UnitedHealthcare Insurance Company, Inc.

www.uhcfeds.com

1-877-835-9861

UnitedHealthcare®

2016

A High Deductible Health Plan

This plan's coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 3 for details.

Serving all or portions of the following states: Alabama, Arizona, Arkansas, Colorado, Iowa, Kentucky, Louisiana, Mississippi, Tennessee

Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See page 13 for specific geographic information /requirements.

Enrollment code for this Plan:

Southeast : Alabama, Louisiana, Mississippi,

Arkansas & Knoxville, TN

LS1 Self Only

LS2 Self and Family

LS3 Self Plus One

Central: Western Kentucky, Des Moines IA

N71 Self Only

N72 Self and Family

N73 Self Plus One

West: Colorado, Phoenix AZ and Tucson AZ

LU1 Self Only

LU2 Self and Family

LU3 Self Plus One

This plan has commendable accreditation from NCQA

FEHB
Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 73-891

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

Medicare's Low Income Benefits

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

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

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

Table of Contents

Introduction

This brochure describes the benefits of under our contract (CS 2950) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 1 (877) 835-9861. The address for UnitedHealthcare Insurance Company administrative offices is:

6220 Old Dobbin Lane, Columbia, MD 21045

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 and Family coverage, each eligible family member is also entitled to these benefits. If you enroll in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits. You do not have a right to benefits that were available before January 1, 2016, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2016, and changes are summarized on page 14. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. 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.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

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 or family member, "we" means.
- 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 health care 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 telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.

- Periodically review your claim history for accuracy to ensure we have not been billed for services 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 HEALTH CARE 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 age 26 or over (unless he/she is disabled and incapable of self-support prior to age 26)
- 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.
- 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.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. 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. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. 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 ask questions and understand answers.

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines 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 medicine 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 medicine, including all warnings and instructions
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

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

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

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

- www.ahrq.gov/consumer/. 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.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

When you enter the hospital for treatment of one medical problem, you don't 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, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

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 reduce medical errors that should never happen. These conditions and errors are called "Never Events." When a Never Event occurs, neither your FEHB plan nor you will incur cost 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. 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 (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. 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, and give you brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

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

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

  Self Only coverage is for you alone. Self Plus One coverage is an enrollment that covers you and one eligible family member. Self and Family coverage is for you, 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 and Family or Self Plus One 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 marry.

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

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

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

Family member coverage

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below. A Self Plus One enrollment covers you and one eligible family member as described in the chart below.

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

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

- **Children's Equity Act**

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- 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 Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

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 doesn't 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 doesn't 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 paid according to the 2016 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2015 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.

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

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

- **Upon divorce**

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

- **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). The Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, etc.

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

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

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

- **Converting to individual coverage**

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

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

You are not eligible for coverage under TCC or the spouse equity law.

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

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Health Insurance Marketplace** — If you would like to purchase health insurance through the Affordable Care Act'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). HDHP's have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans.

We have Point of Service (POS) benefits

Our HDHP 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.

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.

Annual deductible - The annual deductible in-network of $1,500 for Self Only, $3,000 for Self Plus One or Self and Family, must be met before Plan benefits are paid for care other than preventive care services. The annual deductible out-of-network of $2,500 for Self Only, $5,000 for Self Plus One or $5,000 Self and Family must be met before out-of-network benefits are paid.

Health Savings Account (HSA)

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, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), not enrolled in Medicare, not received VA or Indian Health Services (IHS) benefits within the last three months, 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 HDHP.
- 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, the HDHP will pass through (contribute) a portion of the health plan premium to 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**.**
- Some additional services are subject to monthly/activity fees.

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.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed $6,550 for Self Only enrollment, and $13,100 for a Self Plus One or Self and Family enrollment. Please see section 4 for the out-of-pocket limitations for this plan.

Providers:

You should join our 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.

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 copayments or coinsurance when you use in network providers. We calculate a member's coinsurance using the negotiated rates.

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, deductibles or annual limits when received from a network provider.

