list-style-type: none"> To build your personalized list of preventive services go to to https://health.gov/myhealthfinder 	\$0
One annual biometric screening to include the following services if appropriate based upon age and frequency recommendation: <ul style="list-style-type: none"> Body Mass Index (BMI) Blood pressure Lipid/cholesterol levels Glucose/hemoglobin A1c measurement <p>Note: Office visit and lab services must be rendered on the same day and coded by your doctor as preventive to be covered in-full</p> <p>Members can complete their HRA (Health Risk Assessment) on www.myuhc.com</p>	\$0
Routine mammogram Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC); based on the Advisory Committee on Immunization Practices (ACP) schedule. For a complete list of endorsed immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ BRCA genetic counseling and evaluation are covered as preventive services when a woman's family history is associated with an increased risk for deleterious mutations in <i>BRCA1</i> or <i>BRCA2</i> genes and medical necessity criteria has been met	\$0
Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	\$0
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: <ul style="list-style-type: none"> Intensive nutrition and behavioral weight-loss counseling therapy, Family centered programs when medically identified to support obesity prevention and management by an in-network provider. When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) for cost share requirements for anti-obesity medications. When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share. 	\$0
<i>Not covered:</i> <ul style="list-style-type: none"> <i>Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.</i> <i>Immunizations, boosters, and medications for travel or work-related expenses</i> 	<i>All charges</i>

Benefit Description	You pay
<p>Preventive care, children</p> <ul style="list-style-type: none"> Well-child visits, examinations and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org Children's immunizations endorsed by the Centers for Disease Control (CDC) including DTaP/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the website at https://www.cdc.gov/vaccines/schedules/index.html You can also find a complete list of U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations <p>Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.</p>	\$0
<p>Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows:</p> <ul style="list-style-type: none"> Intensive nutrition and behavioral weight-loss counseling therapy, Family centered programs when medically identified to support obesity prevention and management by an in-network provider. When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) for cost share requirements for anti-obesity medications. When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share. 	<i>See Section 5(b) for surgery requirements and cost share</i>
<p>Maternity care</p> <p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> Prenatal and Postpartum care Screening for gestational diabetes Bacteriuria screening Delivery Screening and counseling for prenatal and postpartum depression <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> As part of your coverage, you have access to in-network certified nurse midwives, board-certified lactation specialists during the prenatal and post-partum period. You do not need to precertify your vaginal delivery; see page 18 for other circumstances, such as extended stays for you or your baby. 	<p>You pay</p> <p>\$0 for routine prenatal care or the first postpartum care visit</p> <p>\$25 per primary care physician (PCP) visit</p> <p>\$35 per specialist visit</p>

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.) <ul style="list-style-type: none"> Routine care includes office visits, one office sonogram (as part of prenatal care) and laboratory work. Copays will continue to apply to specialized scanning, any specialist not the member's current OB/GYN, durable medical equipment, prescription drugs, chiropractic and acupuncture services, emergency room visits, urgent care visits, or inpatient hospital copayments as these services are not considered routine. You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b) for applicable copayments. <p>Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits.</p>	\$0 for routine prenatal care or the first postpartum care visit \$25 per primary care physician (PCP) visit \$35 per specialist visit
Breastfeeding and lactation support, supplies and counseling for each birth	\$0
<i>Not covered: Routine sonograms to determine fetal age, size or sex after the first sonogram.</i>	<i>All charges</i>
Family planning	You pay
Contraceptive counseling on an annual basis	\$0
A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories on the HRSA list. This list includes: <ul style="list-style-type: none"> Voluntary female sterilization Surgically implanted contraceptives Injectable contraceptive drugs (such as Depo Provera) Intrauterine devices (IUDs) Diaphragms <p>Note: See additional Family Planning and Prescription drug coverage Section 5(f).</p> <p>Note: Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below.</p>	\$0

Family planning - continued on next page

Benefit Description	You pay
Family planning (cont.)	
Contraceptive products that are not already available at \$0 cost-share can be provided at \$0 member cost-share if the provider determines that a particular contraceptive is medically necessary for that member. The cost-share waiver process requires that providers attest the product is needed for contraceptive purposes and this can be submitted electronically by the provider. To request an exemption, please call customer service at 887-835-9861	\$0
If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov .	
Voluntary male sterilization	<p>\$25 per primary care provider (PCP) visit</p> <p>\$35 per specialist visit</p>
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.	\$35 per specialist visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic testing not medically necessary</i> 	<i>All charges</i>
Infertility services	You pay
Diagnosis and treatment of the cause of infertility	<p>\$25 per primary care provider (PCP) visit</p> <p>\$35 per specialist visit</p>
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.	50% coinsurance of the plan allowance
<p>Covered Services</p> <p>Diagnosis and treatment of infertility specific to:</p> <p>Artificial insemination:</p> <ul style="list-style-type: none"> • Intravaginal Insemination (IVI) • Intracervical Insemination (ICI) • Intrauterine Insemination (IUI) <ul style="list-style-type: none"> - Fertility drugs (see section 5f) • Oral and injectable drugs associated with artificial insemination and IVF (3 cycles annually) procedures <p>Note: Prior Authorization required</p>	

Benefit Description	You pay
Allergy care <ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	<p>\$25 per primary care provider (PCP); visit for members 18 and older; \$0 for children under 18</p> <p>\$35 per specialist visit</p>
Allergy serum	\$0
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Provocative food testing</i> • <i>Sublingual allergy desensitization</i> 	<i>All charges</i>
Treatment therapies <ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 42.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy (Pulmonary rehabilitation) is provided for up to 20 visits per year • Cardiac rehabilitation following qualifying event/condition is provided for up to 36 visits per condition per year • Dialysis – hemodialysis and peritoneal dialysis • Cochlear therapy following cochlear implant up to 30 visits per year • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See <i>Other services under You need prior Plan approval for certain services</i> on page 16.</p> <ul style="list-style-type: none"> • Applied Behavior Analysis (ABA) - Children with autism spectrum disorder 	<p>\$35 per specialist visit</p> <p>\$50 per outpatient facility visit</p>
Physical and occupational therapies <p>Up to 60 per year for rehabilitative/habilitative physical /occupational therapy in any combination of the following:</p> <ul style="list-style-type: none"> • Qualified physical therapists • Occupational therapists • Physician • Licensed therapy provider <p>Services must be performed by a physician or by a licensed therapy provider.</p> <p>Note: We only cover therapy when a physician:</p> <ul style="list-style-type: none"> • orders the care; 	<p>You pay</p> <p>\$35 per specialist visit</p>

Physical and occupational therapies - continued on next page

Benefit Description	You pay
Physical and occupational therapies (cont.) <ul style="list-style-type: none"> • 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. <p>Benefits can be denied or shortened for covered persons who are not progressing in goal-directed rehabilitative services or if rehabilitation goals have not been met.</p> <p>We will pay benefits for up to 20 visits of cognitive rehabilitation therapy only when Medically Necessary following sudden External injuries such as car accidents or falls; or sudden internal injuries such as stroke (cerebral vascular accident), aneurysm, anoxia, encephalitis or brain tumors.</p> <p>All Therapies are subject to medical necessity.</p>	\$35 per specialist visit
<p>Habilitative Services - for children under age 19 with congenital or genetic birth defects. Treatment is provided to enhance the child's ability to function.</p> <p>Services include:</p> <ul style="list-style-type: none"> • Speech therapy • Occupational therapy; and • Physical therapy <p>Includes medically necessary rehabilitative services coverage for children with Autism, an Autism Spectrum disorder, or Cerebral Palsy</p> <p>Note: No day or visits apply to these services. A congenital disorder means a significant structural or functional abnormality that was present from birth</p>	\$35 per specialist visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Exercise programs 	<i>All charges</i>
Speech therapy	You pay
Up to 60 visits per calendar year for rehabilitative/habilitative speech therapy.	\$35 per specialist visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Exercise programs • Voice therapy 	<i>All charges</i>
Hearing services (testing, treatment, and supplies)	You pay
<ul style="list-style-type: none"> • For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist. • First hearing aid and testing only when necessitated by accidental injury. <p>Note: for routine hearing screening performed during a child's preventive care visit, see Section 5(a) Preventive care children</p> <ul style="list-style-type: none"> • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants <p>Note: for benefits for the devices, see Section (a) <i>Orthopedic and prosthetic devices.</i></p>	<p>\$25 per primary care provider (PCP) visit for members 18 and older; \$0 for children under 18</p> <p>\$35 per specialist visit</p>

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

Benefit Description	You pay
Hearing services (testing, treatment, and supplies) (cont.)	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • All other hearing aids and testing for them • Hearing services that are not shown as covered 	<i>All charges</i>
Vision services (testing, treatment, and supplies) <ul style="list-style-type: none"> Initial pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) Annual eye refraction exams <p>Note: Children examinations are covered at no charge as outlined in the Bright Future Guidelines provided by the American Academy of Pediatrics</p> <p><i>Replacement glasses or contact lenses are not covered after the initial pair.</i></p>	You pay <p>\$25 per primary care provider (PCP) visit for members 18 and older; \$0 for children under 18</p> <p>\$35 per specialist visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Eyeglasses or contact lenses, except as shown above • Eye exercises and orthoptics • Radial keratotomy and other refractive surgery 	<i>All charges</i>
Foot care <p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p>	You pay <p>\$25 per primary care provider (PCP) visit for members 18 and older; \$0 for children under 18</p> <p>\$35 per specialist visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • 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) 	<i>All charges</i>
Orthopedic and prosthetic devices <ul style="list-style-type: none"> • Artificial limbs and eyes • Prosthetic sleeve or sock • Orthopedic devices such as braces, medical supplies including colostomy supplies, dressings, urinary catheters and related supplies • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy • A hair prosthesis for hair loss resulting from chemotherapy or radiation treatment for cancer. There is a limit of one hair prosthesis per lifetime with a maximum cost of \$350. • Bone-anchored hearing aids (BAHA) are covered only when the member has either of the following: 	You pay <p>50% of the plan allowance</p>

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.) <ul style="list-style-type: none"> - Craniofacial anomalies in which abnormal or absent ear canals preclude the use of a wearable hearing aid; - Hearing loss of sufficient severity that it cannot be adequately remedied by a wearable hearing aid - Benefits limited to one bone anchored hearing aid per member, who meets the above coverage criteria, during the entire period of time the member is enrolled in the health plan. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome <p>Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.</p> <p>Note: Plan prior authorization required for items that cost \$1,000 or more.</p>	50% of the plan allowance
<i>Not covered:</i> <ul style="list-style-type: none"> • 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 • Speech prosthetics (except electrolarynx) • Prosthetic replacements provided less than 3 years after the last one we covered 	<i>All charges</i>
Durable medical equipment (DME) <p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • CPAP • Walkers • Blood glucose monitors • Insulin pumps <p>Note: Plan prior authorization is required for items that cost \$1,000 or more. Repairs and replacements are covered if needed due to a change in the member's medical condition. Call us at 877-835-9861 as soon as your Plan physician prescribes this equipment. We will arrange with a healthcare provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	50% of the plan allowance

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	50% of the plan allowance
<p><i>Not covered:</i></p> <p><i>Motorized wheelchairs</i></p> <p><i>Audible prescription reading devices</i></p> <p><i>Hearing aids</i></p> <p><i>Speech generating devices</i></p> <p><i>Talkers</i></p> <p><i>Story boards</i></p> <p><i>Scooters</i></p>	<i>All charges</i>
Home health services <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> - It must be delivered or supervised by a licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for safety of the patient - It is ordered by a physician - It is not delivered for the purpose of assisting with activities of daily living including dressing, feeding, bathing or transferring from a bed to a chair - It requires clinical training in order to be delivered safely and effectively - It is not custodial care • We will determine if benefits are available by reviewing both the skill nature of the service and the need for Physician directed medical management. A service will not be determined to be skilled simply because there is not an available caregiver. • Services include administration of oxygen therapy, intravenous therapy and medications • Limit of 60 visits per year <p>Prescription foods covered as follows:</p> <ul style="list-style-type: none"> • Amino acid modified preparations and low protein modified liquid food products for the treatment of inherited metabolic diseases which are prescribed for the therapeutic treatment of inherited metabolic diseases and are administered under the direction of a physician • Specialized formulas for the treatment of a disease or condition and are administered under the direction of a Physician • Medical foods which are determined to be the sole source of nutrition and cannot be obtained without a physician's prescription 	\$25 per visit \$25 per prescription food delivery
<i>Not covered:</i>	<i>All charges</i>

Home health services - continued on next page

Benefit Description	You pay
Home health services (cont.) <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family.</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> • <i>Private duty nursing</i> • <i>Foods that can be obtained over the counter (without a prescription) even if prescribed by a physician</i> 	<i>All charges</i>
Chiropractic <ul style="list-style-type: none"> • Diagnosis and related services for the manipulation of the spine and extremities to remove nerve interference or its effects. Limited to one treatment per day up to 20 visits per calendar year <p>Note: The interference must be the result of, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column.</p>	<i>50% of the plan allowance</i>
Alternative treatments <ul style="list-style-type: none"> Acupuncture – by a doctor of medicine or osteopathy, or licensed or certified acupuncture practitioner for up to 12 visits per year : • Dry Needling – by a licensed or certified practitioner 	<i>\$35 per specialist visit</i>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Naturopathic services</i> • <i>Hypnotherapy</i> • <i>Biofeedback</i> • <i>Massage Therapy</i> • <i>Herbal medicine</i> • <i>Rolfing</i> • <i>Ayurveda</i> • <i>Homeopathy</i> • <i>Other alternative treatments unless specifically listed as covered</i> 	<i>All charges</i>
Educational classes and programs <p>Coverage is provided for:</p> <p>Tobacco Cessation program which includes online learning, Quit Coach, Nicotine Replacement Therapy Coaching and over the counter and prescription drugs approved by the FDA (subject to age and treatment therapy recommendations) to treat tobacco dependence. Learn more about this program in Section 5(h) Wellness and other Special Features.</p> <ul style="list-style-type: none"> • Outpatient self-management training for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin using diabetes and other designated chronic health conditions. • Must be prescribed by a licensed healthcare professional who has appropriate state licensing authority 	<i>\$0</i> <i>\$25 per Primary Care Provider (PCP) visit for members 18 and older; \$0 for children under 18</i> <i>\$35 per specialist visit</i>

Educational classes and programs - continued on next page

Benefit Description	
Educational classes and programs (cont.)	You pay
<ul style="list-style-type: none">• Outpatient self management training includes, but is not limited to, education and medical nutrition therapy. The training must be provided by a certified registered or licensed healthcare professional trained in the care and management of diabetes.• Initial training visit; up to 10 hours, after you are diagnosed with diabetes for the care and management of diabetes	\$25 per Primary Care Provider (PCP) visit for members 18 and older; \$0 for children under 18 \$35 per specialist visit

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

	<p>Important things you should keep in mind about these benefits:</p> <ul style="list-style-type: none"> • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary. • Plan physicians must provide or arrange your care. • We have no deductible. • Be sure to read Section 4, <i>Your Costs for Covered Services</i>, for valuable information about how cost-sharing works. Also, read Section 9, <i>Coordinating benefits with other coverage</i>, including with Medicare. • The amounts listed below are for the charges <u>billed by a physician or other healthcare professional</u> for your surgical care. Look in Section 5(a) for charges associated with an office visit and Section 5(c) for charges associated with a facility (i.e. hospital, surgical center, etc.). • If you enroll in UnitedHealthcare Choice Open Access are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a \$150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.) • YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SERVICES AND/OR PROCEDURES. Please refer to the preauthorization information shown in Section 3 or call customer service to be sure which services require preauthorization. 	
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Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see <i>Reconstructive surgery</i>) • Insertion of internal prosthetic devices. See 5(a) <i>Orthopedic and prosthetic devices</i> for device coverage information • Treatment of burns Note: For female surgical family planning procedures see Family Planning Section 5(a)	\$35 per specialist visit
Note: For male surgical family planning procedures see Family Planning Section 5(a)	
Voluntary sterilization women (tubal ligation)	\$0
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; (see Foot care)</i> 	<i>All charges</i>

Benefit Description	You pay
<p>Bariatric Surgery</p> <p>Surgical treatment of severe morbid obesity (bariatric surgery)</p> <p>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</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> - 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: <ul style="list-style-type: none"> - 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 	\$35 per specialist visit
<p>Revisionsal Bariatric Surgery due to a technical failure or major complication from the initial procedure; potential failure/complications include but are not limited to the following:</p> <ul style="list-style-type: none"> • Bowel perforation (including adjustable gastric band erosion) • Adjustable gastric band migration (slippage) that cannot be corrected with manipulation or adjustment (records must demonstrate that manipulation or adjustment to correct band slippage has been attempted) • Leak • Obstruction (confirmed by imaging studies) • Staple-line failure • Mechanical adjustable gastric band failure • Uncontrollable reflux related to sleeve gastrectomy when all the following criteria are met: <ul style="list-style-type: none"> - Maximum nonpharmacological medical management failure (e.g., positional, dietary modification and behavioral changes); and - Maximum pharmacological medical management failure (e.g., at least one month of double dose PPI, H₂ blocker, and/or sucralfate); and - Severe esophagitis (grade C or D) confirmed by endoscopy despite maximum medical management 	\$35 per specialist visit

Benefit Description	You pay
Bariatric Surgery (cont.) <p>The individual must also meet the following criteria:</p> <p>Both of the following:</p> <ul style="list-style-type: none"> • Completion of a preoperative evaluation that includes a detailed weight history along with dietary and physical activity patterns; a • 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 	\$35 per specialist visit
Iatrogenic infertility services <p>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.</p> <p>Covered benefits include the following procedures:</p> <ul style="list-style-type: none"> • Collection of sperm • Cryo-preservation of sperm • Oocyte cryo-preservation • Embryo cryo-preservation • Ovarian stimulation, retrieval of eggs and fertilization <p>Benefits are not available for:</p> <ul style="list-style-type: none"> • Embryo transfer • Long-term storage costs (greater than 1 year) • Elective fertility preservation. <p>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.</p> <p>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.</p>	\$35 per specialist visit
Reconstructive surgery <ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - 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: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; 	\$35 per specialist visit

Reconstructive surgery - continued on next page

Benefit Description	
Reconstructive surgery (cont.)	You pay
<ul style="list-style-type: none"> - breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>) <p>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.</p>	\$35 per specialist visit
<p>Gender Affirming Surgery</p> <p>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]).</p> <p>Requirements:</p> <ul style="list-style-type: none"> • Must be 18 years of age or older • Must have documented evidence of persistent gender dysphoria • Favorable psychosocial-behavioral evaluation to provide screening and identification of risk factors or potential postoperative challenges • Persistent, well-documented Gender Dysphoria • Capacity to make a fully informed decision and to consent for treatment • Complete at least 12 months of successful continuous full-time real-life experience in the desired gender • Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated) • Treatment plan that includes ongoing follow-up and care by a Qualified Behavioral Health Provider experienced in treating Gender Dysphoria* 	\$35 per specialist visit
<p>Gender reconstructive surgeries include:</p> <ul style="list-style-type: none"> • Bilateral mastectomy or breast reduction • Breast augmentation with breast implants or fat transfer • Chest and breast surgery including bilateral mastectomy • Clitoroplasty (creation of clitoris) • Hysterectomy (removal of uterus) • Labiaplasty (creation of labia) • Laser or electrolysis hair removal in advance of genital reconstruction prescribed by a physician for the treatment of Gender Dysphoria • Metoidioplasty (creation of penis, using clitoris) • Orchiectomy (removal of testicles) • Penectomy (removal of penis) • Penile prosthesis • Phalloplasty (creation of penis) • Salpingo-oophorectomy (removal of fallopian tubes and ovaries) • Scrotoplasty (creation of scrotum) • Testicular prostheses 	

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.) <ul style="list-style-type: none"> • Thyroid cartilage reduction/reduction thyroid chondroplasty/tracheal shave (removal or reduction of the Adam's apple) • Urethroplasty (reconstruction of female urethra) • Urethroplasty (reconstruction of male urethra) • Vaginectomy (removal of vagina) • Vaginoplasty (creation of vagina) • Voice lessons and/or voice therapy • Voice modification surgery (e.g., laryngoplasty, glottoplasty or shortening of the vocal cords) • Vulvectomy (removal of vulva) • Gender Affirming Facial Surgeries • Travel and Lodging (\$2000 maximum) 	\$35 per specialist visit
<p>Note: Prior Authorization is required</p> Oral and maxillofacial surgery	You pay
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Dental care necessary to release pain in treatment of temporomandibular joint pain dysfunction; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. 	\$35 per specialist visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<i>All charges</i>
Temporomandibular joint dysfunction (TMJ) <p>Services for the evaluation and treatment of TMJ and associated muscles</p> <ul style="list-style-type: none"> • Diagnosis: Exam, radiographs and applicable imaging studies and consultation. • Non-surgical treatment including: Clinical exams, Oral appliances (orthotic splints), Arthrocentesis, Trigger-point injections <p>Benefits are provided for surgical treatment if the following criteria are met:</p> <ul style="list-style-type: none"> • There is radiographic evidence of joint abnormality • Non-surgical treatment has not resolved the symptoms • Pain or dysfunction is moderate or severe. 	\$35 per specialist visit

Temporomandibular joint dysfunction (TMJ) - continued on next page

Benefit Description	You pay
Temporomandibular joint dysfunction (TMJ) (cont.) <p>Benefits for surgical services include:</p> <ul style="list-style-type: none"> • Arthrocentesis • Arthroscopy • Arthroplasty • Arthrotomy • Open or closed reduction of dislocations <p>Services are limited to \$3,000 for all TMJ services - facility fees, durable medical and pharmacy fees will apply</p>	\$35 per specialist visit
Organ/tissue transplants <p>These solid organ transplants are covered. Solid organ transplants are limited to:</p> <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> - 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 <p>These tandem blood or marrow stem cell transplants for covered transplants are subject to medical review by the Plan. Refer to <i>Other services</i> in Section 3 for your authorization procedures.</p> <ul style="list-style-type: none"> • Autologous tandem transplants for <ul style="list-style-type: none"> - AL Amyloidosis - Multiple myleoma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer) 	\$35 per specialist visit
Blood or marrow stem cell transplants <p>the plan extends coverage for the diagnoses as indicated below:</p> <ul style="list-style-type: none"> • Allogenic transplants for <ul style="list-style-type: none"> - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma 	\$35 per specialist visit

Organ/tissue transplants - continued on next page

Benefit Description	
Organ/tissue transplants (cont.)	You pay
<ul style="list-style-type: none"> - 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/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome 	\$35 per specialist visit
<ul style="list-style-type: none"> • Autologous transplants for <ul style="list-style-type: none"> - 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 - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors 	\$35 per specialist visit
<p>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.</p> <p>Refer to <i>Other services</i> in Section 3 for prior authorization procedures:</p>	\$35 per specialist visit

Organ/tissue transplants - continued on next page

Benefit Description	You pay
<p>Organ/tissue transplants (cont.)</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - 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 <ul style="list-style-type: none"> - 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 	\$35 per specialist visit
<p>These blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence if approved by the Plan's medical director in accordance with the Plan's protocols.</p>	\$35 per specialist visit
<p>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.</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Sickle Cell Anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning RIC) for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia 	

Organ/tissue transplants - continued on next page

Benefit Description	
Organ/tissue transplants (cont.)	You pay
<ul style="list-style-type: none"> - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myelodysplasia/Myelodysplastic Syndromes - Myeloproliferative disorders (MDDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle Cell anemia • Autologous Transplants for <ul style="list-style-type: none"> - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin's lymphoma - Breast Cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early 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 <p>National Transplant Program (NTP) - OptumHealth Care Solutions (URN) used for organ tissue transplants</p>	\$35 per specialist visit

Organ/tissue transplants - continued on next page

Benefit Description	
Organ/tissue transplants (cont.)	You pay
<p>Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute - or National Institutes of Health - approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor. Transplants must be provided in a Plan designated Center for Transplants. These centers do a large volume of these procedures each year and have a comprehensive program of care. A listing of these centers can be found in the Plan Directory of Health Care Providers, at our member web site www.myuhc.com or call our Customer Service Department at 1-877-835-9861 to request an up-to-date listing.</p>	\$35 per specialist visit
<p>Note: Donor testing for bone marrow/stem cell transplants for up to 4 potential donors whether family or non-family</p>	50% of the plan allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except as shown above</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> • <i>All services related to non-covered transplants</i> • <i>All services associated with complications resulting from the removal of an organ from a non-member</i> 	<i>All charges</i>
Anesthesia	You pay
<p>Professional services provided in:</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital (outpatient department) • Skilled nursing facility • Ambulatory surgical center • Office 	\$35 per specialist visit

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

	<p>Important things you should keep in mind about these benefits:</p> <ul style="list-style-type: none"> • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary. • Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility. • We have no deductible. • Be sure to read Section 4, <i>Your Costs for Covered Services</i> for valuable information about how cost-sharing works. Also, read Section 9, <i>Coordinating benefits with other coverage</i>, including with Medicare. • The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b). • If you enroll in UnitedHealthcare Choice Open Access are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a \$150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.) • YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SERVICES AND/OR PROCEDURES. Please refer to the preauthorization information shown in Section 3 or call customer service to be sure which services require preauthorization. 	
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Benefit Description	You pay
Inpatient hospital	
Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	\$150 per day up to \$750 per admission
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	\$0
<i>Not covered:</i> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools 	<i>All charges</i>

Inpatient hospital - continued on next page

Benefit Description	
You pay	
Inpatient hospital (cont.)	
<ul style="list-style-type: none"> • Personal comfort items, such as phone, television, barber services, guest meals and beds • Private nursing care unless medically necessary 	All charges
Outpatient hospital or ambulatory surgical center	You pay
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>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.</p>	\$150 per outpatient surgical charge at approved free standing surgical facility \$300 per outpatient surgical charge at hospital
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	All charges
Extended care benefits/Skilled nursing care facility benefits	You pay
<ul style="list-style-type: none"> • Room and board in a semi-private room • General nursing • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor • Benefits up to 60 days when full time skilled nursing care is necessary and confinement is medically appropriate. 	\$0 when transferred directly from inpatient \$150 per day for up to \$750 per admission if not transferring from inpatient
<i>Not covered: Custodial care</i>	All charges
Hospice care	You pay
<ul style="list-style-type: none"> • Inpatient care • Outpatient care • Family counseling • Supportive and palliative care for a terminally ill member is covered in the home or hospice 	\$0 when transferred directly from hospital \$150 per day up to 5 days per admission to facility if not transferring from hospital
<i>Not covered: Independent nursing, homemaker services</i>	All charges
Ambulance	You pay
Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities only when the transport meets one of the following: <ul style="list-style-type: none"> • From an out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required. 	\$0

Ambulance - continued on next page

Benefit Description	
Ambulance (cont.)	You pay
<ul style="list-style-type: none"> • 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. 	\$0
<p>For the purpose of this Benefit the following terms have the following meanings:</p> <ul style="list-style-type: none"> • "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting. • "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness. • "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis. 	
<i>Not Covered:</i>	<i>All charges</i>
<i>International Transportation</i>	

Section 5(d). Emergency Services/Accidents

	<p>Important things you should keep in mind about these benefits:</p> <ul style="list-style-type: none"> • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary. • We have no deductible. • If you enroll in UnitedHealthcare Choice Open Access are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a \$150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.) • Be sure to read Section 4, <i>Your Costs for Covered Services</i>, for valuable information about how cost-sharing works. Also, read Section 9, <i>Coordinating benefits with other coverage</i>, including with Medicare. 	
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What is a medical emergency?

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

What to do in case of emergency:

Emergencies within or outside our service area

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

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

Benefit Description	You pay
Emergency within or outside our service area	
• Emergency care at a doctor's office	\$25 per primary care provider (PCP) visit; \$35 per specialist visit
• Emergency care at an urgent care center	\$35 per visit
• Emergency care as an outpatient at a hospital, including doctors' services	\$350 per visit
Note: We waive the ER copay if you are admitted to the hospital.	
Not covered:	<i>All charges</i>

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

Benefit Description	
Emergency within or outside our service area (cont.)	You pay
<ul style="list-style-type: none"> • Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers • Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area • Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area 	<i>All charges</i>
Ambulance - Emergency	You pay
Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance or water vehicle) to the nearest Hospital where the required Emergency Health Care Services can be performed.	\$500 copayment for Air Ambulance
Not Covered:	<i>All Charges</i>
International Transportation	

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

	<p>You need to get Plan approval (preauthorization) for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance use disorder benefits are no greater than for similar benefits for other illnesses and conditions.</p> <p>Important things you should keep in mind about these benefits:</p> <ul style="list-style-type: none"> • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary. • Be sure to read Section 4, <i>Your Costs for Covered Services</i>, for valuable information about how cost-sharing works. Also, read Section 9, <i>Coordinating benefits with other coverage</i>, including with Medicare. • We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required • OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another. • YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SERVICES AND/OR PROCEDURES. Please refer to the preauthorization information shown in Section 3 or call customer service to be sure which services require preauthorization. • If you enroll in UnitedHealthcare Choice Open Access are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a \$150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.) 	
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Benefit Description	You pay
Professional Services	You pay
<p>When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.</p> <p>Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include:</p> <ul style="list-style-type: none"> • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits in office or telemedicine) 	<p>Your cost-sharing responsibilities are no greater than for other illnesses or conditions.</p> <p>\$25 per visit \$150 per day up to 5 days per inpatient admission</p>

Professional Services - continued on next page

Benefit Description	You pay
Professional Services (cont.) <ul style="list-style-type: none"> • Diagnosis and treatment of substance abuse disorders, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy 	\$25 per visit \$150 per day up to 5 days per inpatient admission
Diagnostics	You pay
<ul style="list-style-type: none"> • 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 	\$0
Inpatient Hospital or other covered facility	You pay
Inpatient services provided and billed by a hospital or other covered facility <ul style="list-style-type: none"> • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Services in approved half-way house, residential treatment, full-day hospitalization, partial hospitalization 	\$150 per day up to 5 days per admission
Outpatient hospital or other covered facility	You pay
Outpatient services provided and billed by a hospital or other covered facility <ul style="list-style-type: none"> • Services in facility-based intensive outpatient treatment 	\$0 per visit
Not covered	You pay
<ul style="list-style-type: none"> • <i>Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan physician to be necessary and appropriate</i> • <i>Services and supplies when paid for directly or indirectly by a local, State, or Federal Government agency.</i> • <i>Room and board at therapeutic boarding schools</i> • <i>Services rendered or billed by schools</i> • <i>Services that are not medically necessary</i> • <i>Methodone maintenance unless it is a part of an approved treatment program</i> 	<i>All charges</i>

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

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

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

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice.
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy. Retail or mail order Specialty Pharmacy drugs are only filled at our Specialty Pharmacy. Some drugs are only available at the retail pharmacy for safety or other reasons. To locate the name of a Plan pharmacy near you, call our Customer Service Department 877-835-9861 or visit our website, www.uhcfeds.com. The PDL consists of Tiers 1, 2, 3 and 4.
- **We use a Prescription Drug List (PDL) called the Advantage PDL.** Our PDL Management Committee creates this list that includes FDA approved prescription medications, products, or devices. Our Plan covers all prescription medications written in accordance with FDA guidelines for a particular therapeutic indication except for medications listed under "Not Covered" in this section of the brochure as well as specific drug exclusions. The PDL Management Committee decides the tier placement based upon clinical information from the UnitedHealthcare Pharmacy and Therapeutics (P economic and financial considerations. You will find important information about our PDL as well as other Plan information on our member web site www.myuhc.com or our pre-member website at www.uhcfeds.com along with a listing of specific drug exclusions and medications that are recommended. Please familiarize yourself with the Advantage PDL as it offers both generic and brand drug on all of its tiers. Specialty drugs are on separate tiers described below.
- **The PDL consists of Tiers 1, 2, 3 and 4.**
 - **Tier 1** is your **lowest** co-payment option (\$10 for up to a 30-day supply or \$25.00 for up to a 90-day supply through mail order), and includes a **number of generic medications, as well as select preferred brand medications**. Brand medications in Tier 1 include select insulin products, select inhalers for asthma, and select medications for migraine headaches for which no generic alternative(s) are available. For the lowest out-of-pocket expense, you should always consider Tier 1 medications if you and your provider decide they are appropriate for your treatment.
 - **Tier 2** is your **middle** co-payment option (\$50 for up to a 30-day supply or \$125 for up to a 90-day supply through mail order), and contains a **preferred brand medications not included in Tier 1**. Preferred medications placed in Tiers 1 and 2 are those the PDL Management Committee has determined to provide better overall value than those in Tier 3. If you are currently taking a medication in Tier 2, ask your provider whether there are Tier 1 alternatives that may be appropriate for your treatment.

- **Tier 3** is your **higher** co-payment option (**\$100** for up to a 30-day supply or **\$250.00** for up to a 90-day supply through mail order), and consists of non-preferred medications. Sometimes there are alternatives available in Tier 1 or Tier 2. If you are currently taking a medication in Tier 3, ask your provider whether there are Tier 1 or Tier 2 alternatives that may be appropriate for your treatment.
 - **Tier 4** is your **highest** co-payment option (**\$200** for up to a 30-day supply or **\$500.00** for up to a 90-day supply through mail order) non-preferred medications that do not add clinical value over their covered Tier 1, Tier 2, or Tier 3 alternatives. Some medications on Tier 4 may also have an over-the-counter alternative which can be purchased without a prescription.
- **Mandatory Specialty Pharmacy Program:** Our Specialty Pharmacy Program is designed to address the rare, complex and life threatening diseases. We want to make these medications accessible and cost effective for our members. That's why we offer the Specialty Pharmacy Program. This program supports the health care provider/patient relationship and provides focused support to help better manage rare and complex conditions by offering:**Members who have been prescribed specialty medications must obtain these medications from one of the designated specialty pharmacies.** Prescriptions for specialty medications must be filled for a maximum of a 30-day supply. To locate a specialty pharmacy for your particular needs members can contact customer service at 877-835-9861 and you will be connected to the specialty pharmacy. Your specialty pharmacy will be able to help you transfer your active prescriptions from your current pharmacy. If you're out of refills, the specialty pharmacy will contact your doctor to get a new prescription.
- **Better use of benefits** — Members can make the most of their health benefits by getting the right specialty medications from our network providers when they need them.
 - **Specialty pharmacies and home health care providers** — Our network providers have the resources and expertise needed to store and dispense specialty medications and ancillary supplies.
 - **Expert support** — Members get 24/7 telephone access to specially trained pharmacists who can provide answers, patient education materials, proactive refill monitoring, counseling on side effects and more.
 - **Individualized services** — experienced nurses and pharmacists trained in specialty medications and rare and complex conditions offer personalized therapy support that can lead to better health outcomes.
 - **Supplies, such as sharps containers, needles, syringes** and tubing necessary to administer an injectable specialty drug are provided at **no cost** to you by the specialty pharmacy. Talk with your specialty pharmacy to learn more.
 - **Costs for Specialty Drugs are as follows for 30-day supply**
 - **Tier 1 - \$10**
 - **Tier 2 - \$150**
 - **Tier 3 - \$350**
 - **Tier 4 - \$500**

Changes to Tier level for all covered medications and supplies may occur January 1 and July 1 of each year. Newly marketed brand medications will be evaluated by our PDL Management Committee and then they will be placed in the appropriate Tier. A prescription medication may be moved to the 4th tier of PDL at anytime if the medication changes to over-the-counter status, or removed from the PDL due to safety concerns declared by the Food and Drug Administration (FDA).

These are the dispensing limitations.

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

- Changes to quantity duration and quantity level limits may occur on January 1 and July 1 of each year. We base these processes upon the manufacturer's package size, FDA-approved dosing guidelines as defined in the product package insert and/or the medical literature or guidelines that support the use of doses other than the FDA-recommended dosage. If your prescription written by your provider exceeds the allowed quantity, please refer to Section 8, to file an appeal with the Plan.
- **Day Supply:** “Day supply” means consecutive days within the period of prescription. Where a prescription regimen includes “on and off days” when the medication is taken, the off days are included in the count of the day supply.
- **Injectable medications:** Medications typically covered under the pharmacy benefit and received through a retail or mail order pharmacy are those that are self-administered by you or a non-skilled caregiver. However, injectable medications that are typically administered by a health care professional are covered under your Medical benefit and need to be accessed through your provider or Specialty pharmacy. Contact the Health Plan at 1-877-835-9861 for more information on these medications.
- **Special dispensing circumstances:**
 - The Plan will give special consideration to filling prescription medications for members covered under the FEHB if:
 - You are called to active duty, or
 - You are officially called off-site as a result of a national or other emergency, or
 - You are going to be on vacation for an extended period of time
- **Specific drug exclusions:** The plan will exclude higher cost medications that have therapeutic alternatives available and do not offer any additional clinical value over other options in their class. These drugs cost significantly more than those alternatives. A listing of these drugs can be found on www.uhcfeds.com or you may call customer service at 1-877-835-9861 and they will provide a copy to you.
- Your physician may need to request prior authorization from us in order to fill a prescription for the reasons listed above. Please contact us at 877-835-9861 for additional information.
- **Refill Frequency:** A process that allows you to receive a refill once when you have used 75 percent of the medications for most drugs. For example, a prescription that was filled for a 30-day supply can be refilled after 24 days. While this process provides advancement on your next prescription refill, we cannot dispense more than the total quantity your prescription allows.
- **Half Tablet Program:** With certain medications, you may elect to join the voluntary Half Tablet Program. This Program allows you to save money in co-payments by electing a double strength medication, receiving half the quantity, and splitting the tablet in half. If you take advantage of this Program, you will pay half a co-payment at a retail pharmacy or through mail order. Your provider must write the prescription for the increased dosage, with the instructions to “take a half tablet”. A free tablet splitter is provided. For more information on this Program please contact customer service.
- **Why use Tier 1 drugs?** Medications in Tier 1 offer the best health care value and are available at the lowest co-payment. Tier 2 medications are available at a higher co-payment and Tier 3 and Tier 4 medications are available at the highest co-payment levels. This approach helps to assure access to a wide range of medications and control health care costs for you.

Benefit Description	You pay
<p>Preventive care medications</p> <p>Note: Note: Preventive Medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a health care professional and filled by a network pharmacy.</p> <p>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</p> <p>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.</p>	\$0

Preventive care medications - continued on next page

Benefit Description	
Preventive care medications (cont.)	You pay
<ul style="list-style-type: none"> • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 & 800 mcg • Liquid iron supplements for children age 0-1 year • Pre-natal vitamins for pregnant women • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 • Certain statins to treat cardiovascular disease for adults age 40 to 75 will be covered without a copayment as recommended by the United States Preventive Services Task force (USPSTF) when the following criteria is met: Age 40 to 75 years; and one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and a calculated 10-year risk of a cardiovascular event of 10% or greater. <p>Note: To receive this benefit a prescription from a doctor must be presented to pharmacy. Benefits available at in-network pharmacy only.</p>	\$0
Covered medications and supplies	You pay
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medications that by Federal law of the United States require a physician's prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin with a copayment charge applied every 2 vials • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction are limited. Contact the plan for dosage limits. • Drugs to treat gender dysphoria* <ul style="list-style-type: none"> - Estradiol - testosterone - leuprolide • Oral and injectable contraceptive drugs • Drugs used for Gender Dysphoria - may require prior authorization and may be covered under the specialty drug benefits • oral and injectable drugs associated with artificial insemination and IVF (3 cycles annually) procedures • Medications prescribed to treat obesity* <ul style="list-style-type: none"> - Saxenda - Wegovy - Zepbound <p>Prior Authorization is required</p> <p>Note: Intravenous fluids and medications for home use, implantable drugs, and some injectable drugs are covered under <i>Medical services and supplies Section (5a)</i> or <i>Surgical and anesthesia services Section (5b)</i>.</p>	<p>Plan retail pharmacy up to a maximum of a 30-day supply:</p> <p>Tier 1- \$10</p> <p>Tier 2- \$50</p> <p>Tier 3- \$100</p> <p>Tier 4 -\$200</p> <p>Plan mail order pharmacy for up to a maximum of up to a 90-day supply:</p> <p>Tier 1- \$25</p> <p>Tier 2- \$125</p> <p>Tier 3- \$250</p> <p>Tier 4- \$500</p>

Covered medications and supplies - continued on next page

Benefit Description	
Covered medications and supplies (cont.)	You pay
<p><i>*For a complete list of drugs and medications, visit www.uhcfeds.com or call our Customer Service Department 877-835-9861</i></p>	<p>Plan retail pharmacy up to a maximum of a 30-day supply:</p>
	Tier 1- \$10
	Tier 2- \$50
	Tier 3- \$100
	Tier 4 - \$200
	<p>Plan mail order pharmacy for up to a maximum of up to a 90-day supply:</p>
	Tier 1- \$25
	Tier 2- \$125
	Tier 3- \$250
	Tier 4- \$500
Specialty Medications (up to a 30-day supply)	<p>Tier 1 \$10</p>
	Tier 2 \$150
	Tier 3 \$350
	Tier 4 \$500
COVID-19 Over The Counter (OTC) Test Kits	Tier 3 -\$12 Capped
<ul style="list-style-type: none"> • 8 Tests per member per month 	
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines .	\$0
<p>Contraceptive coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below.</p> <ul style="list-style-type: none"> • Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy. • If you have difficulty accessing contraceptive coverage or other reproductive healthcare you can contact contraception@opm.gov. • Reimbursement for over-the-counter contraceptives can be submitted in accordance with Section 7. By completing a claim form and submitting the form with receipts to OptumRx, PO Box 29044, Hot Springs, AZ 71903. You can reach out to customer service at 877-835-9861 to obtain a prescription drug claim form. • Members may have a clinical review for contraceptives that are excluded. They should reach out to their prescribing provider. Contraceptive products that are not already available at \$0 cost-share can be provided at \$0 member cost-share if the provider determines that a particular contraceptive is medically necessary for that member. The cost-share waiver process requires that providers attest the product is needed for contraceptive purposes and this can be submitted electronically by the provider 	

Covered medications and supplies - continued on next page

Benefit Description	
Covered medications and supplies (cont.)	You pay
Note: For additional Family Planning benefits see Section 5(a)	\$0
<ul style="list-style-type: none"> • Diabetic supplies limited to insulin syringes, needles, glucose test tape, Benedict's solution or equivalents and acetone test tablets. 	50% of the plan allowance
<p>Prescription tobacco cessation medications and FDA approved over the counter tobacco cessation medications with prescription from physician. Note quantity limits and age restrictions may apply.</p> <p>Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Educational Classes and Programs in Section 5(a)</p>	\$0
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies used for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed</i> • <i>Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them</i> • <i>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</i> • <i>Compound drugs that do not contain at least one covered ingredient that requires a Prescription Order or Refill</i> • <i>Alcohol swabs and bio-hazard disposable containers</i> • <i>Medical Marijuana</i> • <i>Drugs for sexual performance for patients that have undergone genital reconstruction</i> • <i>Nonprescription medications unless specifically indicated elsewhere</i> 	<i>All charges</i>
<p>Opioid rescue agents such as naloxone are covered under this Plan with no cost sharing when obtained from a [network] pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections.</p> <p>For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose</p> <p>Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/</p>	\$0

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

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

Benefit Description	You Pay
Accidental injury benefit <p>We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury and</p> <ul style="list-style-type: none"> • The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. You may request an extension of this time period provided you do so within 60 days of the injury and if extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wire from fracture care.) • Benefits for treatment of accidental injury are limited to the following: <ul style="list-style-type: none"> - Emergency examination - Necessary X-rays - Endodontic (root canal) treatment - Temporary splinting of teeth - Prefabricated post and core - Simple minimal restorative procedures (fillings) - Extractions - Placement of a crown if such treatment is the only clinical treatment and in cases of an injury as described above in this section - Replacement of lost teeth due to injury - Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry 	High Option

Accidental injury benefit - continued on next page

Benefit Description	You Pay
Accidental injury benefit (cont.)	High Option
<p>A sound natural tooth is defined as a tooth that:</p> <ul style="list-style-type: none"> • has no active decay, has at least 50% bony support, • has no filling on more than two surfaces; • has no root canal treatment, is not an implant • is not in need of treatment except as a result of the accident, and • functions normally in chewing and speech. • Crowns, bridges, implants and dentures are not considered sound natural teeth 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and related procedures, including bone grafts to support implants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival and aveolar bone)</i> 	<i>All charges</i>
Adjunctive dental	High Option
<p>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.</p> <p>Examples of adjunctive dental care are:</p> <ul style="list-style-type: none"> • 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 <p>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.</p>	\$35 per specialist visit

Section 5(h). Wellness and Other Special features

Feature	Description
UnitedHealthcare's Digital Experience	<p>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</p> <p>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.</p> <p>Download the UnitedHealthcare app* for access to health plan ID cards, benefits information and help answering questions.</p> <p>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</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Download the UnitedHealthcare app from the App Store® or Google Play™</p> <p>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:</p> <p>Your personalized website, myuhc.com®, features tools designed to help you:</p> <ul style="list-style-type: none"> • Find, price and save on care — you can save with Virtual Visits and other tools. You can save an average of 36% * 1 when you compare costs for providers and services • Get care from anywhere with Virtual Visits. A doctor can diagnose common conditions by phone or video 24/7 • Understand your benefits and the financial impact of care decisions • Find tailored recommendations regarding providers, products and services. You can even generate an out-of-pocket estimate based on your specific health plan status • Access claim details, plan balances and your health plan ID card quickly • Follow through on clinical recommendations and access wellness programs • Order prescription refills, get estimates and compare medication pricing • Check your plan balances, access financial accounts and more • Find a quality doctor, clinic, hospital or lab that helps meet their needs. • Use multiple search options to filter results by location, specialty, quality, cost, services offered and more. • See provider ratings created by patients. • Review cost and care options before making an appointment to help control spending and choose the right level of service. • Access personalized cost and provider information specific to the benefit plan.

Myuhc.com Behavioral Health Resources	<p>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.</p> <p>Find the right care for you Using the provider search tool, you can:</p> <ul style="list-style-type: none"> • 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 <p>Tap into behavioral health support</p> <p>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.</p> <p>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</p> <ul style="list-style-type: none"> • You'll get access to: • Articles • Podcasts • Videos • Other tools <p>To find behavioral health care, sign in or register on myuhc.com and then go to Find Care Behavioral Health Directory</p>
Sanvello/ Self Care by Able To	<p>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.</p> <ul style="list-style-type: none"> • Assessments and tracking • Mental health skills and tools – Cognitive Behavioral Therapy skills, meditations 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.
Real Appeal - A Lifestyle and Weight Management Program	<p>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.</p> <p>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.</p> <p>Real Appeal includes:</p> <p>Social community resources such as: Real Appeal LinkedIn community; Facebook community; YouTube videos including getting started, workouts and success stories</p> <p>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:</p> <ul style="list-style-type: none"> • Balanced Portion plate • Electronic food scale • Digital weight scale

	<ul style="list-style-type: none"> • Fitness guide <p>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.</p> <p>24/7 online support and mobile app through our myuhc portal or directly through our myuhc mobile app. Staying accountable to goals may be easier than ever..</p> <ul style="list-style-type: none"> • Customizable food, activity, weight and goal trackers. • Unlimited access to digital content. • An online lifestyle program to help you learn new ways to be your healthiest self
Smoking Cessation Program	<p>Quit for Life provides our members with resources and support for tobacco cessation. Included are:</p> <ul style="list-style-type: none"> • 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) <p>Get started today. Go to myuhc.com, visit the "Health Resources" tab on the top right, Choose the "Quit for Life" tile.</p>
Maternity Health Solutions	<p>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.</p> <ul style="list-style-type: none"> • Maternity-related courses available on myuhc.com regarding course topics such as: <ul style="list-style-type: none"> - 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	<p>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.</p> <p>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.</p> <ul style="list-style-type: none"> • Premium Care Physician meets UnitedHealth Premium program quality & cost efficient care criteria.

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	<ul style="list-style-type: none"> • Quality Care Physician meets UnitedHealth Premium program quality care criteria, but does not meet the program's cost efficient care criteria or is not evaluated for cost-efficient care. Physician is not eligible for a Premium designation. • Not Evaluated for Premium Care physician's specialty is not evaluated and/or does not have enough claims data for program evaluation or the physician's program evaluation is in process
Specialty Pharmacy	<p>What are the benefits of using Optum Specialty Pharmacy?</p> <p>Optum Specialty Pharmacy provides personalized support and resources at no extra cost to help you manage your condition.</p> <p>How does Optum Specialty Pharmacy support you?</p> <ul style="list-style-type: none"> • 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 <p>Tips for working with our Optum Specialty Pharmacy care team.</p> <ul style="list-style-type: none"> • 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. <p>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.</p>
Flexible Benefits Option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claims process (see Section 8).
Cancer Clinical Trials	<p>To be a qualifying clinical trial, a trial must meet the following criteria:</p> <p>Be sponsored and provided by a cancer center that has been designated by the <i>National Cancer Institute (NCI)</i> as a <i>Clinical Cancer Center</i> or <i>Comprehensive Cancer Center</i> or be sponsored by any of the following:</p> <ul style="list-style-type: none"> • <i>National Institutes of Health (NIH)</i>. (Includes <i>National Cancer Institute (NCI)</i>.)

	<ul style="list-style-type: none"> • Centers for Disease Control and Prevention (CDC). • Agency for Healthcare Research and Quality (AHRQ). • Centers for Medicare and Medicaid Services (CMS). • Department of Defense (DOD). • Veterans Administration (VA). • The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals. Benefits are not available for preventive clinical trials. • The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.
Medicare Part B Reimbursement for Retiree Advantage Members	<p><i>Receive reimbursement for your Medicare Part B Premium</i></p> <ul style="list-style-type: none"> • <i>\$150.00 will be paid on your behalf directly to Medicare</i> • <i>See a reduction in your quarterly Medicare bill, or an increase in your Social Security payment or annuity payment</i> <p><i>Receive this benefit for every month you're enrolled in the plan</i></p>
Renew Active Fitness Program for Retiree Advantage Members:	<p>Renew Active is a fitness benefit which is included in the Medicare Advantage plan which provides:</p> <ul style="list-style-type: none"> • A free gym membership to participating facilities <ul style="list-style-type: none"> - To view participating facilities, please visit www.uhcrenewactive.com • Access to an extensive network of gyms and fitness locations near members • A personalized fitness plan • Access to a wide variety of fitness classes • An online brain health program, exclusively from AARP® Staying Sharp • Connecting with others at local health and wellness events, and through the Fitbit® Community for Renew Active
First Line Essentials for Retiree Advantage Members	<p><i>Shop for hundreds of over-the-counter items such as toothpaste, vitamins, and personal care from the Health Products catalog.</i></p> <ul style="list-style-type: none"> • <i>Members will receive \$40 allowance each quarter to spend on items from the provided catalog</i> • <i>Items are delivered directly to your door</i> • <i>Orders can be placed over the phone, by mail, or online</i>
House Calls for Retiree Advantage Members	<p>With the UnitedHealthcare® HouseCalls program, you get an annual in-home preventive care visit from one of our health care practitioners at no extra cost.</p> <p>What does HouseCalls include?</p> <ul style="list-style-type: none"> • One 45 to 60-minute at-home visit from a health care practitioner, each year. • A head-to-toe exam, health screenings and plenty of time to talk about your health questions. • A custom care plan made just for you. • Help connecting you with additional care you may need.
Healthy at Home for Retiree Advantage Members	<p><i>Healthy at Home provides the following benefits up to 30 days following all inpatient and skilled nursing facility discharges when referred by a UnitedHealthcare Advocate:</i></p> <ul style="list-style-type: none"> • <i>Home-Delivered Meals</i> <i>Receive 28 home-delivered meals provided by Mom's Meals</i>

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	<ul style="list-style-type: none"> • <i>Non-emergency transportation</i> Receive 12 one-way rides to medically related appointments and to the pharmacy provided by ModviCare • <i>In-home Personal Care</i> • <i>Receive 6 hours of in-home personal care through our exclusive national provider CareLinx</i>
Real Appeal for Retiree Advantage Members	<p>Real Appeal is a weight loss program that can help members feel and look better. The program provides everything they need to lose weight and keep it off. This program is a pilot for select members residing in Wisconsin.</p> <p>The online program includes:</p> <ul style="list-style-type: none"> • Personalized diabetes prevention coaching • 24/7 online support and mobile app • Customizable food, activity, weight and goal trackers • Success group support, which lets members chat with others who are doing the Real Appeal program • The weekly Real Appeal All-Star Show featuring healthy tips from celebrities, athletes and health experts <p>Success Kit includes:</p> <ul style="list-style-type: none"> • Program, nutrition, and fitness guides • Tools to help cook healthier, tasty meals • Delivered right to their front door after attending their first group coaching session
UnitedHealthcare Hearing for Retiree Advantage Members	<p><i>UnitedHealthcare Hearing provides members with greater technology, choice and convenience</i></p> <ul style="list-style-type: none"> • <i>Rechargeable hearing aids, remote adjustments and other advanced feature devices are available at up to 80% less than standard industry prices through direct delivery, including top brands in multiple styles</i> • <i>6,500+ locations nationwide</i> • <i>Choose home delivery or in person options</i> • <i>3-minute online hearing test to assess hearing loss/need for in-person test</i> • <i>Members receive \$1500 allowance every 36 months towards the purchase of hearing aids</i> • <i>Members must use a UHC hearing provider to use their hearing aid benefit</i>
Quit For Life for Retiree Advantage Members	<p>Quit For Life has helped 3.5 million members quit smoking or using tobacco. It provides the tools and one-on-one support to help you quit your way.</p> <p>And for UnitedHealthcare members, it's offered at \$0 out of pocket.</p> <p>With a 95% satisfaction rate, Quit for Life provides</p> <ul style="list-style-type: none"> • Tools and support to help members quit cigarettes, e-cigarettes, vaping and tobacco • A personal, one-on-one Quit Coach to help you create a customized quit plan • The Quit for Life mobile app, which offers 24/7 urge management support • Text2Quit text messages for daily tips and encouragement • Quit medications – Such as nicotine gum or patches – for no charge, based on eligibility.

Feature	Description
PERS (Personal Emergency Response System) for Retiree Advantage Members	<p>UnitedHealthcare® works with Lifeline to provide a personal emergency response system at no cost for Retiree Advantage plan members</p> <p>Lifeline personal emergency response system (PERS) allows you to ask for help whenever you need it, anytime of day or night – 365 days of the year, 24/7. All you need to do is press the help button, worn as a wristband or pendant, and a Trained Care Specialist will assist you to make sure you quickly get the help you need.</p> <p>Features include:</p> <p>Optional AutoAlert fall detection technology automatically provides access to help if it detects a fall – even if wearer is disoriented, immobilized or unconscious and cannot press their help button</p> <p>Cellular or landline compatible, Lifeline works anywhere in the U.S., where current telephone service is provided</p> <p>Lightweight, waterproof help button can be worn on the wrist or as a pendant</p>
UHC Rewards and One Pass Select	<p>Your health plan comes with a new way to earn up to \$300. With UnitedHealthcare Rewards, you can earn up to \$300 for tracking your steps or sleep, getting an annual checkup and more. The activities you go for are up to you. When you activate UHC Rewards, you can also get started with One Pass Select™, a fitness program that gives you unlimited access to a nationwide network of thousands of fitness centers. Plus, you can use your earnings to help pay for a One Pass Select membership.</p> <p><i>Start earning with UHC Rewards by:</i></p> <ul style="list-style-type: none"> • Download the UnitedHealthcare® app and then: Sign in or register • Select UHC Rewards • Activate UHC Rewards • Select Redeem rewards to access One Pass Select <p><i>UnitedHealthcare Rewards is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you. If any fraudulent activity is detected (e.g., misrepresented physical activity), you may be suspended and/or terminated from the program. If you are unable to meet a standard related to health factor to receive a reward under this program, you might qualify for an opportunity to receive the reward by different means. You may call us toll-free at 1-866-230-2505 or at the number on your health plan ID card, and we will work with you (and, if necessary, your doctor) to find another way for you to earn the same reward. Rewards may be limited due to incentive limits under applicable law. Components subject to change. This program is not available for fully insured members in Hawaii, Vermont and Puerto Rico.</i></p> <p><i>One Pass Select is a voluntary program featuring a subscription-based nationwide gym network, digital fitness and grocery delivery service. The information provided under this program is for general informational purposes only and is not intended to be nor should it be construed as medical advice. Individuals should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for them. Purchasing discounted gym and fitness studio memberships, digital fitness or grocery delivery services may have tax implications. Employers and individuals should consult an appropriate tax professional to determine if they have any tax obligations with respect to the purchase of these discounted memberships or services under this program, as applicable. One Pass Select is a program offered by Optum. Subscription costs are payable to Optum.</i></p>

Non-FEHB Benefits Available to Plan Members

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

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

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

UHC Rewards and One Pass* - UnitedHealthcare Rewards, you can earn dollars for tracking your steps or sleep, getting an annual checkup and more. The activities you go for are up to you. When you activate UHC Rewards, you can also get started with One Pass Select™, a fitness program that gives you unlimited access to a nationwide network of thousands of fitness centers. You can use your earnings to help pay for a One Pass Select membership. 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.uhonetech.com/federal> or call 1-844-620-4814 (worldwide 24-hour a day).

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

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

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

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

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see *Emergencyservices/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental, investigational or unproven procedures, treatments, drugs or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, fetal reduction or non-surgical or drug induced pregnancy terminations except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Surrogate parenting
- Fetal reduction surgery
- Reversal of voluntary sterilization
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.
- Extra care costs or research costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Services or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption.
- Services or supplies we are prohibited from covering under the Federal law.

Section 7. Filing a Claim for Covered Services

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

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

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

Medical and hospital benefits

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

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

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

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

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

Prescription drugs

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

International Claims

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

Deadline for filing your claim

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

Post-service claims procedures

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

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

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

Authorized Representative

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

Notice Requirements

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

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

Section 8. The Disputed Claims Process

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

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

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

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

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

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

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

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none">a) Write to us within 6 months from the date of our decision; andb) Send your request to us at: UnitedHealthcare Federal Employees Health Benefits (FEHB) Program Appeals, P.O. Box 30573, Salt Lake City, UT 84130-0573 ; andc) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andd) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.e) Your email address, if you would like to receive our decision via email. Please note that by providing your email address, you may receive our decision more quickly.
2	<p>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.</p> <p>In the case of a post-service claim, we have 30-days from the date we receive your request to:</p> <ul style="list-style-type: none">a) Pay the claim orb) 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, 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 sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

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

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

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

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

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

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

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

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

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

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

We do not cover services that:

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

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

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

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

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

Clinical trials

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

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

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by the plan.

- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan does not cover these costs.
- Research costs- costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes are considered research costs. This plan does not cover these costs.

When you have Medicare

What is Medicare?

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

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

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

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

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

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

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

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 877-835-9861 or see our Web site at www.uhcfeds.com.

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

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

Medicare Part B Premium Reimbursement

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

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

Medicare**Benefit Description: Deductible****High Option You Pay Without Medicare:** No deductible**High Option You Pay With Medicare Part B:** No deductible**Benefit Description: Out-of-Pocket Maximum****High Option You Pay Without Medicare:** \$5,000 self only/\$10,000 family**High Option You Pay With Medicare Part B:** \$5,000 self only/\$10,000 family**Benefit Description: Part B Premium Reimbursement Offered****High Option You Pay Without Medicare:** N/A**High Option You Pay With Medicare Part B:** N/A**Benefit Description: Primary Care Provider****High Option You Pay Without Medicare:** \$25**High Option You Pay With Medicare Part B:** \$25**Benefit Description: Specialist****High Option You Pay Without Medicare:** \$35**High Option You Pay With Medicare Part B:** \$35**Benefit Description: Inpatient Hospital****High Option You Pay Without Medicare:** \$150 per day up to \$750 per admission**High Option You Pay With Medicare Part B:** \$150 per day up to \$750 per admission**Benefit Description: Outpatient Hospital****High Option You Pay Without Medicare:** \$150 free standing; \$300 hospital based**High Option You Pay With Medicare Part B:** \$150 free standing; \$300 hospital based**Benefit Description: Incentives offered****High Option You Pay Without Medicare:** N/A**High Option You Pay With Medicare Part B:** N/A

- **Tell us about your Medicare Coverage**

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

- **Medicare Advantage (Part C)**

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

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

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

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

You may enroll in the UnitedHealthcare Retiree Advantage Plan if:

- You are enrolled in this UnitedHealthcare FEHBP plan and have both Medicare Part A and Part B
- You are retired and live in our geographic service area. See page 12 for a description of our service area.
- You are a United States citizen or are lawfully present in the United States
- You do NOT have End-Stage Renal Disease (ESRD), with limited exceptions

- You complete an application for enrollment in the UnitedHealthcare Retiree Advantage Plan.

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

We offer a plan designed:

- To help members with their Medicare Part B premium costs
- To provide access to our national network of providers, (in-network or out-of-network) at the same cost share
- To cover eligible medical benefits with little to no out of pocket costs
- Medicare Part D prescription drug coverage with a low \$2,000 out of pocket max

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

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

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

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

Benefit Description: Deductible

Member Cost **without** Medicare: No plan deductible

Member Cost **with** Medicare Part B: No plan deductible

Member Cost **with** UnitedHealthcare Retiree Advantage Health Plan: No plan deductible

Benefit Description: Out-of-Pocket Maximum

Member Cost **without** Medicare: \$5,000 Self Only, \$10,000 Self Plus One, and \$10,000 Self and Family

Member Cost **with** Medicare Part B: \$5,000 Self Only, \$10,000 Self Plus One, and \$10,000 Self and Family

Member Cost **with** UnitedHealthcare Retiree Advantage Health Plan: You pay nothing for Medicare-covered service from any provider

Benefit Description: Primary Care Physician

Member Cost **without** Medicare: \$25 per visit

Member Cost **with** Medicare Part B: \$25 per visit

Member Cost **with** UnitedHealthcare Retiree Advantage Health Plan: \$0

Benefit Description: Specialist

Member Cost **without** Medicare: \$35 per visit

Member Cost **with** Medicare Part B: \$35 per visit

Member Cost **with** UnitedHealthcare Retiree Advantage Health Plan: \$0

Benefit Description: Virtual Visits

Member Cost **without** Medicare: \$0 per visit

Member Cost **with** Medicare Part B: \$5 per visit

Member Cost **with** UnitedHealthcare Retiree Advantage Health Plan: \$0

Benefit Description: Urgent Care

Member Cost **without** Medicare: \$35 per visit

Member Cost **with** Medicare Part B: \$35 per visit

Member Cost **with** UnitedHealthcare Retiree Advantage Health Plan: \$0

Benefit Description: Emergency

Member Cost **without** Medicare: \$350 per visit (waived if admitted)

Member Cost **with** Medicare Part B: \$250 per visit (waived if admitted)

Member Cost **with** UnitedHealthcare Retiree Advantage Health Plan: \$0

Benefit Description: Inpatient Hospital

Member Cost **without** Medicare: \$150 per day (up to \$750 per admission)

Member Cost **with** Medicare Part B: \$150 per day (up to \$750 per admission)

Member Cost **with** UnitedHealthcare Retiree Advantage Health Plan: \$0

Benefit Description: Outpatient Hospital

Member Cost **without** Medicare: Freestanding: \$150, Hospital-based: \$300

Member Cost **with** Medicare Part B: Freestanding: \$150, Hospital-based: \$300

Member Cost **with** UnitedHealthcare Retiree Advantage Health Plan: \$0

Benefit Description: Rx - (30-day at retail)

Member Cost **without** Medicare: Tier 1-\$10, Tier 2-\$50, Tier 3-\$100, Tier 4-\$200

Member Cost **with** Medicare Part B: Tier 1-\$10, Tier 2-\$50, Tier 3-\$100, Tier 4-\$200

Member Cost **with** UnitedHealthcare Retiree Advantage Health Plan: Tier 1-\$5, Tier 2-\$25, Tier 3-\$60, Tier 4-\$90

Benefit Description: Rx – Mail Order (90-day supply)

Member Cost **without** Medicare: 2.5 x retail copay

Member Cost **with** Medicare Part B: 2.5 x retail copay

Member Cost **with** UnitedHealthcare Retiree Advantage Health Plan: 2 x retail copay

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

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

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

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

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

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

Section 10. Definitions of Terms We Use in This Brochure

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. <ul style="list-style-type: none">• We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.• Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.• OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.
Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Clinical Trials Cost Categories	An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application. Routine care costs- costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy <ul style="list-style-type: none">• Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.• Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.
Coinsurance	See Section 4, page 21
Copayment	See Section 4, page 21
Cost-Sharing	See Section 4, page 21
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Services that are non-health related, such as daily living activities, or services which are health related but do not seek to cure, or services which do not require a trained medical professional. Custodial care that lasts 90 days or more is sometimes known as long term care.
Deductible	See Section 4, page 21
Experimental or investigational service	Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States American Hospital Pharmacopoeia Dispensing Information* as appropriate for the proposed use
- Not recognized, in accordance with generally accepted medical standards, as being safe and effective for your condition;
- Subject to review and approval by any institution review board for the proposed use. (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational).
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight

Healthcare professional

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

Infertility

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

Medical necessity

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

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

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

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

Plan Allowance	Allowable Expense (plan allowance) is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense
	You should also see Important Notice About Surprise Billing – Know Your Rights in Section 4 that describes your protections against surprise billing under the No Surprises Act.
Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.
Pre-service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
Surprise bill	An unexpected bill you receive for: <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> • Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.) • Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group).
	We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com .

Please note: If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent care claims

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

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

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

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at **1-877-835-9861**. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We

Us and We refer to UnitedHealthcare Insurance Company, Inc.

You

You refers to the enrollee and each covered family member.

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Summary of Benefits for the High Option Plan of UnitedHealthcare Insurance Company - 2025

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can obtain a copy of our Summary of Benefits as required by the Affordable Care Act at www.uhcfeds.com.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies..

High Option Benefits	You pay	Page
Medical services provided by physicians: Preventive Care	No copayments for preventive care services. This includes items such as, but not limited to, immunizations, physical examinations and screenings as appropriate and recommended by U.S. Preventive Services Task Force. Please refer to Section 5.	28
Medical services provided by physicians: Diagnostic and treatment services provided in the office	\$25 per primary care provider (PCP) visit for ages 18 and older, \$0 for children under 18 visits to PCP \$35 per specialist visit	25
Urgent Care	\$35 copayment per visit	53
Services provided by a hospital: Outpatient Services	\$50 per outpatient non-surgical visit	49
Services provided by a hospital: Outpatient Surgical	\$150 per outpatient surgical visit for services performed at approved free standing surgical facility \$300 per outpatient hospital surgical visit	49
Inpatient	\$150 per day up to 5 days per admission	48
Emergency benefits: In or out-of-area	\$350 per emergency room visit (waived if admitted)	51
Mental health and substance use disorder treatment:	Regular cost-sharing	53
Prescription drugs: Plan Retail pharmacy and Specialty Pharmaceuticals	Tier 1: \$10 Tier 2: \$50 Tier 3: \$100 Tier 4: \$200	58
Prescription drugs: Plan mail order for up to a 90-day fill	Tier 1: \$25 Tier 2: \$125 Tier 3: \$250 Tier 4: \$500	58
Specialty Pharmacy (30-day supply)	Tier 1 \$10 Tier 2 \$150 Tier 3 \$350 Tier 4 \$500	59

High Option Benefits	You pay	Page
Vision care:	\$35 specialist copayment for eye refraction exam every other year for adults	34
Wellness and Other Special features:	UnitedHealthcare mobile app, Smoking cessation program, Maternity Health Solutions, Orthopedic Health Support UnitedHealth Premium, Real Appeal, UHC Rewards and One Pass, Specialty Pharmacy, Flexible Benefits Option, Cancer Clinical Trials	65
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after \$5,000 for Self Only enrollment or \$10,000 for Self Plus One and Self and Family enrollment per year. Some costs do not count toward this protection	20
Non-FEHB Benefits	PPO Preventive dental plan at no charge to all members; Resources for hearing aids and other financial options available for our members	63

2025 Rate Information for UnitedHealthcare Insurance Company, Inc.

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

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

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

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share

District Of Columbia, Maryland, Pennsylvania and Virginia

High Option Self Only	LR1	\$298.08	\$224.56	\$645.84	\$486.55
High Option Self Plus One	LR3	\$650.00	\$473.66	\$1,408.33	\$1,026.27
High Option Self and Family	LR2	\$714.23	\$524.41	\$1,547.50	\$1,136.22

UnitedHealthcare Insurance Company, Inc.

www.uhcfeds.com

Customer Service: 877-835-9861

2025

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 2025: Page 15
- Summary of Benefits: Page 111

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.

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

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

Authorized for distribution by the:



FEHB
Federal Employees
Health Benefits Program

**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, 2025, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates for each plan annually. Benefit changes are effective January 1, 2025, and changes are summarized on page 15. 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 obtain service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

We comply with applicable Federal nondiscrimination laws and do not discriminate on the basis of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity).

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual's protected trait or traits, for example a member's gender identity or the fact that the covered benefit is sought in connection with gender-affirming care, will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined to be medically necessary.

Preventing Medical Mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medications or give your doctor and pharmacist a list of all the 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.
- <https://psnet.ahrq.gov/issue/national-patient-safety-foundation>. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- 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**
- **Minimum essential coverage (MEC)**
- **Minimum value standard**
- **Where you can get information about enrolling in the FEHB Program**

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.

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.

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

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 2025 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 2024 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. Learn 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 2025

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
- **Emergency services** - Emergency room copay increasing from \$275 to \$350 after deductible. See page 72
- **Prescription Drug Benefits** - Retail pharmacy up to 30-day supply, increasing Tier's 2,3,4 drugs from \$40/\$85/\$175 to \$50/\$100/\$200 and Mail order 90-day supply, increasing Tier's 2,3,4 drugs from \$100/\$212.50/\$437.50 to \$125/\$250/\$500. See page
- **Health Savings Account (HSA)** – Increasing the IRS adjusted 2025 annual contribution limits from \$4,150 to \$4,300 for Self Only enrollment and from \$8,300 to \$8,550 for Self and Family enrollment.

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.

You need prior Plan approval for certain services

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.

• Inpatient hospital admission

Preadmission 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 preadmission. Failure to do so may result in denial of services.

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
- Air Ambulance (non-emergent)
- 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.

	<p>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.</p> <p>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.</p> <ul style="list-style-type: none"> • If your treatment needs to be extended <p>What happens when you do not follow the precertification rules when using non-network facilities</p> <p>Circumstances beyond our control</p> <ul style="list-style-type: none"> • To reconsider an urgent care claim <p>If you disagree with our pre-service claim decision</p> <ul style="list-style-type: none"> • To file an appeal with OPM • To reconsider a non-urgent care claim
	<p>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</p> <p>If you fail to obtain authorization/precertifications when using non-network facilities you can be responsible for a portion or all of the charges.</p>
	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p> <ol style="list-style-type: none"> 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. <p>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.</p> <p>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.</p>
	<p>2025 UnitedHealthcare Insurance Company, Inc.</p>

Write to you and maintain our denial.

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

Coinurance 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

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.

• The Federal Flexible Spending Account Program – FSAFEDS

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

Section 5. High Deductible Health Plan Benefits

See page 15 for how our benefits changed for this year. Page 111 provides a summary of benefits for your plan. Make sure that you review the benefits that are available to you.