Health education resources and accounts management tools include:

- **UnitedHealthcare Health4Me™** provides instant access to your family's critical health information – anytime and anywhere. Whether you want to find a physician near you, check the status of a claim or speak directly with a health care professional, Health4Me is a your go-to resource. Key features include:
  - Search for physicians or facilities by location or specialty
  - Store favorite physicians and facilities
  - Have an East Connect representative contact you to answer any questions
  - View and share health plan ID card information
  - Contact and experienced registered nurse 24/7
  - Access and update your Personal Health Record
  - Check health-related financial account balanced
  - Locate nearby convenience clinics urgent care facilities and ER's
  - Check status of deductible and out-of-pocket spending
  - Complete confidentiality
- **myuhc.comSpecialized wellness** Improve your health by subscribing to the free *Healthy Mind Healthy Body®* personalized health & wellness e-newsletter.

Choose the topics that interest you most, and we'll send you an e-newsletter featuring articles based on your choices. Each issue is filled with information and tips that focus on achieving better health and peace of mind. Topics in each issue : News you can use; Ask the Doctor; Member Success Stories; Topics you can choose such as: Heart Health, Diabetes, Asthma, Women's Health, Men's Health, Family and Children's Health, Fitness, Nutrition, Weight Control, Healthy Living and Well-being and more.

To subscribe to the *Healthy Mind Healthy Body* e-newsletter, visit uhc.com.

- **Healthcare Cost Estimator: myHealthcare 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 part 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 and facilities.
- **Wellness Products and Services at a Discount:** Enjoy a healthy lifestyle for less with our discounted products and services. You can get discounts on fitness club memberships, weight loss programs, teeth whitening and more. Access our health discount program* online at uhcfeds.com. * This discount program is not insurance.

Your rights

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

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

Your medical and claims records are confidential

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

Service Area

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

South East - Plan code LS :

The entire states of Alabama, Louisiana, Mississippi, Arkansas as well as the following counties in **Tennessee**: Anderson, Blount, Campbell, Claiborne, Cocke, Cumberland, Fentress, Grainger, Hamblen, Jefferson, Knox, Loudon, Monroe, Morgan, Roane, Scott, Sevier and Union**.**

West - Plan code LU:

Colorado (entire state)

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, 85707,85708,85709,85710,85711,85712,85713,85714,85715,85716,85717,85718,85719,85720,85721,85722,85723,85724,8-5725,85726,85728,85730,85731,85732,85733,85734,85735.85736,85737,85738,85739,85740,85741,85742,85743,85744,8-5745,85746,85747,85748,85749,85750,85751,85752,85754,85755,85756,85757,85775

Phoenix, Arizona – *Including the counties of:* Maricopa and Pinal

Central - Plan code N7:

Des Moines, Iowa (***Including the counties of:*** Adair, Appanoose, Audubon, Boone, Buena Vista, Calhoun, Carroll, Cerrogordo, Chicksaw, Clarke, Clay, Dallas, Davis, Decatur, Dickinson, Emmet, Floyd, Franklin,Greene, Guthrie, Hamilton, Hancock, Hardin, Howard, Humboldt, Jasper, Kissuth, Lucas, Madison, Mahaska, Marion, Marshall, Mitchell, Monroe, Palo Alto, Pocahontas, Polk, Ringgold, SAC, Story, Tama, Union, Warren, Wayne, Webster, Winnebago, Worth, and Wright.

Western Kentucky ***Including the following counties***: Allen, Ballard, Barren, Breckenridge, Bullitt, Butler, Caldwell, Calloway,Carlisle, Carroll, Christian, Crittenden, Cumberland, Edmonson, Fulton, Graves, Grayson, Hancock, Hardin, Hart, Henry, Hickman, Hopkins, Jefferson, Larue, Livingston, Logan, Lyon, Marshall, McCracken, McLean, Meade, Metcalf, Monroe, Muhlenberg, Nelson, Ohio, Oldham, Shelby, Simpson, Spencer, Todd, Trimble, Warren and Webster.

Section 2.Changes for 2016

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

- **Program-wide changes**
  - Self Plus One enrollment type has been added effective January 1, 2016.
  - We have removed the exclusion for services, drugs, or supplies related to sex transformations. See page 80.
- **Changes to this Plan**
  - This is a new plan for 2016.

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 (TTY 301-360-8111) or write to us at UnitedHealthcare's Federal Employees Health Benefits (FEHB) Program at 6200 Old Dobbin Lane, Columbia, MD 21045. 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 pay copayments, deductibles, and/or coinsurance, if you use our network providers, 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 physician or by another participating provider in the network

- **Plan providers**

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

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

- **Plan facilities**

Network 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 physician and you do not need written referrals to see a specialist for medical services. The provider must be participating for services to be covered in-network. Services provided out of network may need prior authorization to be covered.