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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 30 for more details).
• Health Savings Accounts (HSA)	<p>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 2025, 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 \$4,300 for an individual and \$8,550 for a family. See maximum contribution information on page 36. 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.</p> <p>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.</p> <p>HSA features include:</p> <ul style="list-style-type: none"> • 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. <p>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.</p> <p>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.</p> <p>In 2025, 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.</p>

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 (HCFSAs). 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	<p>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.</p>	<p>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.</p>
Fees	<p>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.</p> <p>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.</p> <p>Your account may be subject to fees for services such as:</p> <ul style="list-style-type: none"> • 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 <p>We are not charging fees for some routine charges. Information can be obtained at www.optumbank.com.</p>	<p>None</p>
Eligibility	<p>You must:</p> <ul style="list-style-type: none"> • 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) 	<p>You must enroll in the UnitedHealthcare Insurance Company, Inc. High Deductible Health Plan HDHP.</p> <p>Eligibility is determined on the day of enrollment and will be prorated for length of enrollment.</p>

	<ul style="list-style-type: none"> • 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	<p>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.</p> <p>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.</p> <p>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 uhcfeeds.com.</p>	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 2025, 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 2025, your HRA annual credit will be \$750 which (prorated for mid-year enrollment).
• Self Plus One enrollment	For 2025, a monthly premium pass through of \$125 will be made by the HDHP directly into your HSA each month upon receipt of premium.	For 2025, your HRA annual credit is \$1,500 (prorated for mid-year enrollment).
• Self and Family enrollment	For 2025, 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 2025, your HRA annual credit is \$1,500 (prorated for mid-year enrollment)
Contributions/credits	<p>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 \$4,300 for an individual and \$8,550 for a family.</p> <p>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.</p> <p>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.</p> <p>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.</p>	<p>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.</p>

	<p>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).</p> <p>HSAs earn tax-free interest (does not affect your annual maximum contribution).</p> <p>Additional contribution discussed on page 36.</p>	
• Self Only enrollment	You may make an annual maximum contribution of \$4,300.	You cannot contribute to the HRA.
• Self Plus One enrollment	You may make an annual maximum contribution of \$8,550 (per family)	You cannot contribute to the HRA
• Self and Family enrollment	You may make an annual maximum contribution of \$8,550 (per family)	You cannot contribute to the HRA.
Access funds	<p>You can access your HSA by the following methods:</p> <p>UnitedHealthcare Health Savings Account MasterCard® Debit Card must be activated in order to have access to HSA funds</p> <p>On-line bill payment</p> <p>Checks (if you choose to purchase these)</p> <p>ATM Withdrawals</p>	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)	<p>You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA.</p> <p>See IRS Publication 502 for a list of eligible medical expenses.</p> <p>You may use the UnitedHealthcare Health Savings Account MasterCard® Debit Card or checks (optional) for all qualified expenses.</p>	<p>You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the UnitedHealthcare Insurance Company Inc. HDHP.</p> <p>Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan.</p> <p>See <i>Availability of funds</i> below for information on when funds are available in the HRA.</p> <p>See IRS Publications 502 and 969 for information on 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.</p>

<ul style="list-style-type: none"> • Non-medical 	<p>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.</p> <p>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.</p>	<p>Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.</p>
Availability of funds	<p>Funds are not available for withdrawal until all the following steps are completed:</p> <ul style="list-style-type: none"> • 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. 	<p>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.)</p>

	<ul style="list-style-type: none"> • 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	<p>You can take this account with you when you change plans, separate or retire.</p> <p>If you do not enroll in another HDHP, you can no longer contribute to your HSA. See "HSA eligibility".</p>	<p>If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA.</p> <p>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.</p>
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 date 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, 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 detailed information of IRS-allowable expenses, request a copy of IRS Publications 502 and 969 by calling 1-800-829-3676, or visit the IRS website at www.irs.gov and click on "Forms and Publications." Note: Although 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

	<p>Important things you should keep in mind about these benefits:</p> <ul style="list-style-type: none"> • 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 – <i>Traditional medical coverage subject to the deductible</i>. 	
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Benefit Description	In-Network You pay	Out-of-Network You pay
Preventive care, adult		
<ul style="list-style-type: none"> • Routine physical every year <p>The following preventive services are covered at the time interval recommended at each of the links below</p> <ul style="list-style-type: none"> • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. For a complete list of screenings go to the website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks • 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.hrsa.gov/womens-guidelines • To build your personalized list of preventive services go to https://health.gov/myhealthfinder. 	\$0	<i>All charges</i>
<ul style="list-style-type: none"> • Routine mammogram 	\$0	<i>All charges</i>
<ul style="list-style-type: none"> • Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. For a complete list of endorsed immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ 	\$0	<i>All charges</i>
<ul style="list-style-type: none"> • Routine exams limited to: <ul style="list-style-type: none"> - 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	<i>All charges</i>
Obesity counseling, screening, and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows:	\$0	<i>All charges</i>
<ul style="list-style-type: none"> • Intensive nutrition and behavioral weight-loss counseling therapy, • Family centered programs when medically identified to support obesity prevention and management by an in-network provider. • When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) for cost share requirements for anti-obesity medications. • When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share. 		
One annual biometric screening to include age appropriate screening such as:	\$0	<i>All charges</i>

Preventive care, adult - continued on next page

Benefit Description	In-Network You pay	Out-of-Network You pay
Preventive care, adult (cont.)		
<ul style="list-style-type: none"> • Body Mass Index (BMI) • Blood Pressure • Lipid/cholesterol levels • Glucose/hemoglobin A1C measurement <p>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</p>	\$0	<i>All charges</i>
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	<i>All charges</i>
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.</i> • <i>Immunizations, boosters, and medications for travel or work-related exposure.</i> 	<i>All charges</i>	<i>All charges</i>
Preventive care, children		
<p>Well-child visits examinations, and immunizations as described in the Bright Future Guidelines provided by the American Academy of Pediatrics</p> <p>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.</p> <p>Note: You may also find a complete list of U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at: www.uspreventiveservicestaskforce.org</p> <p>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</p> <p>For additional information: healthfinder.gov/myhealthfinder/default.aspx</p> <p>Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to brightfutures.aap.org/Pages/default.aspx</p>	\$0	<i>All charges</i>
<p>Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows:</p> <ul style="list-style-type: none"> • Intensive nutrition and behavioral weight-loss counseling therapy, • Family centered programs when medically identified to support obesity prevention and management by an in-network provider. • When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) for cost share requirements for anti-obesity medications. 	\$0	<i>All charges</i>

Preventive care, children - continued on next page

Benefit Description	In-Network You pay	Out-of-Network You pay
Preventive care, children (cont.)		
<ul style="list-style-type: none"> When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share. <p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel</i> <i>Immunizations, boosters, and medications for travel or work-related exposure.</i> 	\$0	<i>All charges</i>

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

<p>Important things you should keep in mind about these benefits:</p> <ul style="list-style-type: none"> • 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, <i>Your Costs for Covered Services</i>, 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.). 		
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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: <ul style="list-style-type: none"> • In office/telehealth/Optum primary care • Office medical consultation • Advanced care planning Professional services of specialists: <ul style="list-style-type: none"> • In your physicians office/telehealth • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical opinion • Advanced care planning 	\$15 copayment per Primary care provider (PCP) visit in office/telephonic \$30 copayment per visit	30% of the Plan allowance and any difference between our allowance and the billed amount. 30% of the Plan allowance and any difference between our allowance and the billed amount.
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 : <ul style="list-style-type: none"> • Your doctor is not available • You become ill while traveling 	\$0 copayment per visit	<i>All charges</i>

Virtual visits - continued on next page

Benefit Description		
	In-network You pay after deductible	Out-of-network You pay after deductible
Virtual visits (cont.) <p>Conditions such as: cold, flu, bladder infection, bronchitis, diarrhea, fever, pink eye, rash, sinus problem, sore throat, stomach ache</p> <p>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.</p> <p>Note: There may be state restrictions pertaining to telemedicine and prescribing therefore not all services may be available in all states.</p>	\$0 copayment per visit	<i>All charges</i>
Lab, X-ray and other diagnostic tests <p>Tests, received in your provider's office at the time of your visit such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG <p>Tests received at a facility:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG <p>Major Diagnostic tests:</p> <ul style="list-style-type: none"> • CT scans/MRI • PET scans • Nuclear medicine <p>Preadmission may be required for these tests</p>	<p>In-network You pay after deductible</p> <p>PCP \$15 specialist \$30</p> <p>\$50 copayment per visit</p> <p>\$150 copayment per visit</p>	<p>Out-of-network You pay after deductible</p> <p><i>All charges</i></p> <p><i>All charges</i></p> <p><i>All charges</i></p>

Benefit Description		
Maternity care	In-network You pay after deductible	Out-of-network You pay after deductible
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal and Postpartum care • Screening for gestational diabetes • Bacteriuria screening • Delivery • Screening and counseling for prenatal and postpartum depression • Breastfeeding and lactation support, supplies and counseling for each birth <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • As part of your coverage, you have access to in-network certified nurse midwives, home nurse visits and board-certified lactation specialists during the prenatal and post-partum period. • 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. • 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). 	\$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.
Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits.		
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
<p>A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories on the HRSA list. This list includes:</p> <ul style="list-style-type: none"> • Voluntary female sterilization • Surgically implanted contraceptives 	\$0	30% of the Plan allowance and any difference between our allowance and the billed amount.

Family planning - continued on next page

Benefit Description		
Family planning (cont.)	In-network You pay after deductible	Out-of-network You pay after deductible
<ul style="list-style-type: none"> • 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 <p>Note: See additional Family Planning and Prescription drug coverage Section 5(f)</p> <p>Note: Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below.</p> <p>Contraceptive products that are not already available at \$0 cost-share can be provided at \$0 member cost-share if the provider determines that a particular contraceptive is medically necessary for that member. The cost-share waiver process requires that providers attest the product is needed for contraceptive purposes and this can be submitted electronically by the provider. To request an exemption, please call customer service at 887-835-9861</p> <p>If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov</p>	\$0	30% of the Plan allowance and any difference between our allowance and the billed amount.
Voluntary male sterilization	20% coinsurance of the plan allowance	30% of the Plan allowance and any difference between our allowance and the billed amount
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic testing or counseling not medically necessary</i> 	<i>All charges</i>	<i>All charges</i>
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 services - continued on next page

Benefit Description		
Infertility services (cont.)	In-network You pay after deductible	Out-of-network You pay after deductible
<p>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.</p> <p>Covered Services</p> <p>Diagnosis and treatment of infertility specific to:</p> <p>Artificial insemination:</p> <ul style="list-style-type: none"> • 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 <p>Note: Prior Authorization required</p>	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
<ul style="list-style-type: none"> • Allergy services provided in a Providers office <ul style="list-style-type: none"> - Testing and treatment - Allergy injections - Allergy serum 	<p>\$15 copayment per primary care visit</p> <p>\$30 copayment per specialist visit</p>	<p>You pay 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	All charges	All charges
Treatment therapies	In-network You pay after deductible	Out-of-network You pay after deductible
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>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).</p> <ul style="list-style-type: none"> • 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 	<p>\$15 copayment per PCP visit</p> <p>\$30 copayment per specialist visit</p>	<p>30% of the Plan allowance and any difference between our allowance and the billed amount</p>

Treatment therapies - continued on next page

Benefit Description			
Treatment therapies (cont.)		In-network You pay after deductible	Out-of-network You pay after deductible
<ul style="list-style-type: none"> Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>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 <i>Services requiring our prior approval</i> in Section 3.</p> <ul style="list-style-type: none"> Applied Behavioral Analysis (ABA) - Children with autism spectrum disorder - home visits not covered Dialysis – hemodialysis and peritoneal dialysis 	\$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	
Physical and occupational therapies	In-network You pay after deductible	Out-of-network You pay after deductible	
Up to 60 per year for per condition rehabilitative/habilitative in any combination of the following: <ul style="list-style-type: none"> Qualified physical therapists Occupational therapists <p>Note: We only cover therapy when a physician:</p> <ul style="list-style-type: none"> 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 / 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 <ul style="list-style-type: none"> 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 <p>Note: we only cover therapy when a physician:</p> <ul style="list-style-type: none"> orders the care, identifies the specific professional skills the patient requires and the medical necessity for skilled services; and 	\$30 copayment per specialist visit	30% of the Plan allowance and any difference between our allowance and the billed amount.	

Habiltative / Rehabilitative Therapies - continued on next page

Benefit Description		
Habilitative / Rehabilitative Therapies (cont.)	In-network You pay after deductible	Out-of-network You pay after deductible
<ul style="list-style-type: none"> • 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.
<p>Habilitative services for children under age 19 with congenital or genetic birth defects. Treatment is provided to enhance the child's ability to function.</p> <p>Services include:</p> <ul style="list-style-type: none"> • Speech therapy • Occupational therapy; and • Physical therapy <p>Includes medically necessary habilitative services coverage for children with Autism, an Autism Spectrum disorder, or Cerebral Palsy</p> <p>Note: No day or visits apply to these services. A congenital disorder means a significant structural or functional abnormality that was present from birth</p>	\$30 copayment per specialist visit	30% of the Plan allowance and any difference between our allowance and the billed amount.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Exercise programs 	<i>All charges</i>	<i>All charges</i>
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.
<p><i>Not covered:</i></p> <p><i>Exercise programs, gyms, or pool memberships, work hardening/functional capacity programs or evaluations</i></p>	<i>All charges</i>	<i>All charges</i>
Hearing services (testing, treatment, and supplies)	In-network You pay after deductible	Out-of-network You pay after deductible
<p>For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an MD; DO or audiologist.</p> <ul style="list-style-type: none"> • External hearing aids are not covered • Refer to Non-FEHB page for discount coverage of hearing aids through UnitedHealthcare Hearing <p>Hearing examinations for children through age 17 (refer to preventive care - children)</p>	<p>\$30 copayment per specialist visit</p> <p>\$0</p>	<p>30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p><i>All charges</i></p>

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

Benefit Description	In-network You pay after deductible	Out-of-network You pay after deductible
Hearing services (testing, treatment, and supplies) (cont.)		
<ul style="list-style-type: none"> • 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	<i>All charges</i>
<ul style="list-style-type: none"> • Implanted hearing related devices such as bone anchored hearing aids (BAHA) and cochlear implants. <p>Note: for benefits for the device, see Section 5(a) <i>Orthopedic and prosthetic devices</i></p>	\$30 copayment per specialist visit	30% of the Plan allowance and any difference between our allowance and the billed amount
<i>Not covered:</i> <ul style="list-style-type: none"> • All other hearing testing • Hearing aids 	<i>All charges</i>	<i>All charges</i>
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
Routine eye examination - Basic eye refraction every two years to provide a written lens prescription <i>Note: Children eye exams are covered as preventive as described in the Bright Future Guidelines provided by the American Academy of Pediatrics</i>	\$30 copayment per specialist visit	30% of the Plan allowance and any difference between our allowance and the billed amount
<i>Not covered:</i> <ul style="list-style-type: none"> • Eyeglasses or contact lenses, except as shown above • Eye exercises and orthoptics • Radial keratotomy and other refractive surgery 	<i>All charges</i>	<i>All charges</i>
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
<i>Not covered:</i>	<i>All charges</i>	<i>All charges</i>

Foot care - continued on next page

Benefit Description		
Foot care (cont.)	In-network You pay after deductible	Out-of-network You pay after deductible
<ul style="list-style-type: none"> • 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
<ul style="list-style-type: none"> • 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 • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. <p>Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) <i>Surgical and anesthesia services</i>.</p> <p>For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) <i>Services provided by a hospital or other facility, and ambulance services</i></p>	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
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Orthopedic and corrective shoes • Arch supports • Foot orthotics • Heel pads and heel cups • Lumbosacral supports 	All charges	All charges

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
<ul style="list-style-type: none"> • Corsets, trusses, elastic stockings, support hose, and other supportive devices • Prosthetic replacements provided less than 3 years after the last one we covered (except as needed to accommodate growth in children or socket replacement for members with significant residual limb volume or weight changes) • External penile devices • Speech prosthetics except electrolarynx • Carpal tunnel 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
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • Oxygen and the rental of equipment to administer oxygen including tubing, connectors and masks • Dialysis equipment • Standard Hospital beds • Standard Wheelchairs • Crutches • CPAP • Walker • 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 <p>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.</p> <p>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.</p> <p><i>Not covered:</i></p>	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
<ul style="list-style-type: none"> • 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 • Medical supplies such as dressings and antiseptics • Continuous pulse oximetry unless skilled nursing is involved in home care and it is part of their medically necessary equipment 	All charges	All charges
Home health services	In-network You pay after deductible	Out-of-network You pay after deductible
<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> - 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 	\$30 copayment per visit	30% of the Plan allowance and any difference between our allowance and the billed amount

Home health services - continued on next page

Benefit Description	In-network You pay after deductible	Out-of-network You pay after deductible
Home health services (cont.)		
<ul style="list-style-type: none"> 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 may apply. 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: <ul style="list-style-type: none"> 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
<i>Not covered:</i> <ul style="list-style-type: none"> <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i> <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i> <i>Private duty nursing</i> <i>Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication</i> <i>Foods that can be obtained over the counter (without a prescription) even if prescribed by a physician</i> 	<i>All charges</i>	<i>All charges</i>
Chiropractic		
<ul style="list-style-type: none"> Diagnosis and related services for the manipulation of the spine and extremities to remove nerve interference or its effects. <p>Limited to one treatment per day up to 24 visits per calendar year.</p> <p>Note: The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.</p>	20% coinsurance of the plan allowance	30% of the Plan allowance and any difference between our allowance and the billed amount

Benefit Description		
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: <ul style="list-style-type: none"> • 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
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Naturopathic services</i> • <i>Hypnotherapy</i> • <i>Biofeedback</i> • <i>Acupressure</i> • <i>Aroma therapy</i> • <i>Massage therapy</i> • <i>Rolfing</i> 	<i>All charges</i>	<i>All charges</i>
Educational classes and programs	In-network You pay after deductible	Out-of-network You pay after deductible
<ul style="list-style-type: none"> • Diabetes self management (must be prescribed by a licensed health care professional <ul style="list-style-type: none"> - Outpatient self-management training for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin 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. - 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

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

	<p>Important things you should keep in mind about these benefits:</p> <ul style="list-style-type: none"> • 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, <i>Your Costs for Covered Services</i>, 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. 	
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Benefit Description		
Surgical procedures	In-network You pay after the deductible	Out-of-network You pay after the deductible
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • 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) <i>Orthopedic and prosthetic devices</i> for device coverage information • Treatment of burns <p>Note: For female surgical family planning procedures see Family Planning Section 5(a)</p> <p>Note: For male surgical family planning procedures see Family Planning Section 5(a)</p> <p>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.</p>	20% coinsurance of the plan allowance	30% of the Plan allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description		
Surgical procedures (cont.)	In-network You pay after the deductible	Out-of-network You pay after the deductible
<p>Physician charges for Scopic Procedures such as :</p> <ul style="list-style-type: none"> Endoscopy Colonoscopy (diagnostic) Sigmoidscopy <p>Please note that benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under Surgery. Examples of surgical scopic procedures are arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.</p>	20% coinsurance of the plan allowance	30% of the Plan allowance and any difference between our allowance and the billed amount
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; (see Foot care)</i> 	<i>All charges</i>	<i>All charges</i>
Bariatric Surgery	In-network You pay after the deductible	Out-of-network You pay after the deductible
<p>Surgical treatment of severe morbid obesity (bariatric surgery)</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> - 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: <ul style="list-style-type: none"> - 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 	20% coinsurance of the plan allowance	<i>All charges</i>

Bariatric Surgery - continued on next page

Benefit Description	In-network You pay after the deductible	Out-of-network You pay after the deductible
Bariatric Surgery (cont.)		
<ul style="list-style-type: none"> 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	<i>All charges</i>
<p>Revisonal Bariatric Surgery due to a technical failure or major complication from the initial procedure; potential failure/ complications include but are not limited to the following:</p> <ul style="list-style-type: none"> Bowel perforation (including adjustable gastric band erosion) Adjustable gastric band migration (slippage) that cannot be corrected with manipulation or adjustment (records must demonstrate that manipulation or adjustment to correct band slippage has been attempted) Leak Obstruction (confirmed by imaging studies) Staple-line failure Mechanical adjustable gastric band failure Uncontrollable reflux related to sleeve gastrectomy when all the following criteria are met: <ul style="list-style-type: none"> Maximum nonpharmacological medical management failure (e.g., positional, dietary modification and behavioral changes); and Maximum pharmacological medical management failure (e.g., at least one month of double dose PPI, H2 blocker, and/or sucralfate); and Severe esophagitis (<u>grade C or D</u>) confirmed by endoscopy despite maximum medical management <p>The individual must also meet the following criteria:</p> <p>Both of the following:</p> <ul style="list-style-type: none"> 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	<i>All charges</i>
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.	20% coinsurance of the plan allowance	30% of the Plan allowance and any difference between our allowance and the billed amount
<p>Covered benefits include the following procedures:</p> <ul style="list-style-type: none"> Collection of sperm 		

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
<p>Covered benefits include the following procedures:</p> <ul style="list-style-type: none"> • Collection of sperm • Cryo-preservation of sperm • Oocyte cryo-preservation • Embryo cryo-preservation • Ovarian stimulation, retrieval of eggs and fertilization <p>Benefits are not available for:</p> <ul style="list-style-type: none"> • Embryo transfer • Long-term storage costs (greater than 1 year) • Elective fertility preservation. <p>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.</p> <p>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.</p>	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
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - 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: <ul style="list-style-type: none"> - 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) <p>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.</p> <ul style="list-style-type: none"> • Gender Affirming Surgery - 	20% coinsurance of the plan allowance	30% of the Plan allowance and any difference between our allowance and the billed amount

Benefit Description	In-network You pay after the deductible	Out-of-network You pay after the deductible
<p>Reconstructive surgery (cont.)</p> <p>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]).</p> <p>Requirements:</p> <ul style="list-style-type: none"> • Must be 18 years of age or older • Must have documented evidence of persistent gender dysphoria • Favorable psychosocial-behavioral evaluation to provide screening and identification of risk factors or potential postoperative challenges • Persistent, well-documented Gender Dysphoria • Capacity to make a fully informed decision and to consent for treatment • Complete at least 12 months of successful continuous full-time real-life experience in the desired gender • Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated) • Treatment plan that includes ongoing follow-up and care by a Qualified Behavioral Health Provider experienced in treating Gender Dysphoria* <p>Gender affirming surgeries for (male to female) include:</p> <ul style="list-style-type: none"> • 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 <p>Gender affirming surgeries for (female to male) include:</p> <ul style="list-style-type: none"> • 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 	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	In-network You pay after the deductible	Out-of-network You pay after the deductible
Reconstructive surgery (cont.)		
<ul style="list-style-type: none"> • 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
<p>Note: Prior Authorization is required</p> <p>Gender Dysphoria diagnosis must be well documented and follow diagnostic criteria outlined in UHC Clinical policy.</p>		
Oral and maxillofacial surgery	In-network You pay after the deductible	Out-of-network You pay after the deductible
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • 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
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	All charges	All charges
Temporomandibular Joint Dysfunction (TMJ)	In-network You pay after the deductible	Out-of-network You pay after the deductible
<p>Services for the evaluation and treatment of TMJ and associated muscles</p> <ul style="list-style-type: none"> • Diagnosis: Exam, radiographs and applicable imaging studies and consultation. • Non-surgical treatment including: Clinical exams, Oral appliances (orthotic splints), Arthrocentesis, Trigger-point injections 	20% coinsurance for surgical services or \$30 specialist copayment for non-surgical charges	30% of the Plan allowance and any difference between our allowance and the billed amount

Temporomandibular Joint Dysfunction (TMJ) - continued on next page

Benefit Description	In-network You pay after the deductible	Out-of-network You pay after the deductible
Temporomandibular Joint Dysfunction (TMJ) (cont.)		
<p>Benefits are provided for surgical treatment if the following criteria are met:</p> <ul style="list-style-type: none"> • There is radiographic evidence of joint abnormality. <ul style="list-style-type: none"> - Non-surgical treatment has not resolved the symptoms. - Pain or dysfunction is moderate or severe. <p>Benefits for surgical services include:</p> <ul style="list-style-type: none"> • Arthrocentesis • Arthroscopy • Arthroplasty • Arthrotomy • Open or closed reduction of dislocations. <p>\$3,000 limit for all services pertaining to TMJ</p>	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
<p>These solid organ transplants are covered. Solid organ transplants are limited to:</p> <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> - 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 <p>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.</p> <ul style="list-style-type: none"> • Autologous tandem transplants for <ul style="list-style-type: none"> - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer) 	20% coinsurance of the plan allowance	<i>All charges</i>

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

Benefit Description	In-network You pay after the deductible	Out-of-network You pay after the deductible
<p>Organ/tissue transplants (Transplants must be provided in a Plan Designated Center of Excellence for Transplants) (cont.)</p> <p>Blood or marrow stem cell transplants</p> <p>The Plan extends coverage for the diagnoses as listed below.</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hematopoietic stem cell - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, 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 <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis 	20% coinsurance of the plan allowance	<i>All charges</i>

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

Benefit Description	In-network You pay after the deductible	Out-of-network You pay after the deductible
Organ/tissue transplants (Transplants must be provided in a Plan Designated Center of Excellence for Transplants) (cont.) <ul style="list-style-type: none"> - Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Hematopoietic stem cell - Medulloblastoma - Multiple myeloma - Neuroblastoma - Pineoblastoma - Testicular, Mediastinal, Retroperitoneal and ovarian germ cell tumors 	20% coinsurance of the plan allowance	<i>All charges</i>
<p>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.</p> <p>Refer to Other services in Section 3 for prior authorization procedures:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - 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 <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis 	20% coinsurance of the plan allowance	<i>All charges</i>

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
<ul style="list-style-type: none"> - Neuroblastoma 	20% coinsurance of the plan allowance	<i>All charges</i>
<p>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.</p> <p>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.</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - 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 <ul style="list-style-type: none"> - 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 	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	In-network You pay after the deductible	Out-of-network You pay after the deductible
Organ/tissue transplants (Transplants must be provided in a Plan Designated Center of Excellence for Transplants) (cont.) <ul style="list-style-type: none"> - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for <ul style="list-style-type: none"> - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis 	20% coinsurance of the plan allowance	All charges
<p>National Transplant Program (NTP) OptumHealth Care Solutions used for organ tissue transplants</p> <p>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.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p> <p>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.</p>		
<p>Donor testing for bone marrow /stem cell transplants for up to 4 potential donors whether family or non-family</p> <p><i>Not Covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses except those performed for the actual donor</i> 	20% coinsurance of the plan allowance	<i>All charges</i>
	<i>All charges</i>	<i>All charges</i>

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
<ul style="list-style-type: none"> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered - and all services related to these non-covered transplants</i> • <i>All services associated with complications resulting from the removal of an organ from a non-member</i> 	<i>All charges</i>	<i>All charges</i>
Anesthesia	In-network You pay after the deductible	Out-of-network You pay after the deductible
<p>Professional services provided in:</p> <ul style="list-style-type: none"> • 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		In-network You Pay after deductible	Out-of-network You Pay after deductible
Inpatient hospital			
Room and board, such as:	<ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets <p>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.</p>	\$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:	<ul style="list-style-type: none"> • 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
<ul style="list-style-type: none"> 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.	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Custodial care</i> <i>Non-covered facilities, such as nursing homes, schools</i> <i>Personal comfort items, such as phone, television, barber services, guest meals and beds</i> <i>Private nursing care</i> 	<i>All charges</i>	<i>All charges</i>	
Outpatient hospital or ambulatory surgical center		In-network You Pay after deductible	Out-of-network You Pay after deductible
<ul style="list-style-type: none"> 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 <p>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.</p>	\$250 copayment per surgery	30% of our Plan allowance and any difference between our allowance and the billed amount	
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	<i>All charges</i>	<i>All charges</i>	
Extended care benefits/Skilled nursing care facility benefits		In-network You Pay after deductible	Out-of-network You Pay after deductible
<ul style="list-style-type: none"> 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	
<i>Not covered:</i>	<i>All charges</i>	<i>All charges</i>	
<ul style="list-style-type: none"> <i>Custodial care</i> <i>Rest cures, domiciliary or convalescent care</i> 			

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
<ul style="list-style-type: none"> • 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
<p>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.</p> <ul style="list-style-type: none"> • 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
<i>Not covered: Independent nursing, homemaker services</i>	All charges	All charges
Ambulance	In-network You Pay after deductible	Out-of-network You Pay after deductible
<p>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:</p> <ul style="list-style-type: none"> • 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. <p>For the purpose of this Benefit the following terms have the following meanings:</p> <ul style="list-style-type: none"> • "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
<ul style="list-style-type: none"> • "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
Not Covered: International Transportation	<i>All Charges</i>	<i>All Charges</i>

Section 5(d). Emergency Services/Accidents

	<p>Here are some important things to keep in mind about these benefits:</p> <ul style="list-style-type: none"> • 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, <i>Your Costs for Covered Services</i>, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. 	
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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	In-network You pay after deductible	Out-of-network You pay after deductible
Emergency within or outside our service area		
• 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 <i>Not covered:</i>	\$350 copayment per visit (waived if admitted) <i>All charges</i>	30% of our Plan allowance and any difference between our allowance and the billed amount <i>All charges</i>

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

Benefit Description	In-network You pay after deductible	Out-of-network You pay after deductible
Emergency within or outside our service area (cont.)		
<ul style="list-style-type: none"> • 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
Not Covered: International Transportation	All Charges	All Charges

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	In-network You pay after deductible	Out-of-network You pay after deductible
Professional Services		
<p>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.</p> <p>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.</p>	<p>Your cost-sharing responsibilities are no greater than for other illnesses or conditions.</p>	<p>Your cost-sharing responsibilities are no greater than for other illnesses or conditions</p>
<p>Diagnosis and treatment of psychiatric conditions, mental illness or mental disorders. Services include:</p> <ul style="list-style-type: none"> • 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 	<p>\$30 per specialist visit</p>	<p>30% of our Plan allowance and any difference between our allowance and the billed amount</p>

Professional Services - continued on next page

Benefit Description	In-network You pay after deductible	Out-of-network You pay after deductible
Professional Services (cont.)		
<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> 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 the 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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
<i>Not covered:</i> <ul style="list-style-type: none"> <i>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</i> <i>Methadone maintenance that is not part of a treatment</i> <i>Services and supplies when paid for directly or indirectly by a local State or Federal Government Agency</i> <i>Room and board at a therapeutic boarding school</i> <i>Services rendered or billed by schools</i> 	<i>All charges</i>	<i>All charges</i>

Not covered - continued on next page

Benefit Description	In-network You pay after deductible	Out-of-network You pay after deductible
Not covered (cont.) <ul style="list-style-type: none"> • Services that are not medically necessary <p><i>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.</i></p>	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 (\$50 for up to a 30-day supply or \$125 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 \$100 for up to a 30-day supply or \$250 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 \$200 for up to a 30-day supply or \$500.00 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	In-network You pay after deductible	Out-of-network You pay after deductible
Preventive care medications We cover medications to promote better health currently recommended by ACA. Note: Preventive Medications with USPSTF A and B recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations	\$0	<i>All charges</i>
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. <ul style="list-style-type: none"> • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age at risk for preclampsia • Folic acid supplements for women of childbearing age 400 & 800 mcg 		

Preventive care medications - continued on next page

Benefit Description	In-network You pay after deductible	Out-of-network You pay after deductible
Preventive care medications (cont.)	\$0	<i>All charges</i>
<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> - 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 <p>Note: To receive these benefits a prescription from a doctor must be presented to pharmacy</p>		
Covered medications and supplies	In-network You pay after deductible Network retail pharmacy for up to a maximum of a 30-day supply: Tier 1: \$10 copayment Tier 2: \$50 copayment Tier 3: \$100 copayment Tier 4: \$200 copayment Plan mail order pharmacy for up to a 90-day supply: Tier 1: \$25 copayment Tier 2: \$125 copayment Tier 3: \$250 copayment Tier 4: \$500 copayment	Out-of-network You pay after deductible <i>All charges</i>
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: <ul style="list-style-type: none"> • 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) <ul style="list-style-type: none"> - Estradiol - testosterone - leuprolide • Oral and injectable drugs associated with artificial insemination and IVF (3 cycles annually) procedures • Medications prescribed to treat obesity* <ul style="list-style-type: none"> - Saxenda - Wegovy - Zepbound <p>Prior Authorization is required</p> <p>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.</p>		

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
<p>*For a complete list of drugs and medications, visit www.uhcfeds.com or call our Customer Service Department 877-835-9861</p>	<p>Network retail pharmacy for up to a maximum of a 30-day supply:</p> <p>Tier 1: \$10 copayment Tier 2: \$50 copayment Tier 3: \$100 copayment Tier 4: \$200 copayment</p> <p>Plan mail order pharmacy for up to a 90-day supply:</p> <p>Tier 1: \$25 copayment Tier 2: \$125 copayment Tier 3: \$250 copayment Tier 4: \$500 copayment</p>	<i>All charges</i>
<p>Specialty Pharmacy (30-day supply)</p>	<p>Tier 1: \$10 copayment Tier 2: \$150 copayment Tier 3: \$350 copayment Tier 4: \$500 copayment</p>	<i>All charges</i>

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
<ul style="list-style-type: none"> • 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	<i>All charges</i>
<p>COVID-19 Over The Counter (OTC) Test Kits</p> <ul style="list-style-type: none"> • 8 Tests per member per month 	Tier 3 -\$12 Capped	<i>All charges</i>
<p>Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines.</p> <p>Contraceptive coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below.</p> <p>Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy.</p> <p>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.</p> <p>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.</p> <p>If you have difficulty accessing contraceptive coverage or other reproductive healthcare you can contact contraception@opm.gov.</p> <p>Reimbursement for over-the-counter contraceptives can be submitted in accordance with Section 7. by completing a prescription drug claim form and submitting it with the required documentation to: OptumRx at PO Box 29044, Hot Springs, AR 71903.</p> <p>Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Educational Classes and Programs in Section 5(a)</p>	\$0 (not subject to deductible)	<i>All charges</i>

Covered medications and supplies - continued on next page

Benefit Description	In-network You pay after deductible	Out-of-network You pay after deductible
Covered medications and supplies (cont.) <p>Smoking cessation medications are covered as follows:</p> <ul style="list-style-type: none"> • 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	<i>All charges</i>
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Drugs and supplies used for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed</i> • <i>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</i> • <i>Compound drugs that do not contain at least one covered ingredient that requires a Prescription Order or Refill</i> • <i>Alcohol swabs and bio-hazard disposable containers</i> • <i>Drugs for sexual performance for patients that have undergone genital reconstruction</i> • <i>Medical marijuana</i> • <i>Nonprescription medications unless specifically indicated elsewhere</i> 	<i>All charges</i>	<i>All charges</i>
<p>Opioid rescue agents such as naloxone are covered under this Plan with no cost sharing when obtained from a network pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections.</p> <p>For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose</p> <p>Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/</p>	\$0	<i>All charges</i>

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	In-network You pay	Out-of-network You pay
Accidental injury benefit 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: <ul style="list-style-type: none"> • 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	In-network You pay	Out-of-network You pay
Accidental injury benefit (cont.) <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> - 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
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Oral implants and related procedures, including bone grafts to support implants.</i> • <i>Procedures that involve teeth or their supporting structures (such as periodontal membrane, gingival and aveolar bone).</i> 	<i>All charges</i>	<i>All charges</i>
Adjunctive dental	In-network You pay	Out-of-network You pay
<p>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.</p> <p>Examples of adjunctive dental care are:</p> <ul style="list-style-type: none"> • 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	In-network You pay	Out-of-network You pay
Adjunctive dental (cont.) <p>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.</p>	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	HDHP
UnitedHealthcare's Digital Experience	<p>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</p> <p>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.</p> <p>Download the UnitedHealthcare app* for access to health plan ID cards, benefits information and help answering questions.</p> <p>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</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Download the UnitedHealthcare app from the App Store® or Google Play™</p> <p>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:</p> <p>Your personalized website, myuhc.com®, features tools designed to help you:</p> <ul style="list-style-type: none"> • 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.)	HDHP
	<ul style="list-style-type: none"> 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	<p>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.</p> <p>Find the right care for you</p> <p>Using the provider search tool, you can:</p> <ul style="list-style-type: none"> 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 <p>Tap into behavioral health support</p> <p>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.</p> <p>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</p> <ul style="list-style-type: none"> You'll get access to: <ul style="list-style-type: none"> Articles Podcasts Videos Other tools <p>To find behavioral health care, sign in or register on myuhc.com and then go to Find Care Behavioral Health Directory</p>
Sanvello/ Self Care by Able To	<p>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.</p> <ul style="list-style-type: none"> Assessments and tracking Mental health skills and tools – Cognitive Behavioral Therapy skills, meditations 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 <p>Community support – Peer to peer sharing and learning, see others' experiences</p>

Feature - continued on next page

Feature	Description
Feature (cont.)	HDHP
UHC Rewards and One Pass Select	<p>Your health plan comes with a new way to earn up to \$300. With UnitedHealthcare Rewards, you can earn up to \$300 for tracking your steps or sleep, getting an annual checkup and more. The activities you go for are up to you. When you activate UHC Rewards, you can also get started with One Pass Select™, a fitness program that gives you unlimited access to a nationwide network of thousands of fitness centers. Plus, you can use your earnings to help pay for a One Pass Select membership.</p> <p>Start earning with UHC Rewards by:</p> <ul style="list-style-type: none"> • Download the UnitedHealthcare® app and then: Sign in or register • Select UHC Rewards • Activate UHC Rewards • Select Redeem rewards to access One Pass Select
	<p><i>UnitedHealthcare Rewards is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you. If any fraudulent activity is detected (e.g., misrepresented physical activity), you may be suspended and/or terminated from the program. If you are unable to meet a standard related to health factor to receive a reward under this program, you might qualify for an opportunity to receive the reward by different means. You may call us toll-free at 1-866-230-2505 or at the number on your health plan ID card, and we will work with you (and, if necessary, your doctor) to find another way for you to earn the same reward. Rewards may be limited due to incentive limits under applicable law. Components subject to change. This program is not available for fully insured members in Hawaii, Vermont and Puerto Rico.</i></p> <p><i>One Pass Select is a voluntary program featuring a subscription-based nationwide gym network, digital fitness and grocery delivery service. The information provided under this program is for general informational purposes only and is not intended to be nor should it be construed as medical advice. Individuals should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for them. Purchasing discounted gym and fitness studio memberships, digital fitness or grocery delivery services may have tax implications. Employers and individuals should consult an appropriate tax professional to determine if they have any tax obligations with respect to the purchase of these discounted memberships or services under this program, as applicable. One Pass Select is a program offered by Optum. Subscription costs are payable to Optum.</i></p>
Smoking Cessation	<p>Quit for Life provides our members with resources and support for tobacco cessation. Included are:</p> <p>Portal and mobile app</p> <ul style="list-style-type: none"> • 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)

Feature - continued on next page

Feature	Description
Feature (cont.)	HDHP
	<p>Get started today. Go to myuhc.com, visit the "Health Resources" tab on the top right, Choose the "Quit for Life" tile.</p>
Maternity Health Solutions	<p>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.</p> <ul style="list-style-type: none"> • Maternity-related courses available on myuhc.com regarding course topics such as: <ul style="list-style-type: none"> - 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	<p>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.</p> <p>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.</p> <ul style="list-style-type: none"> • Premium Care Physician meets UnitedHealth Premium program quality & cost efficient care criteria. • Quality Care Physician meets UnitedHealth Premium program quality care criteria, but does not meet the program's cost efficient care criteria or is not evaluated for cost-efficient care. Physician is not eligible for a Premium designation. • Not Evaluated for Premium Care physician's specialty is not evaluated and/or does not have enough claims data for program evaluation or the physician's program evaluation is in process.
Real Appeal - A Lifestyle and Weight Management Program	<p>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.</p> <p>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.</p> <p>Real Appeal includes:</p>

Feature - continued on next page

Feature	Description
Feature (cont.)	HDHP
	<p>Social community resources such as: Real Appeal LinkedIn community; Facebook community; YouTube videos including getting started, workouts and success stories</p> <p>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:</p> <ul style="list-style-type: none"> • Balanced Portion plate • Electronic food scale • Digital weight scale • Fitness guide <p>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.</p> <p>24/7 online support and mobile app through our myuhc portal or directly through our myuhc mobile app. Staying accountable to goals may be easier than ever.</p> <ul style="list-style-type: none"> • 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	<p>What are the benefits of using Optum Specialty Pharmacy?</p> <p>Optum Specialty Pharmacy provides personalized support and resources at no extra cost to help you manage your condition.</p> <p>How does Optum Specialty Pharmacy support you?</p> <ul style="list-style-type: none"> • 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 <p>Tips for working with our Optum Specialty Pharmacy care team.</p> <ul style="list-style-type: none"> • 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. <p>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.</p>
Flexible Benefit Option	Under the flexible benefits option, we determine the most effective way to provide services.

Feature - continued on next page

Feature	Description
Feature (cont.)	HDHP
	<ul style="list-style-type: none"> • 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	<p>To be a qualifying clinical trial, a trial must meet all of the following criteria:</p> <ul style="list-style-type: none"> • Be sponsored and provided by a cancer center that has been designated by the <i>National Cancer Institute (NCI)</i> as a <i>Clinical Cancer Center</i> or <i>Comprehensive Cancer Center</i> or be sponsored by any of the following: <ul style="list-style-type: none"> - <i>National Institutes of Health (NIH)</i>. (Includes <i>National Cancer Institute (NCI)</i>.) - <i>Centers for Disease Control and Prevention (CDC)</i>. - <i>Agency for Healthcare Research and Quality (AHRQ)</i>. - <i>Centers for Medicare and Medicaid Services (CMS)</i>. - <i>Department of Defense (DOD)</i>. - <i>Veterans Administration (VA)</i>. • 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	<p>Understand Your Care Options and Costs. Before You Get Care. (visit myuhc.com)</p> <p>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.</p> <ul style="list-style-type: none"> • 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	<p>IT'S A FACT:</p> <p>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.</p> <ul style="list-style-type: none"> • 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	<p>Health and Wellness articles on topics including:</p> <ul style="list-style-type: none"> • 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.uhcaring.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.uhcaring.com or call 1-855-523-9355, Monday through Friday, 8:00 am to 8:00 pm CT.

UHC Rewards and One Pass* - UnitedHealthcare Rewards, you can earn dollars for tracking your steps or sleep, getting an annual checkup and more. The activities you go for are up to you. When you activate UHC Rewards, you can also get started with One Pass Select™, a fitness program that gives you unlimited access to a nationwide network of thousands of fitness centers. You can use your earnings to help pay for a One Pass Select membership. 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.uhonet.uhc.com/federal> or call 1-844-620-4814 (worldwide 24-hour a day).

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

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

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

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for 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 at UnitedHealthcare'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)**

.
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 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. <ul style="list-style-type: none">• 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. <ul style="list-style-type: none">• 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:

	<ul style="list-style-type: none"> • Not approved by the <i>U.S. Food and Drug Administration (FDA)</i> to be lawfully marketed for the proposed use and not identified in the <i>American Hospital Formulary Service</i> or the <i>United States American Hospital Pharmacopoeia Dispensing Information</i> 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 <i>Humanitarian Use Device</i> 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 <i>FDA</i> regulations, regardless of whether the trial is actually subject to <i>FDA</i> 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	<p>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.</p> <ul style="list-style-type: none"> • In accordance with <i>Generally Accepted Standards of Medical Practice</i>. • 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. <p>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.</p>
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: <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> • 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.

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Summary of Benefits for the HDHP of the UnitedHealthcare Insurance Company Inc. - 2025

- 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 2025 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: <i>All charges</i>	38
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	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	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	67
Emergency benefits: In-area or Out-of-area	In-Network: You pay \$350 copayment per visit Out-of-network: You pay 30% of our Plan allowance and any difference between our allowance and the billed amount	71
Mental health and substance use disorder treatment:	Regular cost-sharing	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: \$50 copayment Tier 3: \$100 copayment Tier 4: \$200 copayment	78
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: \$125 copayment Tier 3: \$250 copayment Tier 4: \$500 copayment	78
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.	83
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	49
Wellness and Other Special features	Health4Me, Quit for Life, Peloton, Maternity Health Solutions, UnitedHealth Premium, Real Appeal, Specialty Pharmacy, Flexible Benefit Option, Cancer Clinical Trials	86
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.	23

Notes

2025 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

Alabama, Arkansas, Florida, Louisiana, Mississippi, North Carolina and Tennessee

HDHP Option Self Only	LS1	\$272.82	\$90.94	\$591.11	\$197.04
HDHP Option Self Plus One	LS3	\$586.55	\$195.51	\$1,270.85	\$423.61
HDHP Option Self and Family	LS2	\$627.47	\$209.16	\$1,359.53	\$453.17

Arizona (Phoenix and Tucson), Colorado, Nevada, Oregon, Washington

HDHP Option Self Only	LU1	\$294.88	\$98.29	\$638.90	\$212.97
HDHP Option Self Plus One	LU3	\$634.00	\$211.33	\$1,373.66	\$457.89
HDHP Option Self and Family	LU2	\$678.23	\$226.08	\$1,469.51	\$489.83

District Of Columbia, Maryland, Pennsylvania, Virginia

HDHP Option Self Only	V41	\$243.05	\$81.02	\$526.61	\$175.54
HDHP Option Self Plus One	V43	\$522.57	\$174.19	\$1,132.24	\$377.41
HDHP Option Self and Family	V42	\$556.35	\$185.45	\$1,205.42	\$401.81

UnitedHealthcare Insurance Company, Inc.

www.uhcfeds.com

Customer Service: 877-835-9861

2025

Choice Primary

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

IMPORTANT

- Rates: Back Cover
- Changes for 2025: Page 15
- Summary of Benefits: Page 92

Serving the states of: Alabama, Arkansas, District of Columbia, Florida, Illinois, Iowa, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Pennsylvania, Tennessee, Texas, and Virginia as well as markets of Atlanta, Georgia and St. Louis, Missouri.

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

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

Enrollment Codes:

Y81 Self Only

Y83 Self Plus One

Y82 Self And Family

Authorized for distribution by the:



FEHB
Federal Employees
Health Benefits Program

**United States
Office of Personnel Management**

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

Important Notice from UnitedHealthcare Insurance Company, Inc.

About

Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

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

Medicare's Low Income Benefits

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

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 2963) between UnitedHealthcare Insurance Company, Inc and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 1-877-835-9861 or through our website www.uhcfebs.com. The address for our administrative offices is:

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

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2025, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates for each plan annually. Benefit changes are effective January 1, 2025, and changes are summarized on page 15. Rates are shown at the end of this brochure.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee and each covered family member, “we” means UnitedHealthcare Insurance Company, Inc.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

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

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

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

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

- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 1-844-359-7736 or go to www.uhc.com/fraud and explain the situation.
- If we do not resolve the issue:

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

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

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

You can also write to:

**United States Office of Personnel Management
 Office of the Inspector General Fraud Hotline
 1900 E Street NW Room 6400
 Washington, DC 20415-1100**

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

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

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

Discrimination is Against the Law

We comply with applicable Federal nondiscrimination laws and do not discriminate on the basis of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity).

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual's protected trait or traits, for example a member's gender identity or the fact that the covered benefit is sought in connection with gender-affirming care, will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined to be medically necessary.

Preventing Medical Mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

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

3. Get the results of any test or procedure.

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

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

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

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

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

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

Patient Safety Links

For more information on patient safety, please visit:

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

Preventable Healthcare Acquired Conditions ("Never Events")

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

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

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

FEHB Facts

Coverage information

- **No pre-existing condition limitation** We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.
- **Minimum essential coverage (MEC)** Coverage under this plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.
- **Minimum value standard** Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.
- **Where you can get information about enrolling in the FEHB Program** See www.opm.gov/healthcare-insurance for enrollment information as well as:
 - Information on the FEHB Program and plans available to you
 - A health plan comparison tool
 - A list of agencies who participate in Employee Express
 - A link to Employee Express
 - Information on and links to other electronic enrollment systemsAlso, 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 beginsWe do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.
- Once enrolled in your FEHB Program Plan, you should contact your carrier directly for address updates and questions about your benefit coverage.
- **Enrollment types available for you and your family** Self Only coverage is 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 carrier to add a family member when there is already family Coverage.

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

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

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

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

- **Family Member Coverage**

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

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

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

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

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

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

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

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

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

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

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

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

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

- **When benefits and premiums start** The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2025 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 **2024** benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

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

When you lose benefits

- **When FEHB coverage ends** You will receive an additional 31-days of coverage, for no additional premium, when:
 - Your enrollment ends, unless you cancel your enrollment, or
 - You are a family member no longer eligible for coverage.

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

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

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get information about your coverage choices. You can also visit OPM's website at <https://www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health>. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.
- **Temporary Continuation of Coverage (TCC)** If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, or if you are a covered child and you turn 26.

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

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

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll.

Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.
- **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 guaranteed issue in your state. For assistance in finding coverage, please contact us at 1-877-835-9861.

- **Health Insurance Market Place**

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

Section 1. How This Plan Works

This Plan is an open access high option health maintenance organization (HMO) plan. OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. UnitedHealthcare Insurance Company, Inc. holds the following accreditations: National Committee for Quality Assurance (NCQA). To learn more about this plan's accreditation(s), please visit the following website:

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

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

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

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

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

General Features of our High Option Plan

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

We have Open Access benefits

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

How we pay providers

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

United Healthcare Insurance Company, Inc. is an individual practice health maintenance organization. You do not need to select a Primary Care Provider (PCP) and you do not need to get written referrals to see a participating specialist for medical service. The provider must be participating for services to be covered. You must call United Behavioral Health at 1-877-835-9861 to obtain information regarding authorization for some services to use Mental Health/Substance Use Disorder benefits.

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

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

Your rights and responsibilities

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

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

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

If you want more information about us, call 1-877-835-9861. You may also visit our Web site at www.uhcfeds.com.

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

Your medical and claims records are confidential

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

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area is:

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

District of Columbia full market

Atlanta, Georgia - the following counties: Carroll, Clayton, Cherokee, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Forsythe, Fulton, Gwinnett, Haralson, Heard, Henry Butts, Jasper, Morgan, Newton, Paulding, Putnam, Rockdale, Spaulding and Walton

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

Section 2. Changes for 2025

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 on back page of this brochure.
- **Prescription drugs** - Retail pharmacy up to 30-day supply, increasing Tier's 1 and 4 drugs from \$5/\$150 to \$10/\$200 and Mail order 90-day supply, increasing Tier's 1, and 4 drugs from \$12.50/\$375 to \$25/\$500. Specialty Tier 1 copay will increase from \$5 to \$10. See page 68

Section 3. How You Get care

Identification cards	We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter. If you do not receive your ID card within 30-days after the effective date of your enrollment, or if you need replacement cards, call us at 1-877-835-9861, or write to us at United Healthcare Insurance Company Inc., Federal Employees Health Benefits (FEHB) Program, at P.O. Box 30432, Salt Lake City, UT 84130-0432. You may also print temporary cards and request replacement cards through our web site www.myuhc.com .
Where you get covered care	You get care from “Plan providers” and “Plan facilities”. You will only pay copayments, and/or coinsurance. If you use our Open Access program you can receive covered services from a participating provider without a required referral from your primary care 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 provider search tool is available on our Web sites at www.myuhc.com and www.uhcfeds.com . This plan recognizes that transgender, non-binary, and other gender diverse members require health care delivered by healthcare providers experienced in <u>gender affirming</u> 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 provider search tool is available from our Web sites www.myuhc.com and www.uhcfeds.com .

What you must do to get covered care

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

• Primary care

Your primary care provider (PCP) can be a family practitioner, internist, or pediatrician. Your primary care provider (PCP) will provide most of your healthcare. This plan includes 100% coverage for your primary care visits, all ages, for wellness and for illness visits.

• Specialty care

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

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

- If you are seeing a specialist when you enroll in our Plan, check with the specialist to verify that the specialist is participating with the Plan. If the specialist is contracted with the Plan, you may continue to see the provider. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you have a chronic and disabling condition and lose access to your specialist because we:
 - terminate our contract with your specialist for other than cause;
 - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or
 - reduce our service area and you enroll in another FEHB plan,

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

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

• Hospital care

Your Plan primary care 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;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

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

You need prior Plan approval for certain services	Since your primary care provider arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under <i>Other services</i> .
Inpatient Hospital Admission	Precertification is the process by which - prior to your inpatient hospital admission - we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.
Other Services	<p>You do not need to have a referral to see a participating specialist. For certain services, however, you or your physician must obtain prior approval from us. We call this review and approval process prior notification. You or your physician must obtain prior notification for some services such as, but not limited to the following:</p> <ul style="list-style-type: none"> • Applied Behavioral Analysis (ABA) • Air Ambulance (non-emergent) • Capsule endoscopy • Clinical trials • Congenital anomaly repair • CT Scans (Computed tomography) • Dialysis • Discectomy/fusion • Durable medical equipment over \$1,000 • Electro-convulsive therapy • Gender dysphoria services • Growth hormone therapy (GHT) • Hysterectomy • Iatrogenic infertility services • Infertility Services • Inpatient Hospitalization • Intensive Outpatient treatments • Joint replacement • Magnetic resonance angiogram (MRA) • Magnetic resonance imaging (MRI) • Morbid obesity surgery • Nuclear medicine studies including nuclear cardiology. • Orthopedic and prosthetic devices over \$1,000 • Partial hospitalization • PET scans • Psychological, neurophysiological and extended developmental testing • Reconstructive surgery • Rhinoplasty/septo-rhinoplasty • Sleep apnea - surgery and appliance (with sleep studies); sleep studies (polysomnograms) - attended • Substance use disorder treatments • TMJ surgery • Vein Ablation • Virtual Colonoscopy

- Transplants

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

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

Next, provide the following information:

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

**Non-urgent care
claims**

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

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

Urgent care claims

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

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

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

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 1-877-835-9861. You may also call OPM's FEHB 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 1-877-835-9861. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

Concurrent care claims	A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.
Emergency inpatient admission	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.
Maternity Care	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
• If your treatment needs to be extended	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 at 877-835-9861 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 his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.
What happens when you do not follow the precertification rules when using non-network facilities	If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.
Circumstances beyond our control	This plan is an HMO and does not offer coverage for non-network facilities. If you use non-network facilities without written authorization from the plan, you will be responsible for 100% of charges.
If you disagree with our pre-service claim decision	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 have a pre-service claim and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call 1-877-835-9861. If you have already received the service, supply, or treatment, then you have a post-service claim and must follow the entire disputed claims process detailed in Section 8.
To reconsider a non-urgent care claim	Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure. In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to 1. Precertify your hospital stay or, if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply; or 2. Ask you or your provider for more information.

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

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

3. Write to you and maintain our denial.

To reconsider an urgent care claim

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

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

To file an appeal with OPM

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

Section 4. Your Costs for Covered Services

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

Cost-Sharing

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

Copayments

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

Example: When you see your primary care provider you have no copayment for any office visits in this plan. Your copayment for a specialist visit is \$60.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them.

- The calendar year medical deductible for Self only is \$500; Your deductible for Self Plus One or Self and Family is \$1,000. Your pharmacy deductible which is applicable only for Tier 3 and Tier 4 drugs for Self Only is \$250 and for Self Plus One or Self and Family is \$500. This deductible does not apply to any Tier 1 or Tier 2 drugs.
- Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach \$500. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach \$1,000. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach \$1,000 under High Option.

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

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

Coinsurance

Coinurance is the percentage of our allowance that you must pay for your care.

Example: In our Plan, you pay 20% of our allowance for some services.

Differences between our Plan allowance and the bill

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

Your catastrophic protection out-of-pocket maximum

After your (copayments and coinsurance) total \$7,350 for Self Only or \$14,700 for Self Plus One or \$14,700 for Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services:

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 877-8345-9861.

• The Federal Flexible Spending Account Program – FSAFEDS

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

Section 5.High Option Benefits

Make sure that you review the benefits that are available under the option in which you are enrolled. Page 92 is a summary of your benefits.

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Section 5. High Option Benefits Overview

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

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

All benefits are subject to the annual deductible unless noted as not subject to deductible.

Our benefit package offers the following unique features:

High Option Benefits	You pay
Medical services provided by physicians: Preventive Care Services	No copayments for preventive care services. This includes items such as, but not limited to, immunizations, physical examinations and screenings as appropriate and recommended by U.S. Preventive Services Task Force. Please refer to Section 5 of the brochure for more detail.
Medical services provided by physicians: Diagnostic and treatment services provided in the office/telephonically	Visit to your Primary Care Provider (PCP) all ages - \$0 Virtual visit - \$0; not subject to deductible Visit to Specialist - you pay \$60 copayment; not subject to deductible
Medical services provided by physicians: Urgent Care	\$50; not subject to deductible
Services provided by a hospital: Inpatient	20% coinsurance of the plan allowance
Services Provided by a hospital: Outpatient surgical	20% coinsurance of the plan allowance in an approved free standing surgical center or 20% of the plan allowance plus \$250 per occurrence deductible in a hospital based surgical center
Emergency benefits: In or out-of-area	20% coinsurance of the plan allowance
Mental health and substance use disorder treatment:	Regular cost sharing
Prescription drugs: Retail (30-day supply)	Tier 1:\$10 Tier 2:\$50 Tier 3:\$100 Tier 4:\$200 Note: Tier 3 and Tier 4 medications subject to a separate pharmacy deductible of \$250 Self Only/\$500 Self Plus One or Self and Family
Prescription drugs: Plan mail order for up to a 90-day fill	Tier 1: \$25 Tier 2: \$125 Tier 3: \$250 Tier 4: \$500

	Note: Tier 3 and Tier 4 medications subject to a separate pharmacy deductible of \$250 Self Only/\$500 Self Plus One or Self and Family
Specialty Pharmacy (30-day supply)	Tier 1 \$10 Tier 2 \$150 Tier 3 \$350 Tier 4 \$500
Vision care: Note: Children have preventive eye examinations as described in the Bright Future Guidelines with 100% coverage	20% coinsurance

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

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

Retiree Advantage Plan Medical Benefits	You pay
Deductible	No deductible - See Section 9
Primary Care Provider Visit	\$0 - See Section 9
Preventive Care	\$0 - See Section 9
Specialist Visit	\$0 - See Section 9
Virtual Visit	\$0 - See Section 9
Urgent Care	\$0 - See Section 9
Urgent Care	\$0 - See Section 9
Emergency Room	\$0 - See Section 9
Pharmacy (30 day supply)	Tier 1 - \$5 Tier 2 - \$30 Tier 3 - \$60 Tier 4 - \$90 See Section 9

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

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

Benefit Description	
Diagnostic and treatment services	You pay
Professional services of physicians - Primary care Provider (PCP) <ul style="list-style-type: none"> • In physician's office/telehealth/Optum primary care • Office medical consultations • Advanced care planning Professional services of physicians - Specialist <ul style="list-style-type: none"> • In physician's office/telehealth • Office medical consultations • Second surgical opinion • Advanced care planning Professional services of physicians in a Facility <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • In a skilled nursing facility • At home 	\$0 \$60 copayment - not subject to deductible 20% coinsurance of the plan allowance

High Option

Benefit Description	You pay
Virtual visits	
<p>Use virtual visits when :</p> <ul style="list-style-type: none"> • Your doctor is not available • You become ill while traveling • Conditions such as: cold, flu, bladder infection, bronchitis, diarrhea, fever, pink eye, rash, sinus problem, sore throat, stomachache <p>Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider.</p> <p>Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at 877-835-9861. Virtual Visits and prescription services are subject to state regulations. You can pre-register with a group. After registering and requesting a visit you will pay your portion of service costs and then you enter a virtual waiting room.</p>	\$0 - not subject to deductible
Lab, X-ray and other diagnostic tests	You pay
<p>Tests, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG <ul style="list-style-type: none"> • CT /CAT Scans • MRI • PET Scans 	20% coinsurance of the plan allowance
Preventive care, adult	You pay
<p>Routine physical every year</p> <p>The following preventive services are covered at the time interval recommended at each of the links below:</p> <ul style="list-style-type: none"> • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. For a complete list of screenings go to the website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendations-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.hrsa.gov/womens-guidelines 	\$0

Preventive care, adult - continued on next page

High Option

Benefit Description	High Option
Preventive care, adult (cont.)	You pay
<ul style="list-style-type: none"> To build your personalized list of preventive services go to https://health.gov/myhealthfinder 	\$0
<p>One annual biometric screening, determined by age and frequency recommendations, to include:</p> <ul style="list-style-type: none"> Body mass index (BMI) Blood pressure Lipid/cholesterol levels Glucose/hemoglobin A1c measurement <p>Note: Office visit and lab services must be rendered on the same day and coded by your doctor as preventive to be covered in-full</p> <p>Members can complete their HRA (Health Risk Assessment) on www.myuhc.com</p>	\$0
<p>Routine mammogram</p> <ul style="list-style-type: none"> Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC); based on the Advisory Committee on Immunization Practices (ACP) schedule. For a complete list of endorsed immunizations go to the Centers for Disease Control (CDC) website athttps://www.cdc.gov/vaccines/schedules/ <p>Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.</p>	\$0
<p>BRCA genetic counseling and evaluation are covered as preventive services when a woman's family history is associated with an increased risk for deleterious mutations in <i>BRCA1</i> or <i>BRCA2</i> genes and medical necessity criteria has been met</p>	\$0
<p>Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows:</p> <ul style="list-style-type: none"> Intensive nutrition and behavioral weight-loss counseling therapy, Family centered programs when medically identified to support obesity prevention and management by an in-network provider. 	\$0
<ul style="list-style-type: none"> When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) for cost share requirements for anti-obesity medications. 	\$0
<ul style="list-style-type: none"> When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share. 	\$0
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.</i> <i>Immunizations, boosters, and medications for travel or work-related expenses</i> 	<i>All charges</i>

High Option

Benefit Description	High Option
Preventive care, children	You pay
<ul style="list-style-type: none"> Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org Children's immunizations endorsed by the Centers for Disease Control (CDC) including DTaP/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the website at https://www.cdc.gov/vaccines/schedules/index.html You can also find a complete list of U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations <p>Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.</p>	\$0
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows:	\$0
<ul style="list-style-type: none"> Intensive nutrition and behavioral weight-loss counseling therapy, Family centered programs when medically identified to support obesity prevention and management by an in-network provider. 	
When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) for cost share requirements for anti-obesity medications.	\$0
When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share.	\$0
Maternity care	You pay
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> Prenatal and Postpartum care Screening for gestational diabetes Delivery Screening and counseling for prenatal and postpartum depression <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> As part of your coverage, you have access to in-network certified nurse midwives, and board-certified lactation specialists during the prenatal and post-partum period. You do not need to precertify your vaginal delivery; see page 18 for other circumstances, such as extended stays for you or your baby. Routine care includes office visits, one office sonogram (as part of prenatal care) and laboratory work. Copays will continue to apply to specialized scanning, any specialist not the member's current OB/GYN, durable medical equipment, prescription drugs, chiropractic and acupuncture services, emergency room visits, urgent care visits, or inpatient hospital copayments as these services are not considered routine. 	20% coinsurance of the plan allowance

Maternity care - continued on next page

High Option

Benefit Description	You pay
Maternity care (cont.)	
<ul style="list-style-type: none"> You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). <p>Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits</p>	20% coinsurance of the plan allowance
Breastfeeding and lactation support, supplies and counseling for each birth	\$0
<i>Not covered: Routine sonograms to determine fetal age, size or sex after the first sonogram.</i>	<i>All charges</i>
Family planning	
<p>A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories on the HRSA list. This list includes:</p> <ul style="list-style-type: none"> Voluntary female sterilization Surgically implanted contraceptives Injectable contraceptive drugs (such as Depo Provera) Intrauterine devices (IUDs) Diaphragms <p>Note: See additional Family Planning and Prescription drug coverage Section 5(f).</p> <p>Note: Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below.</p> <p>Contraceptive products that are not already available at \$0 cost-share can be provided at \$0 member cost-share if the provider determines that a particular contraceptive is medically necessary for that member. The cost-share waiver process requires that providers attest the product is needed for contraceptive purposes and this can be submitted electronically by the provider. To request an exemption, please call customer service at 887-835-9861</p> <p>If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov.</p>	\$0 - not subject to deductible
Voluntary male sterilization	20% coinsurance of the plan allowance

Family planning - continued on next page

High Option

Benefit Description	High Option
Family planning (cont.)	You pay
Genetic testing is covered when medically necessary for conditions such as pregnancy testing for cystic fibrosis, coverage of certain cancer drugs, certain autosomal recessive conditions, autosomal dominant less penetrant conditions, x-linked conditions and certain chromosome abnormalities	\$0
<i>Not covered:</i>	<i>All charges</i>
<ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic testing not medically necessary</i> 	
Infertility services	You pay
Diagnosis and treatment of the cause of infertility	20% coinsurance of the plan allowance
<p>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.</p> <p>Covered Services</p> <p>Diagnosis and treatment of infertility specific to:</p> <p>Artificial insemination:</p> <ul style="list-style-type: none"> • Intravaginal Insemination (IVI) • Intracervical Insemination (ICI) • Intrauterine Insemination (IUI) <p>Fertility drugs (see section 5f)</p> <ul style="list-style-type: none"> • Oral and injectable drugs associated with artificial insemination and IVF (3 cycles annually) procedures <p>Note: Prior Authorization required</p>	50% coinsurance of the plan allowance
Allergy care	You pay
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	20% coinsurance of the plan allowance
Allergy serum	\$0
<i>Not covered:</i>	<i>All charges</i>
<ul style="list-style-type: none"> • <i>Provocative food testing</i> • <i>Sublingual allergy desensitization</i> 	

High Option

Benefit Description	You pay
Treatment therapies <ul style="list-style-type: none"> Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 45.</p> <ul style="list-style-type: none"> Respiratory and inhalation therapy (Pulmonary rehabilitation) is provided for up to 20 visits per year Cardiac rehabilitation following qualifying event/condition is provided for up to 36 visits per condition per year Dialysis – hemodialysis and peritoneal dialysis Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy Growth hormone therapy (GHT) <p>Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See <i>Other services under You need prior Plan approval for certain services</i> on page 18. Note: Growth hormone is covered under the prescription drug benefit.</p> <ul style="list-style-type: none"> Applied Behavior Analysis (ABA) - Children with autism spectrum disorder is covered under section 5(e) 	20% coinsurance of the plan allowance
Physical and occupational therapies <p>Up to 60 per year for rehabilitative/habilitative in any combination of the following:</p> <ul style="list-style-type: none"> Qualified physical therapists Occupational therapists Physician Licensed therapy provider <p>Services must be performed by a physician or by a licensed therapy provider.</p> <p>Note: We only cover therapy when a physician:</p> <ul style="list-style-type: none"> 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. <p>Benefits can be denied or shortened for covered persons who are not progressing in goal-directed rehabilitative services or if rehabilitation goals have not been met.</p> <p>We will pay benefits for up to 20 visits of cognitive rehabilitation therapy only when medically necessary following sudden external injuries such as car accidents or falls; or sudden internal injuries such as stroke (cerebral vascular accident), aneurysm, anoxia, encephalitis or brain tumors.</p> <p>Cochlear therapy- up to 30 visits following post cochlear implant</p> <p>All Therapies are subject to medical necessity.</p>	20% coinsurance of the plan allowance
Habiliative 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:	20% coinsurance of the plan allowance

Physical and occupational therapies - continued on next page

High Option

Benefit Description	You pay
Physical and occupational therapies (cont.)	
<ul style="list-style-type: none"> • Speech therapy • Occupational therapy; and • Physical therapy <p>Includes medically necessary rehabilitative services coverage for children with Autism, an Autism Spectrum disorder, or Cerebral Palsy</p> <p>Note: No day or visits apply to these services. A congenital disorder means a significant structural or functional abnormality that was present from birth</p>	20% coinsurance of the plan allowance
<i>Not covered:</i> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Exercise programs 	<i>All charges</i>
Speech therapy	
Up to 20 visits per calendar year for rehabilitative/habilitative speech therapy.	20% coinsurance of the plan allowance
<i>Not covered:</i> <ul style="list-style-type: none"> • Exercise programs • Voice therapy 	<i>All charges</i>
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist. • Hearing aids covered as follows: Benefits are limited to \$2,500 per year. Benefits are further limited to a single purchase per hearing impaired ear every three years. Repair or replacement of a hearing aid would apply to this limit in the same manner as a purchase. <p>Note: for routine hearing screening performed during a child's preventive care visit, see Section 5(a) Preventive care children</p> <ul style="list-style-type: none"> • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants <p>Note: for benefits for the devices, see Section (a) <i>Orthopedic and prosthetic devices</i>.</p>	20% coinsurance of the plan allowance
<i>Not covered:</i> <ul style="list-style-type: none"> • All other hearing aids and testing for them • Hearing services that are not shown as covered 	<i>All charges</i>
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • Initial pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Basic annual eye refraction exams to obtain a written lens prescription <p>Note: Children examinations are covered at no charge as outlined in the Bright Future Guidelines provided by the American Academy of Pediatrics</p> <p><i>Replacement glasses or contact lenses are not covered after the initial pair.</i></p>	20% coinsurance of the plan allowance
<i>Not covered:</i> <ul style="list-style-type: none"> • Eyeglasses or contact lenses, except as shown above 	<i>All charges</i>

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

High Option

Benefit Description	
Vision services (testing, treatment, and supplies) (cont.)	You pay
<ul style="list-style-type: none"> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> 	<i>All charges</i>
Foot care	You pay
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	20% coinsurance of the plan allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>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)</i> 	<i>All charges</i>
Orthopedic and prosthetic devices	You pay
<ul style="list-style-type: none"> • Artificial limbs and eyes • Prosthetic sleeve or sock • Orthopedic devices such as braces, medical supplies including colostomy supplies, dressings, urinary catheters and related supplies • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy • Bone-anchored hearing aids (BAHA) are covered only when the member has either of the following: <ul style="list-style-type: none"> - Craniofacial anomalies in which abnormal or absent ear canals preclude the use of a wearable hearing aid; - Hearing loss of sufficient severity that it cannot be adequately remedied by a wearable hearing aid - Benefits limited to one bone anchored hearing aid per member, who meets the above coverage criteria, during the entire period of time the member is enrolled in the health plan. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome <p>Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.</p> <p>Note: Plan prior authorization required for items that cost \$1,000 or more.</p>	20% coinsurance of the plan allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Foot orthotics</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Speech prosthetics (except electrolarynx)</i> 	<i>All charges</i>

Orthopedic and prosthetic devices - continued on next page

High Option

Benefit Description	
Orthopedic and prosthetic devices (cont.)	You pay
<ul style="list-style-type: none"> • Prosthetic replacements provided less than 3 years after the last one we covered 	<i>All charges</i>
Durable medical equipment (DME)	You pay
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • CPAP • Walkers • Blood glucose monitors /continuous glucose monitors • Insulin pumps • Wigs for hair loss due to the treatment of cancer - limit \$350 per year <p>Note: Plan prior authorization is required for items that cost \$1,000 or more. Repairs and replacements are covered if needed due to a change in the member's medical condition. Call us at 877-835-9861 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	20% coinsurance of plan allowance
<i>Not covered:</i> <p><i>Motorized wheelchairs</i></p> <p><i>Audible prescription reading devices</i></p> <p><i>Hearing aids</i></p> <p><i>Speech generating devices</i></p> <p><i>Talkers</i></p> <p><i>Story boards</i></p> <p><i>Scooters</i></p>	<i>All charges</i>
Home health services	You pay
<ul style="list-style-type: none"> • Home health care 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: <ul style="list-style-type: none"> - 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 	20% coinsurance of plan the allowance

Home health services - continued on next page

High Option

Benefit Description	You pay
Home health services (cont.) <ul style="list-style-type: none"> - 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 oxygen therapy, intravenous therapy and medications. (Medications may be billed separately) • Limit of 60 visits per year • Prescription foods covered as follows: <ul style="list-style-type: none"> - 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 plan the allowance
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family.</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> • <i>Private duty nursing</i> • <i>Foods that can be obtained over the counter (without a prescription) even if prescribed by a physician</i> 	<i>All charges</i>
Chiropractic <ul style="list-style-type: none"> • Diagnosis and related services for the manipulation of the spine and extremities to remove nerve interference or its effects. Limited to one treatment per day up to 20 visits per calendar year <p>Note: The interference must be the result of, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column.</p>	20% coinsurance of the plan allowance
Alternative treatments <p>Acupuncture - by a doctor of medicine or osteopathy, or licensed or certified acupuncture practitioner</p> <p>Up to 12 visits per year</p> <p>Dry Needling - by a licensed or certified practitioner</p> <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Naturopathic services</i> • <i>Hypnotherapy</i> • <i>Biofeedback</i> • <i>Massage Therapy</i> • <i>Herbal medicine</i> • <i>Rolfing</i> 	20% coinsurance of the plan allowance

Alternative treatments - continued on next page

High Option

Benefit Description	High Option
Alternative treatments (cont.)	You pay
<ul style="list-style-type: none"> • <i>Ayurveda</i> • <i>Homeopathy</i> • <i>Other alternative treatments unless specifically listed as covered</i> 	<i>All charges</i>
Educational classes and programs	You pay
Coverage is provided for: Tobacco Cessation program which includes online learning, Quit Coach, Nicotine Replacement Therapy Coaching and over the counter and prescription drugs approved by the FDA (subject to age and treatment therapy recommendations) to treat tobacco dependence. Learn more about this program in Section 5(h) Wellness and other Special Features.	\$0 - not subject to deductible
<ul style="list-style-type: none"> • Outpatient self-management training for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin using diabetes, and other designated chronic disease conditions. • Must be prescribed by a licensed healthcare professional who has appropriate state licensing authority • Outpatient self management training includes, but is not limited to, education and medical nutrition therapy. The training must be provided by a certified registered or licensed healthcare professional trained in the care and management of diabetes. • Initial training visit; up to 10 hours, after you are diagnosed with diabetes for the care and management of diabetes 	20% coinsurance of the plan allowance

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The calendar year deductible is: \$500 Self Only, \$1,000 Self Plus One and Self and Family. The calendar year deductible applies to almost all benefits in this Section. We indicate "Not subject to deductible" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with other coverage*, including with Medicare.
- The amounts listed below are for the charges **billed by a physician or other healthcare professional** for your surgical care. Look in Section 5(a) for charges associated with an office visit and Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- If you enroll in UnitedHealthcare Choice Primary Plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a \$150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.)
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SERVICES AND/OR PROCEDURES.** Please refer to the preauthorization information shown in Section 3 or call customer service to be sure which services require preauthorization.