Call us at 877-835-9861 to determine if you need authorization for mental health/ substance abuse benefits as some services do require preauthorization. .

Prior authorization for prosthetic devices or durable medical equipment is required when the item costs more than $1,000 or for Growth Hormone Therapy (GHT).

The Plan will provide benefits for covered services only when the services are medically necessary to prevent, diagnose or treat your illness or condition.

- **Transitional care**

Specialty care: 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.

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(TTY 301-360-8111). If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

You need prior Plan approval for certain services

Precertification 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 (TTY 301-360-8111).

- **Inpatient hospital care**

Your Plan physician or specialist will make necessary hospital arrngements 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 (TTY 301-360-8111).

- **How to precertify an admission**

If the admission is a non-urgent admission or if you are being admitted to a non-network hospital, you must get the admission precertified by calling the Plan at 1-877-835-9861 (TTY 301-360-8111). 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 (TTY 301-360-8111) 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 will be reduced by $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:

  - Mental health and substance abuse benefits
  - Inpatient admissions
  - Cancer clinical trials
  - Accidental dental injury
  - Emergency health services
  - Orthopedic and prosthetic devices over $1,000
  - Durable medical equipment over $1,000
  - Growth hormone therapy (GHT)
  - Magnetic resonance imaging (MRI)
  - Magnetic resonance angiogram (MRA)
  - PET scans
  - Nuclear medicine studies including nuclear cardiology
  - Computed tomography (CT) scans
  - Bariatric surgery
  - Transplants
  - Clinical Trials

  Please note this list is subject to change.

- **Non-urgent care claims**

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

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

- **Urgent care claims**

  If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who 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 Health Insurance 3 at (202) 606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at (877)835-9861. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

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

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then 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 telephone 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 to precertify a maternity admission for a routine delivery in a Network facility. We will provide benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery;
- 96 hours for the mother and newborn child following a cesarean section delivery.

NOTE: Non-network benefits require that you notify us as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described above. If you do not notify us, your benefits will be reduced by $100 per admission.

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

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

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

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

Circumstances beyond our control

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

If you disagree with our pre-service claim decision

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

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

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

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

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

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

2. Ask you or your provider for more information.

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

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

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 telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

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

Section 4. Your costs for covered services

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

Cost-sharing

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

Copayments

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

Example: When you see your primary care physician, you pay a copayment of $25 per office visit, and when you go in the hospital, you pay $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. **When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply counts toward the deductible.**

The annual deductible is $1,500 for Self Only or $3,000 for Self Plus One and Self and Family enrollment in-network and $2,500 for Self Only or $5,000 for Self Plus One or Self and Family enrollment out-of-network. The full self plus one or 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 old 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.

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.

Your catastrophic protection out-of-pocket maximum

After your out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance total $4,000 for Self enrollment or $6,850 for Self Plus One or Self and Family enrollment in-network ($6,850 for Self enrollment or $10,000 for Self Plus One or Self and Family enrollment out-of-network) in any calendar year, you do not have to pay any more for covered services. ***The maximum annual limitation on in-network cost sharing listed under Self Only of $4,000 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 $4,000 Self Only maximum out-of-pocket limit and an in-network $6,850 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 in-network medical expenses of $4,000 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 $6,850, 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 $4,000 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 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
- 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 old 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 old 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 old 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 old 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.

Section 5. High Deductible Health Plan Benefits

See page 99 for a summary of benefits.

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 (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 health care benefits.

When you enroll in this HDHP, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. 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. Your full annual HRA credit will be available on your effective date of enrollment.

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 on page 34. 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 health care that is subject to the deductible; savings; catastrophic protection for out-of-pocket expenses; and health education resources and account management tools.

- **Preventive care** — The 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% for out-of-network care.

  Covered services include:

  - Medical services and supplies provided by physicians and other health care professionals
  - Surgical and anesthesia services provided by physicians and other health care professionals
  - Hospital services; other facility or ambulance services
  - Emergency services/accidents
  - Mental health and substance abuse 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.

- **Health Savings Accounts (HSA)**

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else's tax return, have not received VA 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 2016, 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 $125 per month for a 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 do not exceed the limit established by law, which is $3,350 for an individual and $6,750 for a family. See maximum contribution information on page 28. You can use funds in your HSA to help pay your health plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

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

HSA features include:

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

Important consideration if you want to participate in a Health Care Flexible Spending Account (HCFSA): If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a **HCFSA** health care flexible spending account (such as FSAFEDS offers – see Section 11), this HDHP cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA, we will establish an HRA for you.