Benefit Description	You pay
Surgical procedures	You pay
A comprehensive range of services, such as: <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see <i>reconstructive surgery</i>) • Insertion of internal prosthetic devices. See 5(a) <i>Orthopedic and prosthetic devices</i> for device coverage information • Treatment of burns 	20% coinsurance of the plan allowance
Note: For female surgical family planning procedures see Family Planning Section 5 (a)	
Note: For male surgical family planning procedures see Family Planning Section 5(a)	
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; (see Foot care)</i> 	<i>All charges</i>

Benefit Description	You pay
<p>Bariatric Surgery (Surgical Treatment of Morbid Obesity)</p> <p>Surgical treatment of severe obesity (bariatric surgery):</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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
<p>Revisions Bariatric Surgery due to a technical failure or major complication from the initial procedure; potential failure/complications include but are not limited to the following:</p> <ul style="list-style-type: none"> • Bowel perforation (including adjustable gastric band erosion) • Adjustable gastric band migration (slippage) that cannot be corrected with manipulation or adjustment (records must demonstrate that manipulation or adjustment to correct band slippage has been attempted) • Leak • Obstruction (confirmed by imaging studies) • Staple-line failure • Mechanical adjustable gastric band failure • Uncontrollable reflux related to sleeve gastrectomy when all the following criteria are met: <ul style="list-style-type: none"> - Maximum nonpharmacological medical management failure (e.g., positional, dietary modification and behavioral changes); and - Maximum pharmacological medical management failure (e.g., at least one month of double dose PPI, H₂ blocker, and/or sucralfate); and - Severe esophagitis (<u>grade C or D</u>) confirmed by endoscopy despite maximum medical management <p>The individual must also meet the following criteria: Both of the following:</p>	20% coinsurance of the plan allowance

Bariatric Surgery (Surgical Treatment of Morbid Obesity) - continued on next page

High Option

Benefit Description	You pay
Bariatric Surgery (Surgical Treatment of Morbid Obesity) (cont.)	
<ul style="list-style-type: none"> 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
Iatrogenic infertility services	You pay
<p>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.</p> <p>Covered benefits include the following procedures:</p> <ul style="list-style-type: none"> Collection of sperm Cryo-preservation of sperm Oocyte cryo-preservation Embryo cryo-preservation Ovarian stimulation, retrieval of eggs and fertilization <p>The following benefits are not covered</p> <ul style="list-style-type: none"> Embryo transfer Long-term storage costs (greater than 1 year) Elective fertility preservation <p>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.</p> <p>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 combine maximum. Prior authorization is required.</p> <p>Facility fees, pharmacy fees and lab fees will apply</p>	20% coinsurance of the plan allowance and a \$60 copayment for specialist visits
Gender Affirming Surgery	You pay
<p>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]).</p> <p>Requirements:</p> <ul style="list-style-type: none"> Must be 18 years of age or older Must have documented evidence of persistent gender dysphoria Favorable psychosocial-behavioral evaluation to provide screening and identification of risk factors or potential postoperative challenges Persistent, well-documented Gender Dysphoria Capacity to make a fully informed decision and to consent for treatment Complete at least 12 months of successful continuous full-time real-life experience in the desired gender 	20% coinsurance of the plan allowance

Gender Affirming Surgery - continued on next page

Benefit Description	High Option
Gender Affirming Surgery (cont.)	You pay
<ul style="list-style-type: none"> • 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* <p>Gender affirming surgeries for (male to female) include:</p> <ul style="list-style-type: none"> • 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 • 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) <p>Gender affirming surgeries for (female to male) include:</p> <ul style="list-style-type: none"> • 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

Gender Affirming Surgery - continued on next page

High Option

Benefit Description		
Gender Affirming Surgery (cont.)	You pay	
Note: Prior Authorization is required	20% coinsurance of the plan allowance	
Reconstructive surgery	You pay	
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - 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: <ul style="list-style-type: none"> - 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) <p>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.</p>	20% coinsurance of the plan allowance	
Oral and maxillofacial surgery	You pay	
Oral surgical procedures, limited to: <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. 	20% coinsurance of the plan allowance	
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<i>All charges</i>	
Temporomandibular Joint Dysfunction (TMJ)	You pay	
Services for the evaluation and treatment of TMJ and associated muscles <ul style="list-style-type: none"> • 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. <p>Benefits for surgical services include:</p> <ul style="list-style-type: none"> • Arthrocentesis 	20% coinsurance of the plan allowance	

Temporomandibular Joint Dysfunction (TMJ) - continued on next page

High Option

Benefit Description	High Option
Temporomandibular Joint Dysfunction (TMJ) (cont.)	You pay
<ul style="list-style-type: none"> • Arthroscopy • Arthroplasty • Arthrotomy • Open or closed reduction of dislocation <p>\$3,000 limit</p>	20% coinsurance of the plan allowance
Organ/tissue transplants	You pay
<p>These solid organ transplants are covered. Solid organ transplants are limited to:</p> <ul style="list-style-type: none"> • 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 <p>These tandem blood or marrow stem cell transplants for covered transplants are subject to medical review by the Plan. Refer to <i>Other services</i> in Section 3 for your authorization procedures.</p> <ul style="list-style-type: none"> • Autologous tandem transplants for <ul style="list-style-type: none"> - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer) 	20% coinsurance of the plan allowance
Blood or marrow stem cell transplants the plan extends coverage for the diagnoses as indicated below: <ul style="list-style-type: none"> • Allogenic transplants for <ul style="list-style-type: none"> - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hematopoietic stem cell - Hemoglobinopathy 	20% coinsurance of the plan allowance

Organ/tissue transplants - continued on next page

High Option

Benefit Description	You pay
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none"> - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome 	20% coinsurance of the plan allowance
<ul style="list-style-type: none"> • Autologous transplants for <ul style="list-style-type: none"> - 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 - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors 	20% coinsurance of the plan allowance
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.	20% coinsurance of the plan allowance
<p>Refer to <i>Other services</i> in Section 3 for prior authorization procedures:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - 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) 	

Organ/tissue transplants - continued on next page

Benefit Description	High Option
Organ/tissue transplants (cont.)	You pay
<ul style="list-style-type: none"> - 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 <ul style="list-style-type: none"> - 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
<p>These blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence if approved by the Plan's medical director in accordance with the Plan's protocols.</p> <p>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.</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Sickle Cell Anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning RIC) for <ul style="list-style-type: none"> - 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 	20% coinsurance of the plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay
<p>Organ/tissue transplants (cont.)</p> <ul style="list-style-type: none"> - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myelodysplasia/Myelodysplastic Syndromes - Myeloproliferative disorders (MDDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle Cell anemia • Autologous Transplants for <ul style="list-style-type: none"> - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin's lymphoma - Breast Cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early 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 <p>National Transplant Program (NTP) - OptumHealth Care Solutions (URN) used for organ tissue transplants</p> <p>Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute - or National Institutes of Health - approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor. Transplants must be provided in a Plan designated Center for Transplants. These centers do a large volume of these procedures each year and have a comprehensive program of care. A listing of these centers can be found in the Plan Directory of Health Care Providers, at our member web site www.myuhc.com or call our Customer Service Department at 1-877-835-9861 to request an up-to-date listing.</p>	20% coinsurance of the plan allowance

Organ/tissue transplants - continued on next page

High Option

Benefit Description	High Option
Organ/tissue transplants (cont.)	You pay
<p>Note: We cover donor screening tests for up to 4 potential bone marrow/stem cell transplant donors.</p> <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except as shown above</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> • <i>All services related to non-covered transplants</i> • <i>All services associated with complications resulting from the removal of an organ from a non-member</i> 	20% coinsurance of the plan allowance
Anesthesia	You pay
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital (outpatient department) • Skilled nursing facility • Ambulatory surgical center • Office 	You pay 20% coinsurance

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

	<p>Important things you should keep in mind about these benefits:</p> <ul style="list-style-type: none"> • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary. • Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility. • The calendar year deductible is: \$500 Self Only, \$1,000 Self Plus One and Self and Family. The calendar year deductible applies to almost all benefits in this Section. We indicate "Not subject to deductible" to show when the calendar year deductible does not apply. • Be sure to read Section 4, <i>Your Costs for Covered Services</i> for valuable information about how cost-sharing works. Also, read Section 9, <i>Coordinating benefits with other coverage</i>, including with Medicare. • The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b). • If you enroll in UnitedHealthcare Choice Primary Plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a \$150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.) • 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. 	
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Benefit Description	You pay
Inpatient hospital	You pay
Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	20% coinsurance of the plan allowance
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	20% coinsurance of the plan allowance
<i>Not covered:</i> <ul style="list-style-type: none"> • Custodial care 	<i>All charges</i>

Inpatient hospital - continued on next page

Benefit Description	
Inpatient hospital (cont.)	You pay
<ul style="list-style-type: none"> • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as phone, television, barber services, guest meals and beds • Private nursing care unless medically necessary 	<i>All charges</i>
Outpatient hospital or ambulatory surgical center	You pay
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>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.</p>	20% coinsurance of the plan allowance at an approved ambulatory surgical center or 20% coinsurance plus a per occurrence deductible of \$250 at a hospital-based facility
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	<i>All charges</i>
Extended care benefits/Skilled nursing care facility benefits	You pay
<ul style="list-style-type: none"> • Room and board in a semi-private room • General nursing • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor • Benefits up to 60-days when full time skilled nursing care is necessary and confinement is medically appropriate. • 	20% coinsurance of the plan allowance
<i>Not covered: Custodial care</i>	<i>All charges</i>
Hospice care	You pay
<ul style="list-style-type: none"> • Inpatient care • Outpatient care • Family counseling • Supportive and palliative care for a terminally ill member is covered in the home or hospice 	20% coinsurance of plan allowance
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges</i>

Benefit Description	
Ambulance - Non Emergency	You pay
<p>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:</p> <ul style="list-style-type: none"> • 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. 	20% coinsurance of the plan allowance
<p>For the purpose of this Benefit the following terms have the following meanings:</p> <ul style="list-style-type: none"> • "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting. • "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness. • "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis. 	
<p>Not Covered:</p> <p><i>International Transportation</i></p>	<i>All charges</i>

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

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

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within or outside our service area

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

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

Benefit Description	
Emergency within or outside our service area	You pay
<ul style="list-style-type: none"> Emergency care at a doctor's office 	<p>\$0 copayment Primary Care visit; not subject to deductible, or \$60 copayment for Specialist visit; not subject to deductible</p>
<ul style="list-style-type: none"> Emergency care at an urgent care center 	\$50 copayment; not subject to deductible
<ul style="list-style-type: none"> Emergency care as an outpatient at a hospital, including doctors' services 	20% coinsurance of the plan allowance - waived if admitted to hospital
<i>Not covered:</i>	<i>All charges</i>
<ul style="list-style-type: none"> <i>Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers</i> <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> 	
Ambulance - Emergency	You pay
Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance or water vehicle) to the nearest Hospital where the required Emergency Health Care Services can be performed.	20% coinsurance of the plan allowance
Note: See Section 5(c) for non-emergency service.	
Not Covered:	All charges
<i>International Transportation</i>	

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

	<p>You need to get Plan approval (preauthorization) for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance use disorder benefits are no greater than for similar benefits for other illnesses and conditions.</p> <p>Important things you should keep in mind about these benefits:</p> <ul style="list-style-type: none"> • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary. • Be sure to read Section 4, <i>Your Costs for Covered Services</i>, for valuable information about how cost-sharing works. Also, read Section 9, <i>Coordinating benefits with other coverage</i>, including with Medicare. • We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required • The calendar year deductible is: \$500 Self Only, \$1,000 Self Plus One and Self and Family. The calendar year deductible applies to almost all benefits in this Section. We indicate "Not subject to deductible" to show when the calendar year deductible does not apply. • OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another. • If you enroll in UnitedHealthcare Choice Primary Plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a \$150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.) • 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. 	
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Benefit Description	You pay
Professional services	You pay
<p>When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.</p> <p>Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders and services include:</p> <ul style="list-style-type: none"> • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) in office • Diagnosis and treatment of substance use disorders, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting 	<p>Your cost-sharing responsibilities are no greater than for any other illnesses or conditions</p> <p>Your cost share responsibilities are no greater than for other illnesses or conditions</p>

Professional services - continued on next page

Benefit Description	
Professional services (cont.)	You pay
<ul style="list-style-type: none"> • Electroconvulsive therapy <p>Applied Behavioral Analysis (ABA) group and individual office visits - Not subject to deductible Coverage includes Autism Spectrum Disorder Subject to medical necessity</p>	Your cost share responsibilities are no greater than for other illnesses or conditions \$0
Diagnostics	You pay
<ul style="list-style-type: none"> • Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility 	20% coinsurance of the plan allowance
Inpatient hospital or other covered facility	You pay
<p>Inpatient services provided and billed by a hospital or other covered facility</p> <ul style="list-style-type: none"> • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Services in approved half-way house, residential treatment, full-day hospitalization, partial hospitalization 	20% coinsurance of the plan allowance
Outpatient hospital or other covered facility	You pay
<p>Outpatient services provided and billed by a hospital or other covered facility</p> <ul style="list-style-type: none"> • Services in facility-based intensive outpatient treatment 	20% coinsurance of the plan allowance
Not covered	You pay
<ul style="list-style-type: none"> • <i>Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan physician to be necessary and appropriate</i> • <i>Services and supplies when paid for directly or indirectly by a local, State, or Federal Government agency.</i> • <i>Room and board at therapeutic boarding schools</i> • <i>Services rendered or billed by schools</i> • <i>Services that are not medically necessary</i> • <i>Methadone maintenance unless it is a part of an approved treatment program</i> 	All charges

Section 5(f). Prescription Drug Benefits

	<p>Important things you should keep in mind about these benefits:</p> <ul style="list-style-type: none"> • We cover prescription medications, as described in the chart beginning on the next page. Some injectable medications are provided by your medical benefit. Please see below for more information. • Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary. Some prescription medications have Quantity Level Limits (QLL) and Quantity per Duration Limits (QD). Please see below for more information. • Your prescribers must obtain prior approval/authorization for certain prescription drugs before coverage applies. Prior approval/authorizations must be renewed periodically. Drugs requiring prior approval may be limited to quantities prescribed in accordance to acceptable practice standards in the United States. If your pharmacist tells you that your prescription medication requires prior approval, ask your pharmacist or physician to contact the Plan at the number on your Member ID card for further instructions. • Federal law prevents the pharmacy from accepting unused medications. • The calendar year medical deductible is: \$500 Self Only, \$1,000 Self Plus One and Self and Family. The calendar year medical deductible does not apply to your pharmacy benefits. Your prescription drug benefit also has a separate deductible which only applies to the Tier 3 and Tier 4 medications which is \$250 for Self Only, \$500 for Self plus One and Self and Family. Note: this Tier 3 and Tier 4 deductible does not apply to medications in the specialty pharmacy tiers. • <i>Be sure to read Section 4, Your Costs for Covered Services, for valuable information about how cost-sharing works. Also, read Section 9, coordinating benefits with other coverage, including with Medicare.</i> • If you enroll in UnitedHealthcare Choice Primary Plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a \$150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.) 	
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. 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/or certified providers with prescriptive authority prescribing within their scope of practice, must prescribe your medication.
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy. Retail or mail order Specialty Pharmacy drugs are only filled at our Specialty Pharmacy. Some drugs are only available at the retail pharmacy for safety or other reasons. To locate the name of a Plan pharmacy near you, refer to your Directory of Health Care Professionals, call our Customer Service Department 1-877-835-9861 or visit our website, www.uhcfebs.com. Members can log into their account at myuhc.com as well.
- **We use a Prescription Drug List called the Advantage (PDL).** Our PDL Management Committee creates this list that includes FDA approved prescription medications, products, or devices. Our Plan covers prescription medications written in accordance with FDA guidelines for a particular therapeutic indications. The PDL Management Committee decides the tier placement based upon clinical information from the UnitedHealthcare Pharmacy and Therapeutics (P&T) Committee as well economic and financial considerations. You will find important information about our PDL as well as other Plan information on our web site, www.uhcfebs.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 mail order), and includes select generic medications, as well as 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 (**\$50** for up to a 30-day supply or **\$125** for up to a 90-day supply through mail order), and contains most preferred brand medications not included in Tier 1. Preferred medications placed in Tiers 1 and 2 are those the PDL Management Committee has determined to provide better overall value than those in Tier 3. If you are currently taking a medication in Tier 2, ask your provider whether there are Tier 1 alternatives that may be appropriate for your treatment.
- **Tier 3** is your **higher** copayment option (**\$100** for up to a 30-day supply or **\$250** for up to a 90-day supply through mail order), and consists of non-preferred medications. Sometimes there are alternatives available in Tier 1 or Tier 2. If you are currently taking a medication in Tier 3, ask your provider whether there are Tier 1 or Tier 2 alternatives that may be appropriate for your treatment. **This tier is subject to the pharmacy copayment described above.**
- **Tier 4** is your **highest** priced (**\$200** for up to a 30-day supply or **\$500** for up to a 90-day supply through mail order) non-preferred medications that do not add clinical value over their covered Tier 1, Tier 2, or Tier 3 alternatives. Some medications on Tier 4 may also have an over-the-counter alternative which can be purchased without a prescription. **This tier is subject to the pharmacy copayment described above.**
- **Specialty pharmacy medications** are on a separate 4 Tier structure with copayments as follows for a 30-day supply:
 - Tier 1 \$10
 - Tier 2 \$150
 - Tier 3 \$350
 - Tier 4 \$500
- Note: Tier 3 and Tier 4 pharmacy deductible does not apply to specialty medications.

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. 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

Changes to Tier level for all covered medications and supplies may occur January 1 and July 1 of each year. Throughout the year, if new generic medications come to market throughout the Plan year they will be placed on Tier 1 and the brand could move to a higher tier. Newly marketed brand medications will be evaluated by our PDL Management Committee and they will be placed in the appropriate Tier. A prescription medication may be moved to the 4th tier of PDL at anytime if the medication changes to over-the-counter status, or removed from the PDL due to safety concerns declared by the Food and Drug Administration (FDA).

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

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

Contraceptives - Tier 1 hormonal contraceptives are offered with no copayment. Contraceptives on other tiers are subject to copayments corresponding to that tier.

Step Therapy - 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 - Some injectable medications may be covered under the medical policy. Medications typically covered under the pharmacy benefit and received through a retail or mail order pharmacy are those that are self-administered by you or a non-skilled caregiver. However, injectable medications that are typically administered by a health care professional are covered under your medical benefit and need to be accessed through your provider or Specialty pharmacy. Contact the Health Plan at 877-835-9861 for more information on these medications.

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

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

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

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

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

Benefit Description	You pay
<p>Preventive care medications</p> <p>Note: Preventive Medications with USPSTF A and B recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients.</p> <p>For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations The following drugs and supplements are covered without cost-share, even if over-the-counter, are prescribed by a health care professional and filled at a network pharmacy.</p> <ul style="list-style-type: none">• Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age• Folic acid supplements for women of childbearing age 400 & 800 mcg• Liquid iron supplements for children age 0-1 year• Pre-natal vitamins for pregnant women• Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6	\$0

Preventive care medications - continued on next page

High Option

Benefit Description	You pay
Preventive care medications (cont.)	
<ul style="list-style-type: none"> Certain statins to treat cardiovascular disease for adults age 40 to 75 will be covered without a copayment as recommended by the United States Preventive Services Task force (USPSTF) when the following criteria is met: Age 40 to 75 years; and one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and a calculated 10-year risk of a cardiovascular event of 10% or greater. <p>Note: To receive this benefit a prescription from a doctor must be presented to pharmacy. Benefits available at in-network pharmacy only.</p>	\$0
Covered medications and supplies	
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> Drugs and medications that by Federal law of the United States require a physician's prescription for their purchase, except those listed as <i>Not covered</i>. 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* <ul style="list-style-type: none"> - Estradiol - testosterone - leuprolide Oral and injectable drugs associated with artificial insemination and IVF (3 cycles annually) procedures Some drugs may require prior authorization Medications prescribed to treat obesity* <ul style="list-style-type: none"> - Saxenda - Wegovy - Zepbound <p>Prior Authorization is required</p> <p>Note: Intravenous fluids and medications for home use, implantable drugs, and some injectable drugs are covered under <i>Medical services and supplies Section (5a)</i> or <i>Surgical and anesthesia services Section (5b)</i>.</p> <p>*For a complete list of drugs and medications, visit www.uhcfeds.com or call our Customer Service Department 877-835-9861</p> <p>Specialty Pharmacy (30-day supply)</p>	<p>Plan retail pharmacy up to a maximum of a 30-day supply:</p> <p>Tier 1- \$10</p> <p>Tier 2- \$50</p> <p>Tier 3- \$100</p> <p>Tier 4 -\$200</p> <p>Plan mail order pharmacy for up to a maximum of up to a 90-day supply:</p> <p>Tier 1- \$25</p> <p>Tier 2- \$125</p> <p>Tier 3- \$250</p> <p>Tier 4- \$500</p> <p>Note: Please see the beginning of this section for information pertaining to the prescription drug deductible for Tier 3 and Tier 4 medications</p>
COVID-19 Over The Counter (OTC) Test Kits	Tier 3 -\$12 Capped

Covered medications and supplies - continued on next page

High Option

Benefit Description	
Covered medications and supplies (cont.)	You pay
<ul style="list-style-type: none"> • 8 Tests per member per month <p>Contraceptive drugs and devices as listed in the Health Resources and Services Administrationsite.</p> <p>Contraceptive coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categoriesof 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.</p> <ul style="list-style-type: none"> • Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy. • 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. If you have difficulty accessing contraceptive coverage or other reproductive healthcare you can contact contraception@opm.gov. • Reimbursement for over-the-counter contraceptives can be submitted in accordance with Section 7. • Tier 1 hormonal contraceptives • The "morning after pill" (Tier 1) is provided at no cost if prescribed by a physician and purchased at the network pharmacy. 	Tier 3 -\$12 Capped \$0 - Not subject to deductible
Note: For additional Family Planning benefits see Section 5(a)	
Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Educational Classes and Programs in Section 5(a)	\$0
<ul style="list-style-type: none"> • 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
Prescription tobacco cessation medications and FDA approved over the counter tobacco cessation medications with prescription from physician and may be subject to age and frequency limitations.	\$0 - Not subject to deductible
<i>Not covered:</i> <ul style="list-style-type: none"> • 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 • Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them 	<i>All charges</i>

Covered medications and supplies - continued on next page

High Option

Benefit Description	
Covered medications and supplies (cont.)	You pay
<ul style="list-style-type: none"> • Drugs available over-the-counter that do not require a prescription order by federal or state law before being dispensed, and any drug that is therapeutically equivalent to an over-the-counter • Compound drugs that do not contain at least one covered ingredient that requires a Prescription Order or Refill • Alcohol swabs and bio-hazard disposable containers • Medical Marijuana • Drugs for sexual performance for patients that have undergone genital reconstruction • Nonprescription medications unless specifically indicated elsewhere 	<i>All charges</i>
Opioid rescue agents such as naloxone are covered under this Plan with no cost sharing when obtained from a network pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/	\$0

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employees Dental Vision Insurance Program (FEDVIP) Dental Plan your FEHB Plan will be First Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- The calendar year deductible is: \$500 Self Only, \$1,000 Self Plus One and Self and Family. The calendar year deductible applies to almost all benefits in this Section. We indicate "Not subject to deductible" to show when the calendar year deductible does not apply.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9 *Coordinating benefits with other coverage*, including with Medicare.
- If you enroll in UnitedHealthcare Choice Primary Plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a \$150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.)
- **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		
Accidental injury benefit		You pay
<p>We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury and</p> <ul style="list-style-type: none"> • The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. You may request an extension of this time period provided you do so within 60 days of the injury and if extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wire from fracture care.) • Benefits for treatment of accidental injury are limited to the following: <ul style="list-style-type: none"> - 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 plan allowance	

Accidental injury benefit - continued on next page

Benefit Description	
Accidental injury benefit (cont.)	You pay
<ul style="list-style-type: none"> - Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry <p>A sound natural tooth is defined as a tooth that:</p> <ul style="list-style-type: none"> • 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. <p>Crowns, bridges, implants and dentures are not considered sound natural teeth</p>	20% coinsurance of plan allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and related procedures, including bone grafts to support implants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival and aveolar bone)</i> 	<i>All charges</i>
Adjunctive dental	You pay
<p>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.</p> <p>Examples of adjunctive dental care are:</p> <ul style="list-style-type: none"> • 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 <p>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.</p>	20% coinsurance of plan allowance

Section 5(h). Wellness and Other Special features

Feature	Description
UnitedHealthcare's Digital Experience	<p>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</p> <p>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.</p> <p>Download the UnitedHealthcare app* for access to health plan ID cards, benefits information and help answering questions.</p> <p>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</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Download the UnitedHealthcare app from the App Store® or Google Play™</p> <p>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:</p> <p>Your personalized website, myuhc.com®, features tools designed to help you:</p> <ul style="list-style-type: none"> • Find, price and save on care — you can save with Virtual Visits and other tools. You can save an average of 36% * 1 when you compare costs for providers and services • Get care from anywhere with Virtual Visits. A doctor can diagnose common conditions by phone or video 24/7 • Understand your benefits and the financial impact of care decisions • Find tailored recommendations regarding providers, products and services. You can even generate an out-of-pocket estimate based on your specific health plan status • Access claim details, plan balances and your health plan ID card quickly • Follow through on clinical recommendations and access wellness programs • Order prescription refills, get estimates and compare medication pricing • Check your plan balances, access financial accounts and more • Find a quality doctor, clinic, hospital or lab that helps meet their needs. • Use multiple search options to filter results by location, specialty, quality, cost, services offered and more. • See provider ratings created by patients. • Review cost and care options before making an appointment to help control spending and choose the right level of service. • Access personalized cost and provider information specific to the benefit plan.

Feature	Description
Myuhc.com Behavioral Health Resources	<p>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.</p> <p>Find the right care for you Using the provider search tool, you can:</p> <ul style="list-style-type: none"> • 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 <p>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.</p> <p>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</p> <ul style="list-style-type: none"> • You'll get access to: • Articles • Podcasts • Videos • Other tools <p>To find behavioral health care, sign in or register on myuhc.com and then go to Find Care Behavioral Health Directory</p>
Sanvello/ Self Care by Able To	<p>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.</p> <ul style="list-style-type: none"> • Assessments and tracking • Mental health skills and tools – Cognitive Behavioral Therapy skills, meditations 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.
Real Appeal - A Lifestyle and Weight Management Program	<p>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.</p> <p>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.</p> <p>Real Appeal includes:</p> <p>Social community resources such as: Real Appeal LinkedIn community; Facebook community; YouTube videos including getting started, workouts and success stories</p>

	<p>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:</p> <ul style="list-style-type: none"> • Balanced Portion plate • Electronic food scale • Digital weight scale • Fitness guide <p>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.</p> <p>24/7 online support and mobile app through our myuhc portal or directly through our myuhc mobile app. Staying accountable to goals may be easier than ever.</p> <ul style="list-style-type: none"> • 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
UHC Rewards and One Pass Select	<p>Your health plan comes with a new way to earn up to \$300. With UnitedHealthcare Rewards, you can earn up to \$300 for tracking your steps or sleep, getting an annual checkup and more. The activities you go for are up to you. When you activate UHC Rewards, you can also get started with One Pass Select™, a fitness program that gives you unlimited access to a nationwide network of thousands of fitness centers. Plus, you can use your earnings to help pay for a One Pass Select membership.</p> <p>Start earning with UHC Rewards by:</p> <ul style="list-style-type: none"> • Download the UnitedHealthcare® app and then: Sign in or register • Select UHC Rewards • Activate UHC Rewards • Select Redeem rewards to access One Pass Select <p><i>UnitedHealthcare Rewards is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you. If any fraudulent activity is detected (e.g., misrepresented physical activity), you may be suspended and/or terminated from the program. If you are unable to meet a standard related to health factor to receive a reward under this program, you might qualify for an opportunity to receive the reward by different means. You may call us toll-free at 1-866-230-2505 or at the number on your health plan ID card, and we will work with you (and, if necessary, your doctor) to find another way for you to earn the same reward. Rewards may be limited due to incentive limits under applicable law. Components subject to change. This program is not available for fully insured members in Hawaii, Vermont and Puerto Rico.</i></p> <p><i>One Pass Select is a voluntary program featuring a subscription-based nationwide gym network, digital fitness and grocery delivery service. The information provided under this program is for general informational purposes only and is not intended to be nor should it be construed as medical advice. Individuals should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for them. Purchasing discounted gym and fitness studio memberships, digital fitness or grocery delivery services may have tax implications. Employers and individuals should consult an appropriate tax professional to determine if they have any tax obligations with respect to the purchase of these discounted memberships or services under this program, as applicable. One Pass Select is a program offered by Optum. Subscription costs are payable to Optum.</i></p>
Quit for Life®	<p>Quit for Life provides our members with resources and support for tobacco cessation. Included are:</p> <ul style="list-style-type: none"> • Portal and mobile app • Online learning with interactive and personalized content and a community support forum • Integrated online and telephonic experience

	<ul style="list-style-type: none"> • 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) <p>Get started today. Go to myuhc.com, visit the "Health Resources" tab on the top right, Choose the "Quit for Life" tile.</p>
Maternity Health Solutions	<p>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.</p> <ul style="list-style-type: none"> • Maternity-related courses available on myuhc.com regarding course topics such as: <ul style="list-style-type: none"> - 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	<p>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.</p> <p>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.</p> <ul style="list-style-type: none"> • Premium Care Physician meets UnitedHealth Premium program quality & cost efficient care criteria. • Quality Care Physician meets UnitedHealth Premium program quality care criteria, but does not meet the program's cost efficient care criteria or is not evaluated for cost-efficient care. Physician is not eligible for a Premium designation. • Not Evaluated for Premium Care physician's specialty is not evaluated and/or does not have enough claims data for program evaluation or the physician's program evaluation is in process.
Specialty Pharmacy	<p>What are the benefits of using Optum Specialty Pharmacy?</p> <p>Optum Specialty Pharmacy provides personalized support and resources at no extra cost to help you manage your condition.</p> <p>How does Optum Specialty Pharmacy support you?</p> <ul style="list-style-type: none"> • 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

	<ul style="list-style-type: none"> • Supplies you may need to take your medication at no extra cost • Refill reminders • Talk with a nurse about infusion services, if applicable <p>Tips for working with our Optum Specialty Pharmacy care team.</p> <ul style="list-style-type: none"> • 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. <p>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.</p>
Flexible Benefits Option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. 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 in addition to other terms as necessary. 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 do not 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 contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Cancer Clinical Trials	<p>To be a qualifying clinical trial, a trial must meet the following criteria:</p> <p>Be sponsored and provided by a cancer center that has been designated by the <i>National Cancer Institute (NCI)</i> as a <i>Clinical Cancer Center</i> or <i>Comprehensive Cancer Center</i> or be sponsored by any of the following:</p> <ul style="list-style-type: none"> • <i>National Institutes of Health (NIH)</i>. (Includes <i>National Cancer Institute (NCI)</i>.) • <i>Centers for Disease Control and Prevention (CDC)</i>. • Agency for Healthcare Research and Quality (AHRQ). • Centers for Medicare and Medicaid Services (CMS). • Department of Defense (DOD). • Veterans Administration (VA). • The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals. Benefits are not available for preventive clinical trials. • The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

Feature	Description
Medicare Part B Reimbursement for Retiree Advantage Members	<p><i>Receive reimbursement for your Medicare Part B Premium</i></p> <ul style="list-style-type: none"> • <i>\$150.00 will be paid on your behalf directly to Medicare</i> • <i>See a reduction in your quarterly Medicare bill, or an increase in your Social Security payment or annuity payment</i> • <i>Receive this benefit for every month you're enrolled in the plan</i>
Renew Active Fitness Program for Retiree Advantage Members:	<p>Renew Active is a fitness benefit which is included in the Medicare Advantage plan which provides:</p> <ul style="list-style-type: none"> • A free gym membership to participating facilities <ul style="list-style-type: none"> - To view participating facilities, please visit www.uhcnewactive.com • Access to an extensive network of gyms and fitness locations near members • A personalized fitness plan • Access to a wide variety of fitness classes • An online brain health program, exclusively from AARP® Staying Sharp • Connecting with others at local health and wellness events, and through the Fitbit® Community for Renew Active
First Line Essentials for Retiree Advantage Members	<p><i>Shop for hundreds of over-the-counter items such as toothpaste, vitamins, and personal care from the Health Products catalog.</i></p> <ul style="list-style-type: none"> • <i>Members will receive \$40 each quarter to spend on items from the provided catalog</i> • <i>Items are delivered directly to your door</i> • <i>Orders can be placed over the phone, by mail, or online</i>
House Calls for Retiree Advantage Members	<p><i>With the UnitedHealthcare® HouseCalls program, you get an annual in-home preventive care visit from one of our health care practitioners at no extra cost.</i></p> <p><i>What does HouseCalls include?</i></p> <ul style="list-style-type: none"> • <i>One 45 to 60-minute at-home visit from a health care practitioner, each year.</i> • <i>A head-to-toe exam, health screenings and plenty of time to talk about your health questions.</i> • <i>A custom care plan made just for you.</i> • <i>Help connecting you with additional care you may need.</i>
Healthy at Home for Retiree Advantage Members	<p><i>Healthy at Home provides the following benefits up to 30 days following all inpatient and skilled nursing facility discharges when referred by a UnitedHealthcare Advocate:</i></p> <ul style="list-style-type: none"> • <i>Home-Delivered Meals</i> <i>Receive 28 home-delivered meals provided by Mom's Meals</i> • <i>Non-emergency transportation</i> <i>Receive 12 one-way rides to medically related appointments and to the pharmacy provided by ModviCareIn-home Personal Care</i> • <i>Receive 6 hours of in-home personal care through our exclusive national provider CareLinx</i>
Real Appeal for Retiree Advantage Members	<p>Real Appeal is a weight loss program that can help members feel and look better. The program provides everything they need to lose weight and keep it off. This program is a pilot for select members residing in Wisconsin.</p> <p>The online program includes:</p> <ul style="list-style-type: none"> • Personalized diabetes prevention coaching • 24/7 online support and mobile app • Customizable food, activity, weight and goal trackers

	<ul style="list-style-type: none"> Success group support, which lets members chat with others who are doing the Real Appeal program The weekly Real Appeal All-Star Show featuring healthy tips from celebrities, athletes and health experts <p>Success Kit includes:</p> <ul style="list-style-type: none"> Program, nutrition, and fitness guides Tools to help cook healthier, tasty meals Delivered right to their front door after attending their first group coaching session
UnitedHealthcare Hearing for Retiree Advantage Members	<p><i>UnitedHealthcare Hearing provides members with greater technology, choice and convenience</i></p> <ul style="list-style-type: none"> <i>Rechargeable hearing aids, remote adjustments and other advanced feature devices are available at up to 80% less than standard industry prices through direct delivery, including top brands in multiple styles</i> <i>6,500+ locations nationwide</i> <i>Choose home delivery or in person options</i> <i>3-minute online hearing test to assess hearing loss/need for in-person test</i> <i>Members receive \$1500 allowance every 36 months towards the purchase of hearing aids</i> <i>You must use a UnitedHealthcare Hearing provider for the purchase of your hearing aids</i>
Quit For Life for Retiree Advantage - Members	<p><i>Quit For Life has helped 3.5 million members quit smoking or using tobacco. It provides the tools and one-on-one support to help you quit your way.</i></p> <p><i>And for UnitedHealthcare members, it's offered at \$0 out of pocket.</i></p> <p><i>With a 95% satisfaction rate, Quit for Life provides:</i></p> <ul style="list-style-type: none"> <i>Tools and support to help members quit cigarettes, e-cigarettes, vaping and tobacco</i> <i>A personal, one-on-one Quit Coach to help you create a customized quit plan</i> <i>The Quit for Life mobile app, which offers 24/7 urge management support</i> <i>Text2Quit text messages for daily tips and encouragement</i> <p><i>Quit medications – Such as nicotine gum or patches – for no charge, based on eligibility.</i></p>
PERS (Personal Emergency Response System) for Retiree Advantage Members	<p>UnitedHealthcare® works with Lifeline to provide a personal emergency response system at no cost for Retiree Advantage plan members</p> <p>Lifeline personal emergency response system (PERS) allows you to ask for help whenever you need it, anytime of day or night – 365 days of the year, 24/7. All you need to do is press the help button, worn as a wristband or pendant, and a Trained Care Specialist will assist you to make sure you quickly get the help you need.</p> <p>Features include:</p> <ul style="list-style-type: none"> Optional AutoAlert fall detection technology automatically provides access to help if it detects a fall – even if wearer is disoriented, immobilized or unconscious and cannot press their help button Cellular or landline compatible, Lifeline works anywhere in the U.S., where current telephone service is provided Lightweight, waterproof help button can be worn on the wrist or as a pendant

Non-FEHB Benefits Available to Plan Members

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

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

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

UHC Rewards and One Pass* - UnitedHealthcare Rewards, you can earn dollars for tracking your steps or sleep, getting an annual checkup and more. The activities you go for are up to you. When you activate UHC Rewards, you can also get started with One Pass Select™, a fitness program that gives you unlimited access to a nationwide network of thousands of fitness centers. You can use your earnings to help pay for a One Pass Select membership. 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](http://www.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.uhonetline.uhc.com/federal> or call 1-844-620-4814 (worldwide 24-hour a day).

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

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

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

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

We do not cover the following:

- Care or supplies by non-Plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental, investigational or unproven procedures, treatments, drugs or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, fetal reduction or non-surgical or drug induced pregnancy terminations except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Surrogate parenting
- Fetal reduction surgery
- Reversal of voluntary sterilization
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.
- Extra care costs or research costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Services or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption.
- Services or supplies we are prohibited from covering under the 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, date of birth, address, phone number and ID number;
- Name and address of the provider or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN);
- Receipts, if you paid for your services.

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

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

Prescription drugs

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

International Claims

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

Deadline for filing your claim

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

Post-service claims procedures

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

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

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

Authorized Representative

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

Notice Requirements

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

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

Section 8. The Disputed Claims Process

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

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

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

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

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

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

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

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none">a) Write to us within 6 months from the date of our decision; andb) Send your request to us at: UnitedHealthcare Federal Employees Health Benefits (FEHB) Program Appeals, P.O. Box 30573, Salt Lake City, UT 84130-0573 ; andc) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andd) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.e) Your email address, if you would like to receive our decision via email. Please note that by providing your email address, you may receive our decision more quickly.
2	<p>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.</p> <p>In the case of a post-service claim, we have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none">a) Pay the claim orb) 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, 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 sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

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

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

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

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

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

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

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

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

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

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

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

We do not cover services that:

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

Medicaid

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

	Suspended FEHB coverage to enroll in Medicaid or a similar state-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these state programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the state program.
When other Government agencies are responsible for your care	We do not cover services and supplies when a local, state, or federal government agency directly or indirectly pays for them.
When others are responsible for injuries	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>
When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage	Some FEHB plans already cover some dental and vision services. When you are covered by more than one dental/vision plan, coverage provided under your FEHB Plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone at 1-877-888-3337, (TTY 1-877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.
Clinical trials	<p>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.</p> <p>If you are a participant in a clinical trial, and the related care is not covered within the clinical trial, this plan will provide coverage for related costs based on the criteria listed below.</p> <ul style="list-style-type: none"> • Routine care costs - costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by the plan.

- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan does not cover these costs.
- Research costs- costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes are considered research costs. This plan does not cover these costs.

When you have Medicare

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

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

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

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

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

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

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

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 877-835-9861 or see our Web site at www.uhcfeds.com.

We do not waive any costs if the Original Medicare Plan is your primary payor. - We waive some costs if the Original Medicare Plan is your primary payor – We will waive some out-of-pocket costs as follows:

- Medical services and supplies provided by physicians and other healthcare professionals.

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

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

Medicare

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.

Benefit Description: Deductible

High Option You Pay without Medicare: \$500

High Option You Pay with Medicare Part B: \$500

Benefit Description: Out-of-Pocket Maximum

High Option You Pay without Medicare: \$7,350 Self Only/\$14,700 Self Plus One or Self and Family

High Option You Pay with Medicare Part B: \$7,350 Self Only/\$14,700 Self Plus One or Self and Family

Benefit Description: Part B Premium Reimbursement

HighOption You Pay without Medicare: N/A

High Option You Pay with Medicare Part B: N/A

Benefit Description: Primary Care Provider

HighOption You Pay without Medicare: Nothing - not subject to deductible

HighOption You Pay with Medicare Part B: Nothing - not subject to deductible

Benefit Description: Specialist

High Option You Pay without Medicare: \$60 not subject to deductible

High Option You Pay with Medicare Part B: \$60 not subject to deductible

Benefit Description: Inpatient Hospital

HighOption You Pay without Medicare: 20% per admission

HighOption You Pay with Medicare Part B: 20% per admission

Benefit Description: Outpatient (Surgical)

High Option You Pay without Medicare: 20% for free-standing facility or 20% plus \$250 per occurrence deductible hospital-based facility

High Option You Pay with Medicare Part B: 20% for free-standing facility or 20% plus \$250 per occurrence deductible hospital-based facility

Benefit Description: Incentives Offered

High Option You Pay without Medicare: N/A

High Option You Pay with Medicare Part B: N/A

- **Tell us about your Medicare Coverage**

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

Medicare Part B Premium Reimbursement

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

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

- **Medicare Advantage (Part C)**

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

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

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

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

You may enroll in the UnitedHealthcare Retiree Advantage Plan if:

- You are enrolled in this UnitedHealthcare FEHBP plan and have both Medicare Part A and Part B

- You are retired and live in our geographic service area - see page 14 which describes our service area
- You are a United States citizen or are lawfully present in the United States
- You do NOT have End-Stage Renal Disease (ESRD), with limited exceptions
- You complete an application for enrollment in the UnitedHealthcare Retiree Advantage Plan.

As part of this process CMS will verify your Medicare Part B enrollment. If the FEHB subscriber and or dependent enrolls in the Retiree Advantage plan, each family member will have to complete an application by calling into our Retiree Solutions team. (1-844-481-8821) Members who are not eligible for Medicare Part A and B will remain on this FEHB plan. If, for any reason, you do not meet the enrollment requirements, you will no longer be eligible to participate in the Retiree Advantage plan. Your contributions will end and your regular FEHB benefits will resume. You may be required to repay any reimbursements paid to you in error.

We offer a plan designed:

- To help members with their Medicare Part B premium costs
- To provide access to our national network of providers, (in-network or out-of-network) at the same cost share
- To cover eligible medical benefits with little to no out of pocket costs
- Medicare Part D prescription drug coverage with a low \$2,000 out of pocket max

The Retiree Advantage plan provides monthly reimbursement of \$150.00 of your Medicare Part B monthly premium. In addition, we cover benefits, including office visit copayments at (\$0), urgent care and emergency care at (\$0), plus additional coverage for hearing aids discounts and wellness programs. See chart on next page. If you elect to enroll in the the UnitedHealthcare Retiree Advantage plan which includes Medicare part D. Your FEHB plan will not coordinate benefits. The UnitedHealthcare Retiree Advantage plan will take over as the primary and only payer.

If you elect to enroll in the UnitedHealthcare Retiree Advantage plan you must retain your FEHB coverage. Do not suspend your FEHB coverage, as this will make you ineligible for the Retiree Advantage plan.

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

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

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

Benefit Description: Deductible**Member Cost without Medicare:** \$500 Self Only; \$1,000 Self Plus One and Self and Family**Member Cost with Medicare Part B:** \$500 Self Only; \$1,000 Self Plus One and Self and Family**Member Cost with UnitedHealthcare Retiree Advantage Health Plan:** No plan deductible**Benefit Description: Out-of-Pocket Maximum****Member Cost without Medicare:** \$7,350 Self Only; \$14,700 Self Plus One and Self and Family**Member Cost with Medicare Part B:** \$7,350 Self Only; \$14,700 Self Plus One and Self and Family**Member Cost with UnitedHealthcare Retiree Advantage Health Plan:** You pay nothing for Medicare-covered service from any provider**Benefit Description: Primary Care Provider****Member Cost without Medicare:** \$0**Member Cost with Medicare Part B:** \$0**Member Cost with UnitedHealthcare Retiree Advantage Health Plan:** \$0**Benefit Description: Specialist****Member Cost without Medicare:** \$60**Member Cost with Medicare Part B:** \$60**Member Cost with UnitedHealthcare Retiree Advantage Health Plan:** \$0**Benefit Description: Virtual Visits****Member Cost without Medicare:** \$0**Member Cost with Medicare Part B:** \$0**Member Cost with UnitedHealthcare Retiree Advantage Health Plan:** \$0**Benefit Description: Urgent Care****Member Cost without Medicare:** \$50**Member Cost with Medicare Part B:** \$50**Member Cost with UnitedHealthcare Retiree Advantage Health Plan:** \$0**Benefit Description: Emergency****Member Cost without Medicare:** 20% after deductible**Member Cost with Medicare Part B:** 20% after deductible**Member Cost with UnitedHealthcare Retiree Advantage Health Plan:** \$0**Benefit Description: Inpatient Hospital****Member Cost without Medicare:** 20% after deductible**Member Cost with Medicare Part B:** 20% after deductible**Member Cost with UnitedHealthcare Retiree Advantage Health Plan:** \$0**Benefit Description: Outpatient Hospital****Member Cost without Medicare:** 20% after deductible**Member Cost with Medicare Part B:** 20% after deductible**Member Cost with UnitedHealthcare Retiree Advantage Health Plan:** \$0**Benefit Description: Rx (30-day supply at retail)****Member Cost without Medicare:** Deductible- Tier* (3 Tier 1-\$10, Tier 2-\$50, Tier 3-\$100*, Tier 4-\$200*, * Subject to pharmacy deductible**Member Cost with Medicare Part B:** Deductible- Tier* (3 Tier 1-\$10, Tier 2-\$50, Tier 3-\$100*, Tier 4-\$200*, * Subject to pharmacy deductible**Member Cost with UnitedHealthcare Retiree Advantage Health Plan:** No deductible; Tier 1 - \$5, Tier 2 - \$25, Tier 3 - \$60, Tier 4 - \$90

Benefit Description: Rx - Mail Order (90-day supply)

Member Cost without Medicare: 2.5 x retail copay

Member Cost with Medicare Part B: 2.5 x retail copay

Member Cost with UnitedHealthcare Retiree Advantage Health Plan: 2 x retail copay

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

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

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

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

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

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

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

Section 10. Definitions of Terms We Use in This Brochure

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. <ul style="list-style-type: none">• We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.• Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.• OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.
Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Clinical Trials Cost Categories	An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application. Routine care costs- costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy <ul style="list-style-type: none">• Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.• Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.
Coinsurance	See Section 4, page 22
Copayment	See Section 4, page 22.
Cost-Sharing	See Section 4, page 22.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Services that are non-health related, such as daily living activities, or services which are health related but do not seek to cure, or services which do not require a trained medical professional. Custodial care that lasts 90 days or more is sometimes known as long term care.
Deductible	See Section 4, page 22
Experimental or investigational service	Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States American Hospital Pharmacopoeia Dispensing Information* as appropriate for the proposed use
- Not recognized, in accordance with generally accepted medical standards, as being safe and effective for your condition;
- Subject to review and approval by any institution review board for the proposed use. (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational).
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight

Healthcare professional

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

Infertility

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

Medical necessity

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

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

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

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

Plan Allowance	Allowable Expense (plan allowance) is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense
	You should also see Important Notice About Surprise Billing – Know Your Rights in Section 4 that describes your protections against surprise billing under the No Surprises Act.
Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.
Pre-service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
Surprise bill	An unexpected bill you receive for: <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> • 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.

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Summary of Benefits for the High Option Plan of UnitedHealthcare Insurance Company - 2025

- **Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.uhcfeds.com.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- Unless indicated “not subject to deductible” then all services are subject to deductible

High Option Benefits	You pay	Page
Medical services provided by physicians: Preventive Care	No copayments for preventive care services. This includes items such as, but not limited to, immunizations, physical examinations and screenings as appropriate and recommended by U.S. Preventive Services Task Force. Please refer to Section 5.	28
Medical services provided by physicians: Diagnostic and treatment services provided in the office	You pay nothing per primary care provider (PCP) visit for all ages; not subject to deductible. \$60 copayment per specialist visit; not subject to deductible Virtual visits - you pay nothing; not subject to deductible	28
Services provided by a hospital: Inpatient	20% coinsurance	50
Outpatient surgery	20% coinsurance in an ambulatory surgical center; 20% coinsurance plus a \$250 per occurrence deductible in a hospital based facility	51
Emergency benefits: In or out-of-area	20% coinsurance (waived if admitted)	54
Mental health and substance use disorder treatment*:	Regular cost-sharing	55
Prescription drugs: Plan Retail pharmacy	Tier 1: \$10 Tier 2: \$50 Tier 3: \$100 -subject to pharmacy deductible Tier 4: \$200 - subject to pharmacy deductible	57
Prescription drugs: Plan mail order for up to a 90-day fill	Tier 1: \$25 Tier 2: \$125 Tier 3: \$250 -subject to pharmacy deductible Tier 4: \$500 -subject to pharmacy deductible	57
Specialty Pharmacy (30-day supply)	Tier 1 \$10 Tier 2 \$150	57

	Tier 3 \$350 Tier 4 \$500	
Vision care:	20% coinsurance	35
Wellness and Other Special features:	UnitedHealthcare app; Quit for Life, Sanvello, Specialist Management Solutions, UHC Rewards and One Pass, Maternity Support Program, UnitedHealth Premium, Real Appeal, Specialty Pharmacy, Flexible Benefits Option, Cancer Clinical trials	65
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after \$7,350 for Self Only enrollment or \$14,700 for Self Plus One and Self and Family enrollment per year. Some costs do not count toward this protection	22
Non-FEHB Benefits	PPO Dental Plan for all members; UnitedHealthcare Hearing, UHC Rewards and One Pass	72

2025 Rate Information for UnitedHealthcare Insurance Company, Inc.

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

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

Premiums for Tribal employees are shown under the Monthly Premium Rate column. The amount shown under employee 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

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

High Option Self Only	Y81	\$244.31	\$81.43	\$529.33	\$176.44
High Option Self Plus One	Y83	\$525.26	\$175.08	\$1,138.05	\$379.35
High Option Self and Family	Y82	\$577.77	\$192.59	\$1,251.83	\$417.28

UnitedHealthcare Insurance Company, Inc.

www.uhcfeds.com

Customer Service: 877-835-9861

2025

Choice Plus Primary

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

IMPORTANT

- Rates: Back Cover
- Changes for 2025: Page 16
- Summary of Benefits: Page 102

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll.

Enrollment codes for this Plan:

AS1 -Self Only

AS3 -Self Plus One

AS2 - Self and Family

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

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

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

Authorized for distribution by the:



FEHB
Federal Employees
Health Benefits Program

United States
Office of Personnel Management

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

**Important Notice from UnitedHealthcare Insurance Company, Inc. About
Our Prescription Drug Coverage and Medicare**

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

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

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

Please be advised

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

Medicare's Low Income Benefits

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

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

The address for administrative offices is:

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

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

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

OPM negotiates benefits and rates for each plan annually. Benefit changes are effective January 1, 2024, and changes are summarized on page 16. Rates are shown at the end of this brochure.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee and each covered family member, “we” means UnitedHealthcare Insurance Company.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

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

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

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

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

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

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

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

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

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

You can also write to:

**United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100**

- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise).
 - Your child age 26 or over (unless they are disabled and incapable of self support).
- A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to obtain service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

We comply with applicable Federal nondiscrimination laws and do not discriminate on the basis of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity).

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual's protected trait or traits, for example a member's gender identity or the fact that the covered benefit is sought in connection with gender-affirming care, will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined to be medically necessary.

Preventing Medical Mistakes

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

Take these simple steps:

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medications or give your doctor and pharmacist a list of all the 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.
- [www.npsf.orghttps://psnet.ahrq.gov/issue/national-patient-safety-foundation](https://psnet.ahrq.gov/issue/national-patient-safety-foundation). The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.

Preventable Healthcare Acquired Conditions (“Never Events”)

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

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

FEHB Facts

Coverage information

No pre-existing condition limitation

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

Minimum essential coverage (MEC)

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

Minimum value standard

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

Where you can get information about enrolling in the FEHB Program

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

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

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

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

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

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

Enrollment types available for you and your family

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

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

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

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

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

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

Family member coverage

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

Natural children, adopted children, and stepchildren

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

Foster children

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

Children incapable of self-support

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

Married children

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

Children with or eligible for employer-provided health insurance

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

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

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

Children's Equity Act

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

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

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

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

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

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2025 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 2024 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

When you retire

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

When you lose benefits

When FEHB coverage ends

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

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

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

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

Upon divorce

If you are an enrollee and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment.

You **must** contact us to let us know the date of the divorce or annulment and have us remove your ex-spouse. We may ask for a copy of the divorce decree as proof. In order to change enrollment type, you must contact your employing or retirement office. A change will not automatically be made.

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get information about your coverage choices. You can also visit OPM's website at <https://www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health>. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Temporary Continuation of Coverage (TCC)

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

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

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

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

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

Converting to individual coverage

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

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

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

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 1-866-546-0510 or visit our website at www.uhcfeds.com.

**Health Insurance
Marketplace**

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

Section 1. How this Plan Works

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

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

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

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

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

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

General features of our High Option Plan

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

We have Open Access benefits

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

We have Point of Service (POS) benefits

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

How we pay providers

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

Preventive care services

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

Annual deductible

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

Health education resources and accounts management tools:

myuhc.com gives you the ability to:

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

myHealthcare Cost Estimator

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

Your rights and responsibilities

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

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

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

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

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

Your medical and claims records are confidential

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

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area is:

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

District of Columbia

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

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

Section 2. How we Change for 2025

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
- **Prescription drugs** - Retail pharmacy up to 30-day supply, increasing Tier's 1,4 drugs from \$5/\$150 to \$10/\$200 and Mail order 90-day supply, increasing Tier's 1,4 drugs from \$12.50/\$375 to \$25/\$500. Specialty Tier 1 copay will increase from \$5 to \$10. See page 68

Section 3. How You Get Care

Identification cards

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

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

Where you get covered care

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

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

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

- **Plan facilities**

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

A freestanding facility is an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims as a freestanding entity and not as a hospital. You will have a lower out of pocket expenses when you use a freestanding facility instead of a hospital for outpatient services. Outpatient services are health services or treatments that do not require an overnight hospital stay. Outpatient care received in a hospital will typically cost you more. Talk to your doctor about the options available to you for these services.

- **Non-network providers and facilities**

You can access care from any licensed provider or facility. Providers and facilities not in the UnitedHealthcare Choice Plus network are considered non-network providers and facilities.

What you must do to get covered care

It depends on the type of care you need. You can go to any provider you choose to but it will cost you less to get care from our Premium designated providers and in-network providers. We must approve some care in advance.

- **Primary Care**

Your visits to your primary care provider (PCP) are paid at 100% for all ages and all visits whether they are for preventive care or treatment for an illness. Your primary care provider may be a family practitioner, an internist, or pediatrician. Your primary care provider will provide most of your healthcare.

- **Specialty care**

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

- If your current specialist does not participate with us, you may want to consider treatment from a specialist who does to avoid additional costs. If you have a chronic and disabling condition and lose access to your specialist because we:
 - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.
- If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.
- Terminate our contract with your specialist for other than cause;
- You may receive services from your current specialist until we can make arrangements for you to see someone else.

- **Hospital care**

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

If you are hospitalized when your enrollment begins

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 877-835-9861. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

You need prior Plan approval for certain services

- Your hospital stay
- Inpatient hospital admission
- Other services

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

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

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

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

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

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

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

**How to request
precertification for an
admission or get prior
authorization for other
services**

First, your physician, your hospital, you, or your representative, must call us at 1-877-835-9861 before admission or services requiring prior authorization are rendered. Please note that members with Medicare as primary are also required to follow the precertification process.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay

**• Non-urgent care
claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15-days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15-days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60-days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether or not it is an urgent care claim by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 1-877-835-9861. You may also call OPM's FEHB 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 1-877-835-9861. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).
- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.
- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must phone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
- **Maternity Care**

You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, your physician or the hospital must contact us for precertification of additional days for your baby.

Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-network facilities

Circumstances beyond our control

If you disagree with our pre-service claim decision

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 have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call 877-835-9861

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay or, if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by phone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your Costs for Covered Services

This is what you will pay out-of-pocket for covered care.

Cost-sharing Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Copayments A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: When you see your primary care provider you pay a copayment of \$25 per office visit.

Deductible A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

- The calendar year deductible is \$500 Self Only and \$1,000 Self Plus One or Self and Family. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach \$500. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach \$1,000. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach \$1,000. The Out-of-network deductible is \$3,000 Self Only and \$6,000 Self Plus One or Self and Family.
- We also have separate deductibles for:
 - Pharmacy - Tier 3 and 4 prescriptions only. Prescription paid under the pharmacy benefit are not subject to the medical deductible. There is however, a pharmacy deductible which only applies to Tier 3 and Tier 4 prescription drugs. That deductible is \$250 Self Only, \$500 Self Plus One or Self and Family.
 - There are in-network benefits that are paid prior to your deductible being satisfied, such as Primary Care visits, Specialist Visits, Virtual/Telemedicine visits - please refer to the benefits section of this brochure.
 - Note: If you change plans during open season, you do not have to start a new deductible under your prior plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

Coinsurance Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

Example: In our Plan, you pay 20% of our allowance for durable medical equipment when using in-network providers.

Differences between our Plan allowance and the bill Network providers agree to accept our Plan allowance so if you use an in-network provider, you never have to worry about paying the difference between our Plan allowance and the billed amount for covered services.

Non-network Providers: If you use a non-network provider, you will have to pay the difference between our Plan allowance and the billed amount.

By using Premium Designated providers in the UnitedHealthcare network, you can take advantage of the significant discounts we have negotiated to help lower your out-of-pocket costs for medically necessary care. This can help you get the care you need at a lower price.

The example below is based on following the UnitedHealthcare benefits and insurance plan features and assumes that you have already met your deductible.

What your plan pays (plan coinsurance): 80% in network or 50% of the Plan allowance for out of network for benefits with coinsurance . There are in-network benefits that require a copayment only. What you pay (coinsurance): 20% in network 50% out of network (plus the difference between the Plan allowance and the billed amount).

Your out-of-pocket maximum is \$3,000/\$6,000 in network; \$6,000/\$12,000 out of network. Using the UnitedHealthcare cost estimator tool on myuhc.com allows you to compare procedures and the comparison of member costs when utilizing in-network providers as compared to out-of-network providers. Even further savings can be achieved by using UnitedHealthcare premium designated in network providers.

You should also see section Important Notice About Surprise Billing – Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.

Your catastrophic protection out-of-pocket maximum

After your in-network out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance total \$7,350 for Self Only, or \$14,700 for a Self Plus One or Self and Family enrollment in any calendar year, or out-of network \$15,000 per Self Only or \$30,000 for Self Plus One or Self and Family you do not have to pay any more for covered services.

However, copayments and coinsurance, if applicable for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services:

- Expenses for services and supplies that exceed the stated maximum dollar limit or day limit.

Carryover

If you changed to this Plan during Open Season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your prior plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your prior plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your Prior plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your prior plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

When Government Facilities Bill Us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Important Notice About Surprise Billing - Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against “surprise billing” and “balance billing” for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services.

A surprise bill is an unexpected bill you receive for:

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from surprise bills.

Plan: Use language in following sentence that is applicable to your coverage. In addition, your health plan adopts and complies with the surprise billing laws of the District of Columbia.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to uhcfeds.com or contact the health plan at 877-835-9861.

- **The Federal Flexible Spending Account Program – FSAFEDS**

Healthcare FSA (HCFSA) – Reimburses an FSA participant for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, over-the-counter drugs and medications, vision and dental expenses, and much more) for their tax dependents, and their adult children (through the end of the calendar year in which they turn 26).

FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

Section 5. High Option Benefits

On page 92 is a benefits summary for this plan.

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Section 5. High Options Benefit Overview

This Plan is a High Option. The benefits are described in Section 5. Make sure that you review the benefits that are available. Section 5. is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about benefits, contact us at 1-877-835-9861 or on our website at www.uhcfeds.com.

Medical Services Provided by Physicians: Routine Preventive Care provided in-network	Nothing
Medical Services Provided by Physicians: Diagnostic and treatment services provided in office	Primary care physician - zero copayment in-network all ages (deductible does not apply) Specialist: \$60 copayment in network (deductible does not apply); Out-of-network: 40% after deductible has been met and any difference between our allowance and the billed amount
Medical Services Provided by Physicians: Virtual visits - through UHC Designated Virtual Visit Network Provider Group. Call customer service at 1-877-835-9861 for network listing.	In-network: You pay nothing - not subject to deductible. Out-of-network: You pay all charges
Urgent Care	In-network: \$50 copayment (deductible does not apply) Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Services provided by a hospital: Inpatient	In-network 20% coinsurance Out-of-network 40% of the Plan allowance and any difference between our allowance and the billed amount
Services provided by a hospital: Outpatient Surgical	In-network 20% coinsurance Out of Network: 40% of the plan allowance and any difference between our allowance and the billed amount
Emergency Benefits: Emergency room	In-network: 20% coinsurance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Mental Health and Substance Use Disorder Treatment	Regular cost sharing
Prescription Drugs:	Retail 30-day supply Note: In-network only Tier 1-\$10, Tier 2-\$50, Tier 3-\$100, Tier 4-\$200 Mail Order - 90-day supply Tier 1-\$25, Tier 2-\$125, Tier 3-\$250, Tier 4-\$500 Note: Tier 3 and Tier 4 drugs are subject to a pharmacy deductible of \$250 Self Only /\$500 Self Plus One or Self and Family Out-of-network: you pay all charges

Pharmacy - Specialty Medications (30-day supply)	Tier 1 - \$10 Tier 2 - \$150 Tier 3 - \$350 Tier 4 - \$500 Available through in-network designated Specialty Pharmacy Only
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UnitedHealthcare Retiree Advantage Health Plan**Medical Benefit:** Deductible**Member Pays:** No deductible; Brochure Section: 9**Medical Benefit:** Primary Care Visit**Member Pays:** Nothing; Brochure Section: 9**Medical Benefit:** Preventive Care**Member Pays:** Nothing; Brochure Section: 9**Medical Benefit:** Specialist Visit**Member Pays:** Nothing; Brochure Section: 9**Medical Benefit:** Virtual Visit**Member Pays:** Nothing; Brochure Section: 9**Medical Benefit:** Urgent Care**Member Pays:** Nothing; Brochure Section: 9**Medical Benefit:** Emergency Room**Member Pays:** Nothing; Brochure Section: 9**Medical Benefit:** Pharmacy (30-day supply)**Member Pays:** Tier 1 - \$5, Tier 2 - \$25, Tier 3 - \$60, Tier 4 - \$90; Brochure Section: 9

*Note: You must have Medicare Part A and Part B, and Medicare must be primary for you to enroll in the UnitedHealthcare Retiree Advantage Plan. This plan reduces your costs by eliminating your cost sharing for covered medical services. Please see Section 9 in this brochure for additional information on how to enroll in this plan and for details on a reimbursement of \$150.00 of your Medicare Part B premium.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

<p>Important things you should keep in mind about these benefits:</p> <ul style="list-style-type: none"> • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary. • A facility charge applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital. • The calendar year deductible is: \$500 Self only, \$1,000 Self Plus One and Self and Family in-network and \$3,000 Self only \$6,000, Self Plus One and Self and Family out-of-network. The calendar year deductible may apply to some benefits in this Section. We added -"Not subject to Deductible" to show when the calendar year deductible does not apply. • If you enroll in UnitedHealthcare Choice Plus Primary Plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a \$150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.) • Be sure to read Section 4, <i>Your Costs for Covered Services</i>, for valuable information about how cost-sharing works. Also, read Section 9, <i>Coordinating benefits with other coverage</i>, 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.). 	
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Benefit Description		
Diagnostic and treatment services	In Network You pay	Out of Network You pay
Professional services of physicians: <ul style="list-style-type: none"> • In Provider's office / telehealth visit • Primary care / Optum Primary care • Office Medical consultations • Second surgical opinion • Advanced care planning 	Primary care Provider (PCP) visit you pay nothing - Not subject to deductible Specialist per visit \$60 copayment - Not subject to deductible	Primary care Provider (PCP) visit - 40% of the Plan allowance and any difference between our allowance and the billed amount
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • In an emergency room • During a hospital stay • In a skilled nursing facility • At home 	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

High Option

Benefit Description		
Telehealth services	In Network You pay	Out of Network You pay
<p>Use virtual visits through our designated virtual visit network provider groups when:</p> <ul style="list-style-type: none"> • 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 <p>Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider.</p> <p>Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at 1-877-835-9861. Access to Virtual Visits and prescription services may not be available in all states due to state regulations. You can pre-register with a group. After registering and requesting a visit you will pay your portion of service costs and then you enter a virtual waiting room.</p>	\$0 Not subject to deductible	<i>All charges</i>
Lab, X-ray and other diagnostic tests	In Network You pay	Out of Network You pay
<p>Tests, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG 	20% coinsurance of plan allowance	<i>All charges</i>
<p>Major Diagnostic tests</p> <ul style="list-style-type: none"> • CT scans/MRI • PET Scans • Nuclear Medicine <p>Pre-authorization is required</p>	20% coinsurance of plan allowance	<i>All charges</i>
Preventive care, adult	In Network You pay	Out of Network You pay
<p>Routine physical every year</p> <p>The following preventive services are covered at the time interval recommended at each of the links below.</p>	\$0	<i>All charges</i>

Preventive care, adult - continued on next page

High Option

Benefit Description		
Preventive care, adult (cont.)	In Network You pay	Out of Network You pay
<ul style="list-style-type: none"> U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. For a complete list of screenings go to the website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations Individual counseling on prevention and reducing health risks Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women please visit the Health and Human Services (HHS) website at https://www.hrsa.gov/womens-guidelines To build your personalized list of preventive services go to https://health.gov/myhealthfinder 	\$0	<i>All charges</i>
<p>Annual preventive biometric screening in your physician's office to include:</p> <ul style="list-style-type: none"> Body mass index (BMI) Blood pressure Lipid/cholesterol levels Glucose/hemoglobin AIC measurement <p>Services must be coded by your physician as preventive to be covered in full.</p>	\$0	40% of the Plan allowance and any difference between our allowance and the billed amount
Routine mammogram	\$0	40% of the Plan allowance and any difference between our allowance and the billed amount
BRCA genetic counseling and evaluation is covered as preventive when a woman's family history is associated with an increased risk for deleterious mutations in BRCA1 and BRCA2 genes and medical necessity criteria has been met.	\$0	40% of the Plan allowance and any difference between our allowance and the billed amount
Preadmission required		

Preventive care, adult - continued on next page

High Option

Benefit Description		
Preventive care, adult (cont.)	In Network You pay	Out of Network You pay
<p>Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC) based on the Advisory Committee on Immunization Practices (ACIP) schedule. For a complete list of endorsed immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/</p> <p>Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.</p>	\$0	40% of the Plan allowance and any difference between our allowance and the billed amount
<p>Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows:</p> <ul style="list-style-type: none"> Intensive nutrition and behavioral weight-loss counseling therapy, Family centered programs when medically identified to support obesity prevention and management by an in-network provider. 	\$0	<i>All charges</i>
When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) for cost share requirements for anti-obesity medications.	\$0	<i>All charges</i>
When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share.	\$0	<i>All charges</i>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.</i> <i>Immunizations, boosters, and medications for travel or work-related exposure.</i> 	<i>All charges</i>	<i>All charges</i>
Preventive care, children	In Network You pay	Out of Network You pay
<ul style="list-style-type: none"> Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org 	\$0	<i>All charges</i>

Preventive care, children - continued on next page

High Option

Benefit Description		
Preventive care, children (cont.)	In Network You pay	Out of Network You pay
<ul style="list-style-type: none"> Children's immunizations endorsed by the Centers for Disease Control (CDC) including DTaP/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the website at https://www.cdc.gov/vaccines/schedules/index.html You can also find a complete list of U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations <p>Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.</p>	\$0	<i>All charges</i>
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows:	\$0	<i>All charges</i>
<ul style="list-style-type: none"> Intensive nutrition and behavioral weight-loss counseling therapy, Family centered programs when medically identified to support obesity prevention and management by an in-network provider. 		
When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) for cost share requirements for anti-obesity medications.	\$0	<i>All charges</i>
<i>Not covered: Physical examinations and immunizations required for attending camp, school or travel</i>	<i>All charges</i>	<i>All charges</i>
Maternity care	In Network You pay	Out of Network You pay
Complete maternity (obstetrical) care, such as: <ul style="list-style-type: none"> Prenatal and Postpartum care Screening for gestational diabetes Screening for bacteriuria Delivery Screening and counseling for prenatal and postpartum depression Postnatal care	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Note: Here are some things to keep in mind:		

Maternity care - continued on next page

High Option

Benefit Description		
Maternity care (cont.)	In Network You pay	Out of Network You pay
<ul style="list-style-type: none"> • You do not need to pre-certify your vaginal delivery; see page 53 for other circumstances, such as extended stays for you or your baby. • As part of your coverage, you have access to in-network certified nurse midwives, and board-certified lactation specialists during the prenatal and post-partum period. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Circumcisions are covered 100% during newborn stay. Note: Circumcisions following the newborn stay are covered under the surgical benefits at the applicable copayment or coinsurance. • Hospital services are covered under Section 5(c) and Surgical benefits section 5(b). • When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits. 	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Breastfeeding and lactation support, supplies and counseling for each birth	\$0	\$0
<i>Not covered:</i> <i>Routine sonograms to determine fetal age, size or sex</i>	<i>All charges</i>	<i>All charges</i>
Family planning	In Network You pay	Out of Network You pay
A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories on the HRSA list. This list includes: <ul style="list-style-type: none"> • Voluntary female sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragms Note: See additional Family Planning and Prescription drug coverage Section 5(f).	\$0	40% of the Plan allowance and any difference between our allowance and the billed amount

Family planning - continued on next page

High Option

Benefit Description		
Family planning (cont.)	In Network You pay	Out of Network You pay
<p>Note: Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below.</p> <p>If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov.</p> <p>Note: We cover oral contraceptives under the prescription drug benefit.</p> <ul style="list-style-type: none"> • Voluntary male sterilization 	\$0	40% of the Plan allowance and any difference between our allowance and the billed amount
<p>Genetic testing is covered when medically necessary for certain conditions such as pregnancy testing for cystic fibrosis, coverage of certain cancer drugs, certain autosomal recessive conditions autosomal dominant less penetrant conditions, x-linked conditions and certain chromosome abnormalities.</p> <p>Prior authorization is required</p> <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic testing and counseling unless medically necessary. Interruption of pregnancy unless the life of the mother is at risk</i> 	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Infertility services	In Network You pay	Out of Network You pay
<p>Diagnosis and treatment of infertility</p> <p>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.</p> <p>Diagnosis and treatment of infertility specific to:</p> <ul style="list-style-type: none"> • Artificial insemination: • Intravaginal insemination (IVI) 	20% coinsurance of the plan allowance	50% coinsurance of plan allowance

Infertility services - continued on next page

High Option

Benefit Description		
Infertility services (cont.)	In Network You pay	Out of Network You pay
<ul style="list-style-type: none"> • Intracervical insemination (ICI) • Intrauterine insemination (IUI) <p>Fertility drugs (see section 5f)</p> <ul style="list-style-type: none"> • Oral and injectable drugs associated with artificial insemination and IVF (3 cycles annually) procedures 	50% coinsurance of plan allowance	50% of the Plan allowance and any difference between our allowance and the billed amount
Note: Prior Authorization required		
Allergy care	In Network You pay	Out of Network You pay
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections - including serum <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Provocative food testing</i> • <i>Sublingual allergy desensitization</i> 	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Treatment therapies	In Network You pay	Out of Network You pay
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 47.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy (pulmonary rehabilitation) is provided for up to 20 sessions • Cardiac rehabilitation following qualifying event/ condition is provided for up to 36 sessions • Intravenous (IV)/Infusion Therapy - Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See Services requiring our prior approval in Section 3.</p>	20% coinsurance of the plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

High Option

Benefit Description		
Habilitative/Rehabilitative Therapies	In Network You pay	Out of Network You pay
<p>Habilitative/Rehabilitative Services Outpatient Therapy when performed by qualified physical therapists and occupational therapists:</p> <ul style="list-style-type: none"> • Physical Therapy/ Occupational therapy - up to 60 visits per year combined • Cognitive Rehabilitation up to 20 visits per year • Post cochlear implant rehabilitation and aural therapy up to 30 visits per year <p>Note: We only cover therapy when a physician:</p> <ul style="list-style-type: none"> • 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. 	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Exercise programs 	<i>All charges</i>	<i>All charges</i>
Speech therapy	In Network You pay	Out of Network You pay
Up to 20 visits per year for speech therapy	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Exercise programs, gyms or pool memberships • Work hardening/functional capacity programs or evaluations • Voice therapy 	<i>All charges</i>	<i>All charges</i>
Hearing services (testing, treatment, and supplies)	In Network You pay	Out of Network You pay
<ul style="list-style-type: none"> • For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist <p>Routine hearing for children is covered as preventive services with no copayment</p>	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
External Hearing Aids - <ul style="list-style-type: none"> • Limit of \$2,500 per ear and limited to a single purchase (including repair/replacement) per hearing impaired ear every three (3) years . Repair and replacement of a hearing aid would apply to this limit in the same manner as a purchase. 	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Implanted hearing related devices, such as bone anchored hearing aids (BAHA) and coclear implants	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Hearing services (testing, treatment, and supplies) - continued on next page

High Option

Benefit Description		
Hearing services (testing, treatment, and supplies) (cont.)	In Network You pay	Out of Network You pay
For therapy associated with cochlear implants please refer to the rehabilitative treatment therapy section of this brochure	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
<i>Not covered:</i> <ul style="list-style-type: none"> • All other hearing testing 	<i>All charges</i>	<i>All charges</i>
Vision services (testing, treatment, and supplies)	In Network You pay	Out of Network You pay
One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Diagnosis and treatment of diseases of the eye	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Routine Eye Examination - Eye refraction every two years examination to provide a written lens prescription Note: Eye examinations for children follow the Bright Futures Guidelines (American Academy of Pediatrics) at no charge	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
<i>Not covered:</i> <ul style="list-style-type: none"> • Eyeglasses or contact lenses, except as shown above • Eye exercises and orthoptics • Radial keratotomy and other refractive surgery 	<i>All charges</i>	<i>All charges</i>
Foot care	In Network You pay	Out of Network You pay
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
<i>Not covered:</i> <ul style="list-style-type: none"> • 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) 	<i>All charges</i>	<i>All charges</i>
Orthopedic and prosthetic devices	In Network You pay	Out of Network You pay
<ul style="list-style-type: none"> • Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Enteral equipment and supplies 	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Orthopedic and prosthetic devices - continued on next page

Benefit Description	In Network You pay	Out of Network You pay
<p>Orthopedic and prosthetic devices (cont.)</p> <ul style="list-style-type: none"> • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. • See Section 5(c) for payment information. Insertion of the device is paid as surgery • Ostomy supplies and urinary catheters • Orthotic braces and splints not available over the counter that straighten or change the shape of a body part • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome and/or Myofascial Pain Dysfunction (MDP). See section 5(b) for limitations • Bone anchored hearing aids (BAHA) limited to one per member per lifetime, when the member has either of the following <ul style="list-style-type: none"> - Craniofacial anomalies in which abnormal or absent ear canals preclude the use of a wearable hearing aid - Hearing loss of sufficient severity that it cannot be adequately remedied by a wearable hearing aid • Single purchase of each type of prosthetic device every three (3) years (in-network). Prior authorization is required for prosthetic devices in excess of \$1,000. <p>Note: Most orthopedic and prosthetic devices must be preauthorized. Call us at 1-877-835-9861 if your plan physician prescribes this and you need assistance locating a health care physician or health care practitioner to sell or rent you orthopedic or prosthetic equipment. You may also call us to determine if certain devices are covered.</p> <p>Internal prosthetic devices are paid as hospital benefits. For information on the professional charges for the surgery to insert an implant please refer to Section 5(b) surgical procedures. For information on the hospital and/or ambulatory surgical center benefits see Section 5(c) Services provided by a hospital or other facility.</p>	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Foot orthotics</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Prosthetic replacements provided less than 5 years after the last one (except as needed to accommodate growth in children or socket replacement for members with significant residual limb volume or weight changes)</i> 	<i>All charges</i>	<i>All charges</i>

Orthopedic and prosthetic devices - continued on next page

Benefit Description	In Network You pay	Out of Network You pay
Orthopedic and prosthetic devices (cont.)		
<ul style="list-style-type: none"> • 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	Out of Network You pay
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <p>A single purchase of a type of durable medical equipment (including repair and replacement) every three (3) years. This limit does not apply to wound vacuums. Prior authorization is required for durable medical equipment in excess of \$1,000.</p> <ul style="list-style-type: none"> • Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks) • Dialysis equipment • Standard hospital beds • Wheelchairs • Crutches • CPAP • Walkers • Blood glucose monitors/continuous glucose monitors • Insulin pumps. and insulin pump supplies • Surgical dressings not available over-the-counter • Burn garments • Braces, including necessary adjustments to shoes to accommodate braces, which are used for the purpose of supporting a weak or deformed body part • Braces restricting or eliminating motion in a diseased or injured part of the body • Hair prosthesis (wigs for hair loss due to cancer treatment) - limited to \$350 per year <p>Note: Many DME items must be preauthorized. Call us at 1-877-835-9861 if your plan physician prescribes this and you need assistance locating a healthcare physician or health care practitioner to sell or rent you equipment. You may also call us to determine if certain devices are covered.</p>	20% coinsurance of plan allowance	All charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Power operated vehicles unless medically necessary based upon diagnosis • Duplicate or back up equipment 	All charges.	All charges

Durable medical equipment (DME) - continued on next page

High Option

Benefit Description		
Durable medical equipment (DME) (cont.)	In Network You pay	Out of Network You pay
<ul style="list-style-type: none"> • <i>Parts and labor costs for supplies and accessories replaced due to wear and tear such as tires and tubes</i> • <i>Educational, vocational or environmental equipment</i> • <i>Deluxe or upgraded equipment or supplies</i> • <i>Home or vehicle modifications; seat lifts</i> • <i>Over-the-counter medical supplies</i> • <i>Activities of daily living aids (such as grab bars and utensil holders)</i> • <i>Personal hygiene equipment</i> • <i>Paraffin baths, whirlpools and cold therapy</i> • <i>Augmentative communication devices</i> • <i>Physical fitness equipment</i> • <i>Continuous pulse oximetry unless skilled nursing is involved in home care and it is part of their medically necessary equipment</i> • <i>Out-of-network purchases</i> 	<i>All charges.</i>	<i>All charges</i>
Home health services	In Network You pay	Out of Network You pay
<ul style="list-style-type: none"> • Medically necessary Home healthcare ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true: <ul style="list-style-type: none"> - It must be delivered or supervised by a licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for safety of the patient - It is ordered by a physician - It is not delivered for the purpose of assisting with the activities of daily living including dressing, feeding, bathing or transferring from a bed to a chair - It requires clinical training in order to be delivered safely and effectively - It is not custodial care - We will determine if benefits are available by reviewing both the skill nature of the service and the need for the Physician directed medical management. A service will not be determined to be skilled simply because there is not an available caregiver. - Services include the administration of: oxygen therapy, intravenous therapy and medications. - Limited to 60 visits per year • Prescription foods covered when the following criteria have been met: 	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Home health services - continued on next page

High Option

Benefit Description		
Home health services (cont.)	In Network You pay	Out of Network You pay
<ul style="list-style-type: none"> - 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 <p>Note: medications delivered will be subject to pharmacy charges.</p>		40% of the Plan allowance and any difference between our allowance and the billed amount
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i> • <i>Private duty nursing</i> • <i>Foods that can be obtained over the counter (without a prescription) even if prescribed by your physician</i> 	<i>All charges</i>	<i>All charges</i>
Chiropractic	In Network You pay	Out of Network You pay
<ul style="list-style-type: none"> • Manipulation of the spine and extremities up to 20 visits per year • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application 	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Alternative treatments	In Network You pay	Out of Network You pay
<p>Acupuncture - by a doctor of medicine or osteopathy, or licensed or certified acupuncture practitioner Up to 12 visits per year</p> <p>Dry Needling – by a licensed or certified practitioner</p>	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Naturopathic services</i> • <i>Hypnotherapy</i> • <i>Massage Therapy</i> • <i>Herbal medicine</i> • <i>Rolfing</i> • <i>Ayurveda</i> • <i>Homeopathy</i> 	<i>All charges</i>	<i>All charges</i>

Alternative treatments - continued on next page

High Option

Benefit Description		
Alternative treatments (cont.)	In Network You pay	Out of Network You pay
<ul style="list-style-type: none"> • Other alternative treatments unless specifically listed as covered 	<i>All charges</i>	<i>All charges</i>
Educational classes and programs	In Network You pay	Out of Network You pay
<p>Outpatient self-management training for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin using diabetes and designated chronic conditions. Diabetes outpatient self-management training, education and medical nutrition therapy services must be prescribed by a licensed health care professional who has appropriate state licensing authority. Outpatient self-management training includes, but is not limited to, education and medical nutrition therapy. The training must be given by a certified registered or licensed health care professional trained in the care and management of diabetes.</p> <p>Coverage includes:</p> <ul style="list-style-type: none"> Initial training visit, up to 10 hours, after you are diagnosed with diabetes, for the care and management of diabetes, including but not limited to: Counseling in nutrition , the use of equipment and supplies, training and education, up to four hours, as a result of a subsequent diagnosis by a Physician of a significant change in your symptoms or condition which require modification of your program of self-management of diabetes. Also included is training and education, up to four hours, because of the development of new techniques and treatments. 	20% coinsurance	40% of the Plan allowance and any difference between our allowance and the billed amount
<p>Coverage is provided for:</p> <p>Tobacco Cessation program including online learning, Nicotine Replacement Therapy and over-the-counter and prescription drugs approved by the FDA (subject to age and treatment therapy recommendations) to treat tobacco dependence. Learn more about this program in Section 5(h) Wellness and other Special Features.</p>	\$0	\$0

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: \$500 Self Only, \$1,000 Self Plus One and Self and Family in-network and \$3,000 Self Only, \$6,000 Self Plus One and Self and Family out-of-network. The calendar year deductible applies to most benefits in this Section. We indicate "Not subject to deductible" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost sharing works. Also read Section 9, *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 the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SERVICES AND/OR PROCEDURES.** Please refer to the preauthorization information shown in Section 3 or call customer service to be sure which services require preauthorization.
- If you enroll in UnitedHealthcare Choice Plus Primary Plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a \$150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.)

Benefit Description		
Surgical procedures	In-Network You pay	Out-of-Network You pay
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see <i>Reconstructive surgery</i>) • Insertion of internal prosthetic devices . See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information • Treatment of burns <p>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.</p>	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description	In-Network You pay	Out-of-Network You pay
Surgical procedures (cont.)		
Note: For female surgical family planning procedures see Family Planning Section 5(a) Note: For male surgical family planning procedures see Family Planning Section 5(a)	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Physician charges for Scopic Procedures such as: <ul style="list-style-type: none"> • Endoscopy • Colonoscopy (Diagnostic) • Sigmoidscopy Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under <i>Surgery</i> . Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<i>All charges</i>	<i>All charges</i>
Bariatric Surgery	In-Network You pay	Out-of-Network You pay
Surgical treatment of severe obesity (Bariatric surgery) when the following criteria has been met: Eligible members must be age 18 or older or for adolescents, have achieved greater than 95% of estimated adult height AND a minimum Tanner Stage of 4 <ul style="list-style-type: none"> • A Body Mass Index (BMI) above 40 kg/m² without comorbidity; or • A BMI of 35 kg/m² or greater with obesity-related comorbid medical conditions including: <ul style="list-style-type: none"> - 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: 	20% coinsurance of plan allowance	<i>All charges</i>

Bariatric Surgery - continued on next page

Benefit Description	In-Network You pay	Out-of-Network You pay
Bariatric Surgery (cont.) <ul style="list-style-type: none"> 1. One structured diet program for six consecutive months; or 2. 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 plan allowance	<i>All charges</i>
<p>Revisonal Bariatric Surgery due to a technical failure or major complication from the initial procedure; potential failure/complications include but are not limited to the following:</p> <ul style="list-style-type: none"> • Bowel perforation (including adjustable gastric band erosion) • Adjustable gastric band migration (slippage) that cannot be corrected with manipulation or adjustment (records must demonstrate that manipulation or adjustment to correct band slippage has been attempted) • Leak • Obstruction (confirmed by imaging studies) • Staple-line failure • Mechanical adjustable gastric band failure • Uncontrollable reflux related to sleeve gastrectomy when all the following criteria are met: <ul style="list-style-type: none"> - Maximum nonpharmacological medical management failure (e.g., positional, dietary modification and behavioral changes); and - Maximum pharmacological medical management failure (e.g., at least one month of double dose PPI, H2 blocker, and/or sucralfate); and - Severe esophagitis (grade C or D) confirmed by endoscopy despite maximum medical management <p>and</p> • The individual must also meet the following criteria: <p style="padding-left: 40px;">Both of the following:</p> <ul style="list-style-type: none"> • Completion of a preoperative evaluation that includes a detailed weight history along with dietary and physical activity patterns; and • Psychosocial-behavioral evaluation by an individual who is professionally recognized as part of a behavioral health discipline to provide screening and identification of risk factors or potential postoperative challenges that may contribute to a poor postoperative outcome 	20% coinsurance of plan allowance	<i>All charges</i>

High option

Benefit Description		
Iatrogenic Infertility Services	In-Network You pay	Out-of-Network You pay
<p>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.</p> <p>Covered benefits include the following procedures:</p> <ul style="list-style-type: none"> • Collection of sperm • Cryo-preservation of sperm • Oocyte cryo-preservation • Embryo cryo-preservation • Ovarian stimulation, retrieval of eggs and fertilization <p>Benefits are not available for:</p> <ul style="list-style-type: none"> • Embryo transfer • Long-term storage costs (greater than 1 year) • Elective fertility preservation. <p>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.</p> <p>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.</p>	20% coinsurance of plan allowance; \$60 per specialist visit	40% of the Plan allowance and any difference between our allowance and the billed amount
Gender Affirming Surgery	In-Network You pay	Out-of-Network You pay
<p>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]).</p> <p>Requirements:</p> <ul style="list-style-type: none"> • Must be 18 years of age or older • Must have documented evidence of persistent gender dysphoria • Favorable psychosocial-behavioral evaluation to provide screening and identification of risk factors or potential postoperative challenges • Persistent, well-documented Gender Dysphoria • Capacity to make a fully informed decision and to consent for treatment • Complete at least 12 months of successful continuous full-time real-life experience in the desired gender • Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated) 	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Gender Affirming Surgery - continued on next page

Benefit Description		
Gender Affirming Surgery (cont.)	In-Network You pay	Out-of-Network You pay
<ul style="list-style-type: none"> Treatment plan that includes ongoing follow-up and care by a Qualified Behavioral Health Provider experienced in treating Gender Dysphoria* <p>Gender reconstructive surgeries for (male to female) include:</p> <ul style="list-style-type: none"> 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 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) <p>Gender reconstructive surgeries for (female to male) include:</p> <ul style="list-style-type: none"> 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 Tracheal shave Voice modification surgery Voice modification lessons and therapy Chest and breast surgery including bilateral mastectomy Breast reduction and Breast augmentation 	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

High option

Benefit Description		
Gender Affirming Surgery (cont.)	In-Network You pay	Out-of-Network You pay
<ul style="list-style-type: none"> • Gender Affirming Facial Surgeries • Travel and Lodging (\$2000 maximum) <p>Note: Prior Authorization is required</p>	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Reconstructive surgery	In-Network You pay	Out-of-Network You pay
<p>Physician charges for :</p> <ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birthmarks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - Surgery to produce a symmetrical appearance of breasts; - Treatment of any physical complications, such as lymphedemas; - Breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>) 	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Oral and maxillofacial surgery	In-Network You pay	Out-of-Network You pay
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures 	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<i>All charges</i>	<i>All charges</i>

High option

Benefit Description		
Temporomandibular Joint Dysfunction (TMJ)	In-Network You pay	Out-of-Network You pay
<p>Services for the evaluation and treatment of TMJ and associated muscles</p> <ul style="list-style-type: none"> • Diagnosis: Exam, radiographs and applicable imaging studies and consultation. • Non-surgical treatment including: Clinical exams, Oral appliances (orthotic splints), Arthrocentesis, Trigger-point injections <p>Benefits are provided for surgical treatment if the following criteria are met:</p> <ul style="list-style-type: none"> • There is radiographic evidence of joint abnormality. <ul style="list-style-type: none"> • Non-surgical treatment has not resolved the symptoms. • Pain or dysfunction is moderate or severe. <p>Benefits for surgical services include:</p> <ul style="list-style-type: none"> • Arthrocentesis • Arthroscopy • Arthroplasty • Arthrotomy • Open or closed reduction of dislocations. <p>\$3,000 limit for all services pertaining to TMJ</p>	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants)	In-Network You pay	Out-of-Network You pay
<p>These solid organ transplants are covered. Solid organ transplants are limited to:</p> <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung: single/bilateral/lobar • Pancreas 	20% coinsurance of plan allowance	<i>All charges</i>

Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants) - continued on next page

Benefit Description	In-Network You pay	Out-of-Network You pay
Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants) (cont.)		
<p>These tandem blood or marrow stem cell transplants for covered transplants are subject to medical necessity review by the Plan. Refer to <i>Other services</i> in Section 3 for prior authorization procedures.</p> <ul style="list-style-type: none"> • Autologous tandem transplants for <ul style="list-style-type: none"> - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer) 	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
<p>Blood or marrow stem cell transplants</p> <p>The plan extends coverage for the diagnoses as indicated below.</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hematopoietic stem cell - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia 	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Benefit Description	In-Network You pay	Out-of-Network You pay
Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants) (cont.) <ul style="list-style-type: none"> - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Hematopoietic stem cell - Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors 	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to <i>Other services</i> in Section 3 for prior authorization procedures: <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MDPs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes 	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Benefit Description	In-Network You pay	Out-of-Network You pay
Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants) (cont.) <ul style="list-style-type: none"> - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma 	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
<p>These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols.</p> <p>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.</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - 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 <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia 	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Benefit Description	In-Network You pay	Out-of-Network You pay
<p>Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants) (cont.)</p> <ul style="list-style-type: none"> - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MDDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for: <ul style="list-style-type: none"> - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis <p>National Transplant Program (NTP) - OptumHealth Care Solutions (URN) used for organ tissue transplants</p> <p>Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols.</p>	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

High option

Benefit Description	In-Network You pay	Out-of-Network You pay
Organ/tissue transplants (Transplants must be provided in a Plan designated Center for Transplants) (cont.)		
<p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p> <p>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.</p>	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Donor testing for bone marrow/stem cell transplants for up to 4 potential donors whether family or non-family	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor - except as listed above</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> • <i>All services related to non-covered transplants</i> • <i>All services associated with complications resulting from the removal of an organ from a non-member</i> 	<i>All charges</i>	<i>All charges</i>
Anesthesia	In-Network You pay	Out-of-Network You pay
Professional services provided in : <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital (outpatient) • Surgical center • Skilled nursing center • Office 	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

<p>Important things you should keep in mind about these benefits:</p> <ul style="list-style-type: none"> • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary. • The calendar year deductible is: \$500 Self Only, \$1,000 Self Plus One and Self and Family in-network and \$3,000 Self Only, \$6,000 Self Plus One and Self and Family out-of-network. The calendar year deductible applies to almost all benefits in this Section. We indicate "Not subject to deductible" to show when the calendar year deductible does not apply. • Be sure to read Section 4, <i>Your Costs for Covered Services</i> for valuable information about how cost sharing works. Also read Section 9, <i>Coordinating benefits with other coverage</i>, including with Medicare. • The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge such as physician charges are in Sections 5(a) or (b). • YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SERVICES AND/OR PROCEDURES. Please refer to the preauthorization information shown in Section 3 or call customer service to be sure which services require preauthorization. • If you enroll in UnitedHealthcare Choice Plus Primary Plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a \$150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.) 	
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Benefit Description		
Note: When the calendar year deductible does not apply we indicate - "Deductible does not apply"		
Inpatient hospital	In-Network You pay	Out-of-Network You pay
Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen 	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
<ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays 	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Inpatient hospital - continued on next page

High Option

Benefit Description		
Inpatient hospital (cont.)	In-Network You pay	Out-of-Network You pay
<ul style="list-style-type: none"> • Administration of blood and blood products • Blood products, derivatives and components, artificial blood products and biological serum. Blood products include any product created from a component of blood such as, but not limited to, plasma, packed red blood cells, platelets, albumin, Factor VIII, immunoglobulin, and prolastin • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthesia services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Non-covered facilities, such as nursing homes, schools</i> • <i>Personal comfort items, such as phone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> 	<i>All charges</i>	<i>All charges</i>
Outpatient hospital or ambulatory surgical center	In-Network You pay	Out-of-Network You pay
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, x-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>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.</p>	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	<i>All charges</i>	<i>All charges</i>

High Option

Benefit Description		
Extended care benefits/Skilled nursing care facility benefits	In-Network You pay	Out-of-Network You pay
<p>Services and supplies provided during Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for up to 60 days per year when full-time nursing care is medically necessary as determined by the Plan.</p> <p>Services include:</p> <ul style="list-style-type: none"> • Room and board in a Semi-private Room (a room with two or more beds), and general nursing care • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a physician. 	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Rest cures, domiciliary or convalescent care</i> • <i>Personal comfort items, such as phone, barber services, guest meals and beds</i> 	<i>All charges</i>	<i>All charges</i>
Hospice care	In-Network You pay	Out-of-Network You pay
<p>Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill.</p> <p>Hospice care includes:</p> <ul style="list-style-type: none"> • Physical • Psychological • Social • Spiritual • Respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care • Benefits are available when hospice care is received from a licensed hospice agency. 	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
<p><i>Not covered: Independent and private duty nursing, homemaker services</i></p>	<i>All charges</i>	<i>All charges</i>
Ambulance	In-Network You pay	Out-of-Network You pay
<p>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:</p> <ul style="list-style-type: none"> • From an Out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required. 	20% coinsurance of plan allowance	40% coinsurance of the Plan allowance and any difference between our allowance and the billed amount

Ambulance - continued on next page

High Option

Benefit Description		
Ambulance (cont.)	In-Network You pay	Out-of-Network You pay
<ul style="list-style-type: none"> 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. <p>For the purpose of this Benefit the following terms have the following meanings:</p> <ul style="list-style-type: none"> "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting. "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness. "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis. 	20% coinsurance of plan allowance	40% coinsurance of the Plan allowance and any difference between our allowance and the billed amount
Not Covered: International Transportation	<i>All charges</i>	<i>All charges</i>

Section 5(d). Emergency Services/Accidents

	<p>Important things you should keep in mind about these benefits:</p> <ul style="list-style-type: none"> • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary. • The calendar year deductible is: \$500 Self Only, \$1,000 Self Plus One and Self and Family in-network and \$3,000 Self Only, \$6,000 Self Plus One and Self and Family out-of-network. The calendar year deductible applies to almost all benefits in this Section. We indicate "Not subject to deductible" to show when the calendar year deductible does not apply.. • Be sure to read Section 4, <i>Your Costs for Covered Services</i>, for valuable information about how cost sharing works. Also read Section 9, <i>Coordinating benefits with other coverage</i>, including with Medicare. • If you enroll in UnitedHealthcare Choice Plus Primary Plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a \$150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.) 	
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What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Emergencies within or outside our service area

If you are in an emergency situation, please call your Primary Care Physician. In extreme emergencies, if you are unable to contact your physician, contact the local emergency system (e.g., the 911 phone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan or Primary Care Physician within 48 hours, unless it was not reasonably possible to notify us within that time. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify us within that time.

Benefit Description		
Emergency Care	In-Network You pay	Out-of-Network You pay
• Emergency care at a Provider's office (PCP)	Primary care Provider (PCP) \$0 Not subject to deductible	Primary care physician (PCP) \$0 Not subject to deductible
• Emergency care at a doctor's office - Specialist	\$60 copayment specialist visit Not subject to deductible	40% of the Plan allowance and any difference between our allowance and the billed amount
• Emergency care at an urgent care center	\$50 copayment Not subject to deductible	40% of the Plan allowance and any difference between our allowance and the billed amount

Emergency Care - continued on next page

High Option

Benefit Description		
Emergency Care (cont.)	In-Network You pay	Out-of-Network You pay
• Emergency care as an outpatient at a hospital, including providers' services	20% coinsurance of plan allowance (waived if admitted)	40% of the Plan allowance and any difference between our allowance and the billed amount (waived if admitted)
<i>Not covered: Elective care or non-emergency care at hospital emergency room</i>	<i>All charges</i>	<i>All charges</i>
Ambulance	In-Network You pay	Out-of-Network You pay
Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance or water vehicle) to the nearest Hospital where the required Emergency Health Care Services can be performed.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between allowance and the billed amount
<i>Not Covered:</i> <i>International Transportation</i>	<i>All charges</i>	<i>All charges</i>

Section 5(e). Mental Health and Substance Use Disorder Benefits

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- The calendar year deductible is: \$500 Self Only, \$1,000 Self Plus One and Self and Family in-network and \$3,000 Self Only, \$6,000 Self Plus One and Self and Family out-of-network. The calendar year deductible applies to almost all benefits in this Section. We indicate "Not subject to deductible" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost sharing works. Also read Section 9 *Coordinating benefits with other coverage*, including with Medicare.
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SERVICES AND/OR PROCEDURES.** Please refer to the preauthorization information shown in Section 3 or call customer service to be sure which services require preauthorization.
- If you enroll in UnitedHealthcare Choice Plus Primary Plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a \$150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.)

Benefit Description	In-Network You pay	Out-of-network You pay
Professional services When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: <ul style="list-style-type: none"> • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and medication management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of substance use disorders, including detoxification, treatment and counseling 	\$0 copayment per specialist visit - Not subject to deductible	40% of the Plan allowance and any difference between our allowance and the billed amount

Professional services - continued on next page

High option

Benefit Description		
Professional services (cont.)	In-Network You pay	Out-of-network You pay
<ul style="list-style-type: none"> • Professional charges for outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy 	\$0 copayment per specialist visit - Not subject to deductible	40% of the Plan allowance and any difference between our allowance and the billed amount
Autism Spectrum Disorder for children with autism spectrum disorder <ul style="list-style-type: none"> • Assessments, evaluations, or tests by a licensed physician or licensed psychologist to diagnose whether an individual has an autism spectrum disorder; • Treatment of autism spectrum disorders when it is determined by a licensed physician or licensed psychologist that the treatment is medically necessary health care. A licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity 	\$0 copayment per specialist visit - Not subject to deductible	40% of the Plan allowance and any difference between our allowance and the billed amount
Diagnostics	In-Network You pay	Out-of-network You pay
<ul style="list-style-type: none"> • Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility 	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Inpatient Hospital or other covered facility	In-Network You pay	Out-of-network You pay
Inpatient services provided and billed by a hospital or other covered facility <ul style="list-style-type: none"> • Room and board, such as semi-private or intensive accommodations, general nursing care, meals and special diets, and other hospital services. Prior authorization is required • Partial day treatment • Residential Treatment 	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Outpatient hospital	In-Network You pay	Out-of-network You pay
Outpatient services provided by and billed by a covered facility such as: <ul style="list-style-type: none"> • Facility based intensive outpatient treatment programs 	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount.

High option

Benefit Description		
Not covered	In-Network You pay	Out-of-network You pay
<ul style="list-style-type: none">• <i>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</i>• <i>Methadone Maintenance for substance use unless it is part of an approved treatment program</i>• <i>Services and supplies when paid for directly or indirectly by a local state or Federal Government agency</i>• <i>Room and board at a therapeutic boarding school</i>• <i>Services rendered or billed by schools</i>• <i>Services that are not medically necessary</i>• <i>Out-of-network lab or X-ray</i> <p><i>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.</i></p>	<i>All charges</i>	<i>All charges</i>

Section 5(f). Prescription Drug Benefits

	<p>Important things you should keep in mind about these benefits:</p> <ul style="list-style-type: none"> • We cover prescribed drugs and medications, as described in the chart beginning on the next page. Some injectable medications may be covered under your medical benefit. • Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary. • Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically. • Be sure to read Section 4, <i>Your Costs for Covered Services</i>, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare. Be sure to read Section 4, <i>Your costs for covered services</i>, for valuable information about how cost sharing works. Also read Section 9, <i>Coordinating benefits with other coverage</i>, including with Medicare. • Your Medical deductible for Self only is \$500; Your deductible for Self Plus One or Self and Family is \$1,000. Your pharmacy deductible which is applicable only for Tier 3 and Tier 4 drugs for Self Only is \$250 and for Self Plus One or Self and Family is \$500. This deductible does not apply to any Tier 1 or Tier 2 drugs or to medications on the specialty pharmacy tiers. • Federal law prevents the pharmacy from accepting unused medications. • Prescription drugs paid under the pharmacy benefit are not subject to the medical deductible. • If you enroll in UnitedHealthcare Choice Plus Primary Plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a \$150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.) 	
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There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice, must prescribe your medication.
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy. Retail or mail order Specialty Pharmacy drugs are only filled at our Specialty Pharmacy. Some drugs are only available at the retail pharmacy for safety or other reasons. To locate the name of a Plan pharmacy near you, refer to your Directory of Health Care Professionals, call our Customer Service Department 1-877-835-9861 or visit our website, www.uhcfeds.com.
- **We use a Prescription Drug List (PDL) called the Advantage PDL.** Our PDL Management Committee creates this list that includes FDA approved prescription medications, products, or devices. Our Plan covers all prescription medications written in accordance with FDA guidelines for a particular therapeutic indication except for prescription medications or classes of medications listed under "Not Covered" in this section of the brochure. The PDL Management Committee decides the tier placement based upon clinical information from the UnitedHealthcare Pharmacy and Therapeutics (P&T) Committee as well economic and financial considerations. You will find important information about our PDL as well as other Plan information on our web site, www.uhcfeds.com.
- **Tier 1** is your **lowest** copayment option (**\$10** for up to a 30-day supply or **\$25** for up to a 90-day supply through mail order), and includes select generic medications, as well as select preferred medications. Brand medications in Tier 1 include select insulin products, select inhalers for asthma, and select medications for migraine headaches for which no generic alternative(s) are available. For the lowest out-of-pocket expense, you should always consider Tier 1 medications if you and your provider decide they are appropriate for your treatment.

- **Tier 2** is your **middle** copayment option (\$50 for up to a 30-day supply or \$125 for up to a 90-day supply through mail order), and contains most preferred brand medications not included in Tier 1. Preferred medications placed in Tiers 1 and 2 are those the PDL Management Committee has determined to provide better overall value than those in Tier 3. If you are currently taking a medication in Tier 2, ask your provider whether there are Tier 1 alternatives that may be appropriate for your treatment.
- **Tier 3** is your **higher** copayment option (\$100 for up to a 30-day supply or \$250 for up to a 90-day supply through mail order), and consists of non-preferred medications. Sometimes there are alternatives available in Tier 1 or Tier 2. If you are currently taking a medication in Tier 3, ask your provider whether there are Tier 1 or Tier 2 alternatives that may be appropriate for your treatment. **This tier is subject to the pharmacy deductible described above.**
- **Tier 4** is your **highest** priced (\$200 for up to a 30-day supply or \$500 for up to a 90-day supply through mail order) non-preferred medications that do not add clinical value over their covered Tier 1, Tier 2, or Tier 3 alternatives. Some medications on Tier 4 may also have an over-the-counter alternative which can be purchased without a prescription. **This tier is subject to the pharmacy deductible described above.**

Changes to Tier level for all covered medications and supplies may occur January 1 and July 1 of each year. Throughout the year, if new generic medications come to market throughout the Plan year they will be placed on Tier 1 and the brand could move to a higher tier. Newly marketed brand medications will be evaluated by our PDL Management Committee and they will be placed in the appropriate Tier. A prescription medication may be moved to the 4th tier of PDL at anytime if the medication changes to over-the-counter status, or removed from the PDL due to safety concerns declared by the Food and Drug Administration (FDA).

Specific Drug Exclusions - The plan will exclude higher cost medications that have therapeutic alternatives available without any additional clinical value over other options in their class. These drugs cost significantly more than those alternatives.

These are the dispensing limitations: Some drugs may only be available at a retail pharmacy or through a designated Specialty Pharmacy.

Mandatory Specialty Pharmacy Program - Our Specialty Pharmacy Program includes medications for rare, unusual or complex diseases. Members must obtain these medications through our designated specialty pharmacy. For costs associated with these prescriptions please see below. You will receive up to a maximum of a consecutive 30-day supply of your prescription medication. Our specialty pharmacy providers will give you superior assistance and support during your treatment. This Program offers the following benefits to members:

- Tier 1 \$10; Tier 2 \$150; Tier 3 \$350, Tier 4 \$500 (there is no additional pharmacy deductible for specialty medications)
- Expertise in storing, handling and distributing these unique medications
- Access to products and services that are not available through a traditional retail pharmacy
- Access to nurses and pharmacists with expertise in complex and high cost diseases
- Free supplies such as syringes and needles
- Educational materials as well as support and development of a necessary care plan

Contraceptives - You pay one copay for up to a 90-day supply of contraceptive medications, subject to QLL and QD limitations. Note: Tier 1 hormonal contraceptives are offered with no copayment.

Step Therapy - is a tool used to control costs for certain drug types as well as ensure quality and safety. If you have a new prescription for certain kinds of medications, you must first try the most cost-effective (first-line) drug in that category before another one is covered. In most cases, the cost-effective drug will work for you, but if it doesn't, your physician will need to request preauthorization for another (second-line) drug in the same category.

Quantity Duration (QD) - Some medications have a limited amount that can be covered for a specific period of time.

Quantity Level Limits (QLL) - Some medications have a limited amount that can be covered at one time.

Day Supply - "Day supply" means consecutive days within the period of prescription. Where a prescription regimen includes "on and off days" when the medication is taken, the off days are included in the count of the day supply.

Changes to quantity duration and quantity level limits may occur on January 1 and July 1 of each year. We base these processes upon the manufacturer's package size, FDA-approved dosing guidelines as defined in the product package insert and/or the medical literature or guidelines that support the use of doses other than the FDA-recommended dosage. If your prescription written by your provider exceeds the allowed quantity, please refer to Section 7, to file an appeal with the Plan.

Injectable medications - Some injectable medications may be covered under the medical policy. Medications typically covered under the pharmacy benefit and received through a retail or mail order pharmacy are those that are self-administered by you or a non-skilled caregiver. However, injectable medications that are typically administered by a health care professional are covered under your medical benefit and need to be accessed through your provider or Specialty pharmacy. Contact the Health Plan at 1-877-835-9861 for more information on these medications.

Special dispensing circumstances - UnitedHealthcare will give special consideration to filling prescription medications for members covered under the FEHB if:

- You are called to active duty, or
- You are officially called off-site as a result of a national or other emergency, or
- You are going to be on vacation for an extended period of time

Your physician may need to request prior authorization from us in order to fill a prescription for the reasons listed above. Please contact us on 1-877-835-9861 for additional information

Refill Frequency - A process that allows you to receive a refill for most medications when you have used 75 percent of the medications. For example, a prescription that was filled for a 30-day supply can be refilled after 23-days. While this process provides advancement on your next prescription refill, we cannot dispense more than the total quantity your prescription allows.

Why use Tier 1 drugs? Medications in Tier 1 offer the best health care value and are available at the lowest copayment. Tier 2 and Tier 3 medications are available at a progressively higher copayment and Tier 4 medications are available at the highest copayment level. This approach helps to assure access to a wide range of medications and control health care costs for you.

Benefit Description	In-network You pay	Out-of-Network You pay
<p>Preventive care medications</p> <p>Medications to promote better health as recommended by ACA.</p> <p>Note: Preventive Medications with a USPSTF recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations</p> <p>The following drugs and supplements are covered without cost-share, even if over-the-counter, are prescribed by a health care professional, and filled at a network pharmacy.</p> <ul style="list-style-type: none">• Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age• Folic acid supplements for women of childbearing age 400 & 800 mcg• Liquid iron supplements for children age 0-1 year• Pre-natal vitamins for pregnant women• Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6• Certain statins to treat cardiovascular disease for adults age 40 to 75 will be covered without a copayment as recommended by the United States Preventive Services Task force (USPSTF) when the following criteria is met:	\$0	<i>All charges</i>

Preventive care medications - continued on next page

High Option

Benefit Description		
Preventive care medications (cont.)	In-network You pay	Out-of-Network You pay
<ul style="list-style-type: none"> - one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); - and a calculated 10-year risk of a cardiovascular event of 10% or greater 	\$0	<i>All charges</i>
Covered medications and supplies	In-network You pay	Out-of-Network You pay
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medications that by Federal law of the United States require a physician's prescription for their purchase, except those listed as <i>Not covered</i>. • 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* <ul style="list-style-type: none"> - Estradiol - testosterone - leuprolide • Oral and injectable drugs associated with artificial insemination and IVF (3 cycles annually) procedures • Medications prescribed to treat obesity* <ul style="list-style-type: none"> - Saxenda - Wegovy - Zepbound • Some drugs may require prior authorization <p>Prior Authorization is required</p> <p>Note: Intravenous fluids and medications for home use, implantable drugs, and some injectable drugs are covered under Medical services and supplies Section (5a) or Surgical and anesthesia services Section (5b).</p>	Non-maintenance medications at a retail pharmacy: Up to a 30-day supply <ul style="list-style-type: none"> • Tier 1: \$10 copayment • Tier 2: \$50 copayment • Tier 3: \$100 copayment • Tier 4: \$200 copayment Maintenance medications from the Plan mail order pharmacy for up to a maximum of a 90-day supply <ul style="list-style-type: none"> • Tier 1: \$25 copayment • Tier 2: \$125 copayment • Tier 3: \$250 copayment • Tier 4: \$500 copayment 	<i>All charges</i>
<p>*For a complete list of drugs and medications, visit www.uhcfeds.com or call our Customer Service Department 877-835-9861</p> <p>Specialty Medications (per 30-day supply)</p>	Tier 1 \$10 Tier 2 \$150 Tier 3 \$350 Tier 4 \$500	<i>All charges</i>
COVID-19 Over The Counter (OTC) Test Kits	Tier 3 -\$12 Capped	<i>All charges</i>
<ul style="list-style-type: none"> • 8 Tests per member per month 		

Covered medications and supplies - continued on next page

High Option

Benefit Description	In-network You pay	Out-of-Network You pay
Covered medications and supplies (cont.)		
<p>Contraceptive drugs and devices as listed in the Health Resources and Services Administration site.</p> <p>Contraceptive coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below.</p> <ul style="list-style-type: none"> • Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy. • Members have a clinical review for contraceptives that are excluded. They should reach out to their prescribing provider. Contraceptive products that are not already available at \$0 cost-share can be provided at \$0 member cost-share if the provider determines that a particular contraceptive is medically necessary for that member. The cost-share waiver process requires that providers attest the product is needed for contraceptive purposes and this can be submitted electronically by the provider. If you have difficulty accessing contraceptive coverage or other reproductive healthcare you can contact contraception@opm.gov • Reimbursement for over-the-counter contraceptives can be submitted in accordance with Section 7. • The "morning after pill" (tier 1) is provided at no cost if prescribed by a physician and purchased at the network pharmacy <p>Note: For additional Family Planning benefits see Section 5(a) Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Educational Classes and Programs in Section 5(a)</p>	\$0	<i>All charges</i>
<p>Smoking cessation medications are covered as follows:</p> <ul style="list-style-type: none"> • Prescription medications for smoking cessation • Over-the-counter smoking cessation medications with a prescription from physician as part of our smoking cessation program 	\$0	<i>All charges</i>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Medications, drugs and supplies used for cosmetic purposes • Medical Marijuana • Drugs to enhance athletic performance • Medical supplies such as dressings and antiseptics • Artificial insemination fertility drugs other than used for the iatrogenic services • Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies 	<i>All charges</i>	<i>All charges</i>

Covered medications and supplies - continued on next page

High Option

Benefit Description		
Covered medications and supplies (cont.)	In-network You pay	Out-of-Network You pay
<ul style="list-style-type: none"> • Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed • Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them • Nonprescription medications unless specifically indicated elsewhere • Drugs for sexual performance for patients that have undergone genital reconstruction • Drugs available over-the-counter that do not require a prescription order by federal or state law before being dispensed • Alcohol swabs and bio-hazard disposable containers • Compound drugs that do not contain at least one covered ingredient that requires a prescription order to fill 	All charges	All charges
<p>Opioid rescue agents such as naloxone are covered under this Plan with no cost sharing when obtained from a network pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections.</p> <p>For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose</p> <p>Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/</p>	\$0	All charges

Section 5(g). Dental Benefits

- Important things you should keep in mind about these benefits:**
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
 - If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9, *Coordinating benefits with other coverage*.
 - The calendar year deductible is: \$500 Self Only, \$1,000 Self Plus One and Self and Family in-network and \$3,000 Self Only, \$6,000 Self Plus One and Self and Family out-of-network. The calendar year deductible applies to almost all benefits in this Section. We indicate "Not subject to deductible" to show when the calendar year deductible does not apply.
 - We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
 - **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SERVICES AND/OR PROCEDURES.** Please refer to the preauthorization information shown in Section 3 or call customer service to be sure which services require preauthorization.
 - If you enroll in UnitedHealthcare Choice Plus Primary Plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a \$150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.)
 - Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with other coverage*, including with Medicare.

Benefit Description	In-Network You pay	Out-of-Network You pay
Accidental injury benefit 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: <ul style="list-style-type: none"> • has no active decay, has at least 50% bony support, • has no filling on more than two surfaces; • has no root canal treatment, is not an implant • is not in need of treatment except as a result of the accident, and • functions normally in chewing and speech. • Crowns, bridges, implants and dentures are not considered sound natural teeth. Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry	20% coinsurance	40% of the Plan allowance and any difference between our allowance and the billed amount

Accidental injury benefit - continued on next page

High Option

Benefit Description		
In-Network You pay	Out-of-Network You pay	
Accidental injury benefit (cont.) <p>The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period provided you do so within 60 days of the injury and if extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wire from fracture care.)</p> <p>Benefits for treatment of accidental injury are limited to the following:</p> <ul style="list-style-type: none"> • Emergency examination • Necessary X-rays /periapical and panoral radiographs • Endodontic (root canal) treatment • Emergency, temporary splinting of teeth • Prefabricated post and core • Simple minimal restorative procedures (fillings) • Emergency extractions • Post-traumatic crowns are covered if it is the only clinical treatment available • Replacement of tooth due lost due to accidental injury 	20% coinsurance	40% of the Plan allowance and any difference between our allowance and the billed amount
Adjunctive dental services <p>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.</p> <p>Examples of adjunctive dental care are:</p> <ul style="list-style-type: none"> • 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 <p>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.</p> <p><i>Not Covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and related procedures, including bone grafts to support implants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva and alveolar bone</i> 	In-Network You pay 20% coinsurance <i>All charges</i>	Out-of-Network You pay 40% of the Plan allowance and any difference between our allowance and the billed amount <i>All charges</i>

Section 5(h) Wellness and Other Special features

Feature	Description
UnitedHealthcare's Digital Experience	<p>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</p> <p>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.</p> <p>Download the UnitedHealthcare app* for access to health plan ID cards, benefits information and help answering questions.</p> <p>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</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Download the UnitedHealthcare app from the App Store® or Google Play™</p> <p>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:</p> <p>Your personalized website, myuhc.com®, features tools designed to help you:</p> <ul style="list-style-type: none"> • Find, price and save on care — you can save with Virtual Visits and other tools. You can save an average of 36% * 1 when you compare costs for providers and services • Get care from anywhere with Virtual Visits. A doctor can diagnose common conditions by phone or video 24/7 • Understand your benefits and the financial impact of care decisions • Find tailored recommendations regarding providers, products and services. You can even generate an out-of-pocket estimate based on your specific health plan status • Access claim details, plan balances and your health plan ID card quickly • Follow through on clinical recommendations and access wellness programs • Order prescription refills, get estimates and compare medication pricing • Check your plan balances, access financial accounts and more • Find a quality doctor, clinic, hospital or lab that helps meet their needs. • Use multiple search options to filter results by location, specialty, quality, cost, services offered and more. • See provider ratings created by patients. • Review cost and care options before making an appointment to help control spending and choose the right level of service. • Access personalized cost and provider information specific to the benefit plan.

Feature	Description
Myuhc.com Behavioral Health Resources	<p>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.</p> <p>Find the right care for you</p> <p>Using the provider search tool, you can:</p> <ul style="list-style-type: none"> • 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 <p>Tap into behavioral health support</p> <p>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.</p> <p>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</p> <ul style="list-style-type: none"> • You'll get access to: • Articles • Podcasts • Videos • Other tools <p>To find behavioral health care, sign in or register on myuhc.com and then go to Find Care Behavioral Health Directory</p>
Sanvello/ Self Care by Able To	<p>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.</p> <ul style="list-style-type: none"> • Assessments and tracking • Mental health skills and tools – Cognitive Behavioral Therapy skills, meditations 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.
Real Appeal - A Lifestyle and Weight Management Program	<p>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.</p> <p>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.</p> <p>Real Appeal includes:</p> <p>Social community resources such as: Real Appeal LinkedIn community; Facebook community; YouTube videos including getting started, workouts and success stories</p>

	<p>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:</p> <ul style="list-style-type: none"> • Balanced Portion plate • Electronic food scale • Digital weight scale • Fitness guide <p>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 myuhc portal or directly through our myuhc mobile app. Staying accountable to goals may be easier than ever. Staying accountable to goals may be easier than ever.</p> <ul style="list-style-type: none"> • Customizable food, activity, weight and goal trackers. • Unlimited access to digital content. • An online lifestyle program to help you learn new ways to be your healthiest self
Smoking Cessation Program	<p>Our smoking cessation program provides our members with resources and support for tobacco cessation. Included are:</p> <ul style="list-style-type: none"> • 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) <p>Get started today. Go to myuhc.com, visit the "Health Resources" tab on the top right, Choose the "Quit for Life" tile</p> <p>Available from the App Store; Android available in Google play</p>
Maternity Health Solutions	<p>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.</p> <ul style="list-style-type: none"> • Maternity-related courses available on myuhc.com regarding course topics such as: <ul style="list-style-type: none"> - 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	<p>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.</p>

High Option

	<p>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.</p> <ul style="list-style-type: none"> • Premium Care Physician meets UnitedHealth Premium program quality & cost efficient care criteria. • Quality Care Physician meets UnitedHealth Premium program quality care criteria, but does not meet the program's cost efficient care criteria or is not evaluated for cost-efficient care. Physician is not eligible for a Premium designation. • Not Evaluated for Premium Care physician's specialty is not evaluated and/or does not have enough claims data for program evaluation or the physician's program evaluation is in process.
UHC Rewards and One Pass Select	<p>Your health plan comes with a new way to earn up to \$300. With UnitedHealthcare Rewards, you can earn up to \$300 for tracking your steps or sleep, getting an annual checkup and more. The activities you go for are up to you. When you activate UHC Rewards, you can also get started with One Pass Select™, a fitness program that gives you unlimited access to a nationwide network of thousands of fitness centers. Plus, you can use your earnings to help pay for a One Pass Select membership.</p> <p>Start earning with UHC Rewards by:</p> <ul style="list-style-type: none"> • Download the UnitedHealthcare® app and then: Sign in or register • Select UHC Rewards • Activate UHC Rewards • Select Redeem rewards to access One Pass Select <p><i>UnitedHealthcare Rewards is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you. If any fraudulent activity is detected (e.g., misrepresented physical activity), you may be suspended and/or terminated from the program. If you are unable to meet a standard related to health factor to receive a reward under this program, you might qualify for an opportunity to receive the reward by different means. You may call us toll-free at 1-866-230-2505 or at the number on your health plan ID card, and we will work with you (and, if necessary, your doctor) to find another way for you to earn the same reward. Rewards may be limited due to incentive limits under applicable law. Components subject to change. This program is not available for fully insured members in Hawaii, Vermont and Puerto Rico.</i></p> <p><i>One Pass Select is a voluntary program featuring a subscription-based nationwide gym network, digital fitness and grocery delivery service. The information provided under this program is for general informational purposes only and is not intended to be nor should it be construed as medical advice. Individuals should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for them. Purchasing discounted gym and fitness studio memberships, digital fitness or grocery delivery services may have tax implications. Employers and individuals should consult an appropriate tax professional to determine if they have any tax obligations with respect to the purchase of these discounted memberships or services under this program, as applicable. One Pass Select is a program offered by Optum. Subscription costs are payable to Optum.</i></p>
Specialty Pharmacy	<p>What are the benefits of using Optum Specialty Pharmacy?</p> <p>Optum Specialty Pharmacy provides personalized support and resources at no extra cost to help you manage your condition.</p> <p>How does Optum Specialty Pharmacy support you?</p>

	<ul style="list-style-type: none"> • 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 <p>Tips for working with our Optum Specialty Pharmacy care team.</p> <ul style="list-style-type: none"> • 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. <p>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.</p>
Flexible Benefits Option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Cancer Clinical Trials	<p>To be a qualifying clinical trial, a trial must meet all of the following criteria:</p> <ul style="list-style-type: none"> • Be sponsored and provided by a cancer center that has been designated by the <i>National Cancer Institute (NCI)</i> as a <i>Clinical Cancer Center</i> or <i>Comprehensive Cancer Center</i> or be sponsored by any of the following: <ul style="list-style-type: none"> - <i>National Institutes of Health (NIH)</i>. (Includes <i>National Cancer Institute (NCI)</i>) - <i>Centers for Disease Control and Prevention (CDC)</i> - <i>Agency for Healthcare Research and Quality (AHRQ)</i> - <i>Centers for Medicare and Medicaid Services (CMS)</i> - <i>Department of Defense (DOD)</i> - <i>Veterans Administration (VA)</i>

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	<ul style="list-style-type: none"> The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals. Benefits are not available for preventive clinical trials. The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.
Medicare Part B Reimbursement for Retiree Advantage Members	<p><i>Receive reimbursement for your Medicare Part B Premium</i></p> <ul style="list-style-type: none"> <i>\$150.00 will be paid on your behalf directly to Medicare</i> <i>See a reduction in your quarterly Medicare bill, or an increase in your Social Security payment or annuity payment</i> <i>Receive this benefit for every month you're enrolled in the plan</i>
Renew Active Fitness Program for Retiree Advantage Members	<p>Renew Active is a fitness benefit which is included in the Medicare Advantage plan which provides:</p> <ul style="list-style-type: none"> A free gym membership to participating facilities <ul style="list-style-type: none"> To view participating facilities, please visit www.uhcrenewactive.com Access to an extensive network of gyms and fitness locations near members A personalized fitness plan Access to a wide variety of fitness classes An online brain health program, exclusively from AARP® Staying Sharp Connecting with others at local health and wellness events, and through the Fitbit® Community for Renew Active
First Line Essentials for Retiree Advantage Members	<p><i>Shop for hundreds of over-the-counter items such as toothpaste, vitamins, and personal care from the Health Products catalog.</i></p> <ul style="list-style-type: none"> <i>Members will receive \$40 allowance each quarter to spend on items from the provided catalog</i> <i>Items are delivered directly to your door</i> <i>Orders can be placed over the phone, by mail, or online</i>
House Calls for Retiree Advantage Members	<p><i>With the UnitedHealthcare® HouseCalls program, you get an annual in-home preventive care visit from one of our health care practitioners at no extra cost.</i></p> <p><i>What does HouseCalls include?</i></p> <ul style="list-style-type: none"> <i>One 45 to 60-minute at-home visit from a health care practitioner, each year.</i> <i>A head-to-toe exam, health screenings and plenty of time to talk about your health questions.</i> <i>A custom care plan made just for you.</i> <i>Help connecting you with additional care you may need.</i>
Healthy at Home for Retiree Advantage Members	<p><i>Healthy at Home provides the following benefits up to 30 days following all inpatient and skilled nursing facility discharges when referred by a UnitedHealthcare Advocate:</i></p> <ul style="list-style-type: none"> <i>Home-Delivered Meals</i> <i>Receive 28 home-delivered meals provided by Mom's Meals</i> <i>Non-emergency transportation</i> <i>Receive 12 one-way rides to medically related appointments and to the pharmacy provided by ModviCare</i> <i>In-home Personal Care</i>

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	<ul style="list-style-type: none"> • Receive 6 hours of in-home personal care through our exclusive national provider CareLinx
Real Appeal for Retiree Advantage Members	<p>Real Appeal is a weight loss program that can help members feel and look better. The program provides everything they need to lose weight and keep it off. This program is a pilot for select members residing in Wisconsin.</p> <ul style="list-style-type: none"> • The online program includes: • Personalized diabetes prevention coaching • 24/7 online support and mobile app • Customizable food, activity, weight and goal trackers • Success group support, which lets members chat with others who are doing the Real Appeal program • The weekly Real Appeal All-Star Show featuring healthy tips from celebrities, athletes and health experts <p>Success Kit includes:</p> <ul style="list-style-type: none"> • Program, nutrition, and fitness guides • Tools to help cook healthier, tasty meals • Delivered right to their front door after attending their first group coaching session
UnitedHealthcare Hearing for Retiree Advantage Members	<p><i>UnitedHealthcare Hearing provides members with greater technology, choice and convenience</i></p> <ul style="list-style-type: none"> • <i>Rechargeable hearing aids, remote adjustments and other advanced feature devices are available at up to 80% less than standard industry prices through direct delivery, including top brands in multiple styles</i> • <i>6,500+ locations nationwide</i> • <i>Choose home delivery or in person options</i> • <i>3-minute online hearing test to assess hearing loss/need for in-person test</i> • <i>Members receive \$1500 allowance every 36 months towards the purchase of hearing aids</i> • <i>Members must use a UHC hearing provider to use their hearing aid benefit</i>
Quit For Life for Retiree Advantage Members	<p>Quit For Life has helped 3.5 million members quit smoking or using tobacco. It provides the tools and one-on-one support to help you quit your way.</p> <p>And for UnitedHealthcare members, it's offered at \$0 out of pocket.</p> <p>With a 95% satisfaction rate, Quit for Life provides</p> <ul style="list-style-type: none"> • Tools and support to help members quit cigarettes, e-cigarettes, vaping and tobacco • A personal, one-on-one Quit Coach to help you create a customized quit plan • The Quit for Life mobile app, which offers 24/7 urge management support • Text2Quit text messages for daily tips and encouragement • Quit medications – Such as nicotine gum or patches – for no charge, based on eligibility
PERS (Personal Emergency Response System) for Retiree Advantage Members	<p>UnitedHealthcare® works with Lifeline to provide a personal emergency response system at no cost for Retiree Advantage plan members</p> <p>Lifeline personal emergency response system (PERS) allows you to ask for help whenever you need it, anytime of day or night – 365 days of the year, 24/7. All you need to do is press the help button, worn as a wristband or pendant, and a Trained Care Specialist will assist you to make sure you quickly get the help you need.</p> <p>Features include:</p>

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| | <ul style="list-style-type: none">• Optional AutoAlert fall detection technology automatically provides access to help if it detects a fall – even if wearer is disoriented, immobilized or unconscious and cannot press their help button• Cellular or landline compatible, Lifeline works anywhere in the U.S., where current telephone service is provided• Lightweight, waterproof help button can be worn on the wrist or as a pendant |
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Non-FEHB Benefits Available to Plan Members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 1-877-835-9861 TTY 711.

PPO Dental Plan* - Your plan includes preventive benefits for each family member covered under your policy. Eligible family members receive \$500 per member per year in preventive dental services both in and out of network, such as; Oral exams, cleanings, X-rays, sealants & fluoride treatments. Visit www.uhcfdeds.com. For your dental benefit certificate of coverage.

UnitedHealthcare Hearing* - You have access to a wide selection of hearing aid styles and technology from name brand and private label manufacturers at significant savings. Plus, you'll receive personalized care from experienced hearing providers along with professional support every step of the way, helping you to hear better and live life to the fullest. Visit www.uhcsharing.com or call 1-855-523-9355, Monday through Friday, 8:00 am to 8:00 pm CT. Please reference code **HEARFEHBP** when accessing services.

UHC Rewards and One Pass* - UnitedHealthcare Rewards, you can earn dollars for tracking your steps or sleep, getting an annual checkup and more. The activities you go for are up to you. When you activate UHC Rewards, you can also get started with One Pass Select™, a fitness program that gives you unlimited access to a nationwide network of thousands of fitness centers. You can use your earnings to help pay for a One Pass Select membership. 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.uhonet.uhc.com/federal> or call 1-844-620-4814 (worldwide 24-hour a day).

Accidental Insurance - Program options that offer benefits paid in a lump sum directly to you for eligible expenses related to accidental injury. These benefits are paid regardless of other insurance coverage you have, up to your chosen annual maximum. Visit <http://cloud.uhonet.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.uhonet.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.uhonet.uhc.com/federal> or call 1-844-620-4814 for details and plan cost and availability in your area.

UnitedHealthOne® is a brand name used for many UnitedHealthcare individual insurance products. UnitedHealthcare and UnitedHealthOne® family and individual insurance plans are underwritten by Golden Rule Insurance Company and UnitedHealthcare Life Insurance Company. Prior to being purchased by UnitedHealthcare in 2003, Golden Rule Insurance Company had served the insurance needs of families and individuals for decades. The expertise brought in by Golden Rule has now become an important component of UnitedHealthcare and UnitedHealthOne® insurance products offered on UHOne.com. Shopping here or calling, means browsing products supported by over 75 years of personal insurance experience.

Section 6. General Exclusions – Services, Drugs and Supplies We Do not Cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, contact 1-877-835-9861.**

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational or unproven treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Fetal reduction surgery;
- Surrogate parenting;
- The reversal of voluntary sterilization;
- Extra care costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.
- Research costs related to conducting a clinical trial such as research physician and nurse-time, analysis of results, and clinical tests performed only for research purposes.
- Services or supplies we are prohibited from covering under the Federal law.

Section 7. Filing a Claim for Covered Services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan providers, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider.

If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Providers must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 1-877-835-9861.

When you must file a claim – such as for services you received outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the provider or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit domestic medical claims to:

UnitedHealthcare, P.O. Box 740817, Atlanta, GA 30374-0817.

Submit international medical claims to:

UnitedHealthcare, PO Box, 740817, Atlanta GA 30374-0817.

Prescription drugs

Submit your claims to:

Usually, there are no claim forms to fill out when you fill a prescription at a Plan pharmacy. In some cases, however you may pay out-of-pocket, in an emergency medical situation. If this happens, send the following information:

- Your receipt
- The drug NDC number
- The pharmacy's NABP number
- The prescribing physician's or dentist's DEA number

Submit your claims to: OptumRx at PO Box 29044, Hot Springs, AR 71903.

Other supplies or services

Submit your claims to: UnitedHealthcare, P.O. Box 740825, Atlanta, GA 30374-0825.

Deadline for filing your claim	Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.
When we need more information	Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond.
Post-service claims procedures	We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected. If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.
	If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.
Authorized Representative	You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a healthcare professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.
Notice Requirements	If you live in a county where at least 10% of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as phone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language. Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision*, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing UnitedHealthcare, Federal Employees Health Benefits Program at P.O. Box 30432, Salt Lake City, UT 84130-0432 or by calling 1-877-835-9861.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

1 Ask us in writing to reconsider our initial decision. You must:

- a) Write to us within 6 months from the date of our decision; and
- b) Send your request to us at: UnitedHealthcare, Federal Employees Health Benefit Program (FEHB) Appeals, P.O. Box 30573, Salt Lake City, UT 84130-0573; and
- c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
- d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
- e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

2 In the case of a post-service claim, we have 30-days from the date we receive your request to:

- a) Pay the claim or
- b) Write to you and maintain our denial or.

c) Ask you or your provider for more information

You or your provider must send the information so that we receive it within 60-days of our request. We will then decide within 30 more days.

If we do not receive the information within 60-days we will decide within 30-days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90-days after the date of our letter upholding our initial decision; or
- 120-days after you first wrote to us -- if we did not answer that request in some way within 30-days; or
- 120-days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, FEHB 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision or notify you of the status of OPM's review within 60-days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 877-835-9861. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's FEHB 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9 Coordinating Benefits With Other Coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.myuhc.com.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan processes the benefit, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

If you elect to enroll in the UnitedHealthcare Retiree Advantage plan, your FEHB plan will not coordinate benefits. The UnitedHealthcare Retiree Advantage plan will take over as the primary and only payer.

TRICARE and CHAMPUS

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Workers' Compensation

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar federal or state agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Medicaid

When you have this Plan and Medicaid, we pay first.

When other Government agencies are responsible for your care

When others are responsible for injuries

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Clinical Trials

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

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

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.

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone 877-888-3337 (TTY 877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.

- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare?

For more detailed information on “What is Medicare?” and “Should I Enroll in Medicare?” please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

- **The Original Medicare Plan (Part A or Part B)** The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 1-877-835-9861 or see our member website at www.myuhc.com.

We do not waive any costs if the Original Medicare Plan is your primary payor.

Please review the following table it illustrates your cost share if you are enrolled in Medicare Part B. Medicare will be primary for all Medicare eligible services. Members must use providers who accept Medicare’s assignment.

- **Medicare (In-Network)**

Benefit Description: Deductible
High Option You Pay **without** Medicare In-Network: \$500 Self Only; \$1,000 Self Plus One or Self and Family
High Option You Pay **with** Medicare Part B In-Network: \$500 Self Only; \$1,000 Self Plus One or Self and Family

Benefit Description: Out-of-Pocket Maximum
High Option You Pay **without** Medicare In-Network: \$3,000 Self Only/\$6,000 Self Plus One or Self and Family
High Option You Pay **with** Medicare Part B In-Network: \$3,000 Self Only/\$6,000 Self Plus One or Self and Family

Benefit Description: Part B Premium Reimbursement
High Option You Pay **without** Medicare In-Network: N/A
High Option You Pay **with** Medicare Part B In-Network: N/A

Benefit Description: Primary Care Provider
High Option You Pay **without** Medicare In-Network: Nothing- Not subject to deductible
High Option You Pay **with** Medicare Part B In-Network: Nothing- Not subject to deductible

Benefit Description: Specialist
High Option You Pay **without** Medicare In-Network: \$60 copayment - Not subject to deductible
High Option You Pay **with** Medicare Part B In-Network: \$60 copayment - Not subject to deductible

Benefit Description: Inpatient Hospital
High Option You Pay **without** Medicare In-Network: 20% after annual deductible
High Option You Pay **with** Medicare Part B In-Network: 20% after deductible

Benefit Description: Outpatient
High Option You Pay **without** Medicare In-Network: 20% after deductible
High Option You Pay **with** Medicare Part B In-Network: 20% after deductible

Benefit Description: Incentives Offered
High Option You Pay **without** Medicare In-Network: N/A
High Option You Pay **with** Medicare Part B In-Network: N/A
- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.
- Medicare Part B Premium Reimbursement**

We offer a plan designed to help members with their Medicare Part B premium. This plan is called, UnitedHealthcare Retiree Advantage. If you have Medicare Parts A and B primary and enroll in the UnitedHealthcare Retiree Advantage, you will be **reimbursed \$150.00 of your Medicare Part B monthly premium**. Part B reimbursements will begin approximately 90 days following the approval of your Retiree Advantage application.

To learn more about UnitedHealthcare Retiree Advantage and how to enroll, call us at 1-844-481-8821, 8 a.m. to 8 p.m., local time 7 days per week, For TTY for the deaf, hard of hearing, or speech impaired, call 711. We will send you additional information.
- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private healthcare choices (like HMOs and regional PPOs) in some areas of the country.

To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE, 1-800-633-4227, TTY 1-877-486-2048 or at www.medicare.gov or UnitedHealthcare Retiree Solutions at 1-844-481-8821.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Retiree Advantage plan: If you enroll in our Medicare Advantage plan you MUST also remain enrolled in our FEHB plan. Do not suspend or terminate your FEHB coverage. For more information on our Medicare Advantage plan, please contact us at 1-844-481-8821.

You may enroll in the UnitedHealthcare Retiree Advantage Plan if:

- You are enrolled in this UnitedHealthcare FEHBP plan and have both Medicare Part A and Part B
- You are retired and live in our geographic service area (See page 13 for details on our service area).
- You are a United States citizen or are lawfully present in the United States
- You do NOT have End-Stage Renal Disease (ESRD), with limited exceptions
- You complete an application for enrollment in the UnitedHealthcare Retiree Advantage Plan.

Part B reimbursements will begin within approximately 90 days following the approval of your Retiree Advantage application. As part of this process CMS will verify your Medicare Part B enrollment. If the FEHB subscriber and/or dependent enrolls in the Retiree Advantage plan, each family member will have to complete an application by calling into our Retiree Solutions team (1-844-481-8821). **If you enroll in the Retiree Advantage Plan do not suspend or terminate your FEHB plan or all benefits will be termed in both FEHB and Retiree Advantage and you will be without any coverage.** Members who are not eligible for Medicare Part A and B will remain on the FEHB plan benefits. If, for any reason, you do not meet the enrollment requirements, you will no longer be eligible to participate in the Retiree Advantage plan. Your contributions will end and your regular FEHB benefits will resume. You may be required to repay any reimbursements paid to you in error.

We offer a plan designed:

- To help members with their Medicare Part B premium costs
- To provide access to our national network of providers, (in-network or out-of-network) at the same cost share
- To cover eligible medical benefits with little to no out of pocket costs
- Medicare Part D prescription drug coverage with a low \$2,000 out of pocket max

The UnitedHealthcare Retiree Advantage plan provides monthly **reimbursement of \$150.00 of your Medicare Part B monthly premium.** In addition, we cover benefits, including office visit copayments at (\$0), for urgent care and emergency care plus coverage for hearing aid discounts and wellness programs. See chart on next page.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers). However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

If you enroll in the UnitedHealthcare Retiree Advantage Group Medicare Advantage plan you must retain your FEHB coverage. Do not suspend your FEHB coverage as this will make you ineligible for the Retiree Advantage plan. **The UnitedHealthcare Retiree Advantage plan includes Medicare part D. Your FEHB plan will not coordinate benefits. The UnitedHealthcare Retiree Advantage plan will take over as the primary and only payer.**

Benefit Description: Deductible

Member Cost without Medicare (In-Network): \$500 Self Only; \$1,000 Self Plus One and Self and Family

Member Cost with Medicare Part B (In-Network): \$500 Self Only; \$1,000 Self Plus One and Self and Family

Member Cost with UnitedHealthcare Retiree Advantage Health Plan: No plan deductible

Benefit Description: Out-of-Pocket Maximum

Member Cost without Medicare (In-Network): \$7,350 Self Only; \$14,700 Self Plus One and \$14,700 Self and Family

Member Cost with Medicare Part B (In-Network): \$7,350 Self Only; \$14,700 Self Plus One and \$14,700 Self and Family

Member Cost with UnitedHealthcare Retiree Advantage Health Plan: You pay nothing for Medicare-covered service from any provider

Benefit Description: Primary Care Provider

Member Cost without Medicare (In-Network): \$0

Member Cost with Medicare Part B (In-Network): \$0

Member Cost with UnitedHealthcare Retiree Advantage Health Plan: \$0

Benefit Description: Specialist

Member Cost without Medicare (In-Network): \$60 per visit

Member Cost with Medicare Part B (In-Network): \$60 per visit

Member Cost with UnitedHealthcare Retiree Advantage Health Plan: \$0

Benefit Description: Virtual Visits

Member Cost without Medicare (In-Network): \$0 per visit

Member Cost with Medicare Part B (In-Network): \$0 per visit

Member Cost with UnitedHealthcare Retiree Advantage Health Plan: \$0

Benefit Description: Urgent Care

Member Cost without Medicare (In-Network): \$50 per visit

Member Cost with Medicare Part B (In-Network): \$50 per visit

Member Cost with UnitedHealthcare Retiree Advantage Health Plan: \$0

Benefit Description: Emergency

Member Cost without Medicare (In-Network): 20% after deductible

Member Cost with Medicare Part B (In-Network): 20% after deductible

Member Cost with UnitedHealthcare Retiree Advantage Health Plan: \$0

Benefit Description: Inpatient Hospital

Member Cost without Medicare (In-Network): 20% after deductible

Member Cost with Medicare Part B (In-Network): 20% after deductible

Member Cost with UnitedHealthcare Retiree Advantage Health Plan: \$0

Your FEHB plan will not coordinate benefits with the Retiree Advantage plan. The UnitedHealthcare Retiree Advantage plan will take over as the primary and only payer.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area. **This Plan and another plan's Medicare Advantage plan:** You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers). However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan. If you elect to enroll in the UnitedHealthcare Retiree Advantage plan which includes Medicare part D, your FEHB plan will not coordinate benefits. The UnitedHealthcare Retiree Advantage plan will take over as the primary and only payer.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. (**Having coverage under more than two health plans may change the order of benefits determined on this chart.**)

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payor for the individual with Medicare is...	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation		✓ *
9) Are a Federal employee receiving disability benefits for six months or more	✓	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD (for 30 month coordination period)		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD (for the 30 month coordination period)		✓
• Medicare based on ESRD (after the 30 month coordination period)	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse		

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of Terms We Use in This Brochure

Assignment	An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider. <ul style="list-style-type: none">• We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.• Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.• OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.
Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Clinical trials cost categories	An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application. <ul style="list-style-type: none">• 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: <ul style="list-style-type: none">• Not approved by the <i>U.S. Food and Drug Administration (FDA)</i> to be lawfully marketed for the proposed use and not identified in the <i>American Hospital Formulary Service</i> or the <i>United States American Hospital Pharmacopoeia Dispensing Information</i> as appropriate for the proposed use

- Not recognized, in accordance with generally accepted medical standards, as being safe and effective for your condition;
- Subject to review and approval by any institution review board for the proposed use. (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Healthcare professional

A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.

Infertility

A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. It is defined by the failure to achieve a successful pregnancy after 12 months or more of unprotected intercourse or artificial insemination for individuals under age 35. Earlier evaluation and treatment for those individuals actively looking to achieve a conception may be justified based on medical history and diagnostic testing and is warranted after six (6) months for individuals aged 35 years or older.

Medical necessity

Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, Substance Use Disorder disease or its symptoms, that are all of the following as determined by us or our designee, within our discretion.

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, Substance Use Disorder, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider
- Not more costly than an alternate drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. The fact that a Physician may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered by this Plan.

If no credible scientific evidence is available then standards are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary.

Plan allowance

Allowable expense (plan allowance) is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid.

You should also see Important Notice About Surprise Billing – Know Your Rights in Section 4 that describes your protections against surprise billing under the No Surprises Act.

Post-service claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
Surprise bill	An unexpected bill you receive for: <ul style="list-style-type: none"> · emergency care – when you have little or no say in the facility or provider from whom you receive care, or for · non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for · air ambulance services furnished by nonparticipating providers of air ambulance services.
Unproven Service(s)	Unproven services, including medications, are services that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature. <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • Waiting could seriously jeopardize your life or health; • Waiting could seriously jeopardize your ability to regain maximum function; or • In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve pre-service claims and not post-service claims. We will determine whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at **877-835-9861**. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We

Us and We refer to UnitedHealthcare

You

You refers to the enrollee and each covered family member.

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Summary of Benefits - Choice Plus Primary Plan - 2025

- Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage at www.uhcfeds.com.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- All benefits are subject to deductible unless noted that they are not subject to deductible. The calendar year deductible is: \$500 Self Only \$1,000 Self Plus One and Self and Family in-network and \$3,000 Self Only and \$6,000 Self Plus One and Self and Family out-of-network.

High Option Benefits	You Pay
Medical services provided by physicians: Diagnostic and treatment services provided in the office	In-network: Primary care physician (PCP) You pay nothing - not subject to deductible Specialist: In-network: \$60 copayment not subject to deductible Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Services provided by a hospital: Inpatient	In-network: 20% coinsurance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Services provided by a hospital: Outpatient (Non-surgical)	In-network: 20% coinsurance Out-of-network: 40% of the plan allowance and any difference between our allowance and the billed amount
Emergency benefits: Emergency Room of Hospital	In-network 20% coinsurance (waived if admitted) Out-of-network 40% of the plan allowance and any difference between our allowance and the billed amount
Emergency benefits: Urgent Care Facility	In-network: \$50 copayment per visit- Not subject to deductible *Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Mental health and substance use disorder treatment:	Regular cost sharing
Prescription drugs: Retail pharmacy (in-network only)	Up to 30-day supply at retail Tier 1: \$10 copayment Tier 2: \$50 copayment Tier 3: \$100 copayment * subject to pharmacy deductible - See Section 5(f) Tier 4: \$200 copayment * subject to pharmacy deductible - See Section 5(f)
Prescription drugs: Mail order	Up to 90-days at Mail Order (in-network only) Tier 1: \$25 copayment Tier 2: \$125 copayment

	Tier 3: \$250 copayment * Subject to pharmacy deductible - See Section 5(f) Tier 4: \$500 copayment * Subject to pharmacy deductible - See Section 5(f)
Specialty Pharmacy 30-day supply	Tier 1 \$10 Tier 2 \$150 Tier 3 \$350 Tier 4 \$500
Vision care:	Routine eye examination for children as described in the Bright Future Guidelines is covered at 100% - not subject to deductible Routine Eye Examination for Adults* *In-network: 20% coinsurance *Out-of-Network: 40% of the Plan allowance and any difference between our allowance and the billed amount
• Annual Deductible	In-network <ul style="list-style-type: none">• \$500 Self only• \$1,000 Self Plus One and Self and Family Out-of-network: <ul style="list-style-type: none">• \$3,000 Self only• \$6,000 Self Plus One and Self and Family Pharmacy: <ul style="list-style-type: none">• Tier 3 and Tier 4 Only subject to deductible• \$250 Self Only• \$500 Self Plus One and Self and Family
Protection against catastrophic costs (out-of-pocket maximum):	You pay nothing after: In-network: <ul style="list-style-type: none">• \$7,350 Self Only• \$14,700 Self Plus One and Self and Family Out-of-Network: <ul style="list-style-type: none">• \$15,000 Self Only• \$30,000 Self Plus One and Self and Family

Notes

2025 Rate Information for UnitedHealthcare Insurance Company, Inc.

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium.

Premiums for Tribal employees are shown under the Monthly Premium Rate column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share

Alabama, Arkansas, District of Columbia, Florida, Georgia (Atlanta Area), Illinois, Iowa, Kentucky, Louisiana, Maryland, Mississippi, Missouri (St. Louis), North Carolina, Pennsylvania, Tennessee, Texas and Virginia

High Option Self Only	AS1	\$284.81	\$94.93	\$617.08	\$205.69
High Option Self Plus One	AS3	\$612.32	\$204.11	\$1,326.70	\$442.23
High Option Self and Family	AS2	\$673.57	\$224.52	\$1,459.40	\$486.46