- **Health Reimbursement Account (HRA)**

If you aren't 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.

In 2016, 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 enrollment or $1,500 per year for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don't count toward the deductible.

HRA features include:

- For our HDHP option, the HRA is administered by Optum Bank

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

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

When you use network providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to $4,000 per person or $6,850 per Self Plus One enrollment or, $6,850 Self and Family enrollment. When you use out of network providers your annual maximum is limited to $6,850 per person or $10,000 per Self Plus One or Self and Family. 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 health care and your health care 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 when you are ineligible for an HSA
Administrator	The Plan will establish a HSA for you with OptumHealth Bank, this HDHP's fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS).	UnitedHealthcare Insurance Company, Inc. is the HRA fiduciary for this Plan.
Fees	When you enroll in our HSA, you will automatically be enrolled in the Health eAccess HSA option. This account does not earn interest, but may be the right choice for you if you would like lower monthly fees and are an active spender. A letter will be mailed to you within approximately 90 days after you have opened your HSA explaining interest bearing options. These options have higher monthly fees.	None.
Eligibility	You must: • Enroll in the UnitedHealthcare Insurance Company, Inc. High Deductible Health Plan (HDHP) • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not be enrolled in Medicare • Not be claimed as a dependent on someone else's tax return • Not have received VA benefits in the last three months • Complete and return all banking paperwork including the initial application to open your HSA with OptumHealth Bank	You must enroll in the UnitedHealthcare Insurance Company, Inc. High Deductible Health Plan HDHP. Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.
Funding *(this section continues on the next page)*		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 upon your enrollment.

	If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the UnitedHealthcare Insurance Company Inc. High Deductible Health Plan. Note: If you are new to this Plan based on an Open Season change, your first premium pass-through will be made on or about the fourth Thursday in February. This is due to the Government payment cycle. 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 2016, a premium pass through of $62.50 will be made by the UnitedHealthcare Insurance Company Inc. into your HSA each month.	For 2016, your HRA annual credit is $750 (prorated for mid-year enrollment).
• **Self Plus One enrollment**	For 2016, a monthly premium pass through of $125 will be made by the UnitedHealthcare Insurance Company, Inc. High Deductible Health Plan directly into your HSA each month.	For 2016, your HRA annual credit is $1,500 (prorated for mid-year enrollment).
• **Self and Family enrollment**	For 2016, a monthly premium pass through of $125 will be made b y the HDHP directly into your HSA each month	For 2016, your HRA annual credit is $1,500 (prorated for mid-year enrollment)
Contributions/credits *(this section continues on the next page)*	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 $3,350 for an individual and $6,750 for a family. If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution.	The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.

	You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year. If you do not meet the 12 month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability. You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP). HSAs earn tax-free interest (does not affect your annual maximum contribution). Catch-up contribution discussed on page 32.	
• **Self Only enrollment**	You may make an annual maximum contribution of $2,600.	You cannot contribute to the HRA.
• **Self Plus One enrollment**	You may make an annual maximum contribution of $5,250 (per family)	You cannot contribute to the HRA
• **Self and Family enrollment**	You may make an annual maximum contribution of $5,250	You cannot contribute to the HRA.
Access funds	You can access your HSA by the following methods: UnitedHealthcare Health Savings Account MasterCard® Debit Card must be activated in order to have access to HSA funds On-line bill payment Checks (if you choose to purchase these) ATM Withdrawals	For qualified medical expenses under the UnitedHealthcare Insurance Company Inc. High Deductible Health Plan, you will be automatically reimbursed when claims are submitted through the UnitedHealthcare Insurance Company Inc. High Deductible Health Plan.

Distributions/withdrawals *(this section continues on the next page)* • **Medical**	You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not coverd by the HDHP) from the funds available in your HSA. See IRS Publication 502 for a list of eligible medical expenses. You may use the UnitedHealthcare Health Savings Account MasterCard® Debit Card or checks (optional) for all qualified expenses. Medical expenses are not allowable if they occur before the first full month your enrollment is effective, and they are not reimbursable from your HSA until the first of the month following the effective date of your enrollment in this HDHP and the date your HSA account is established.	You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the UnitedHealthcare Insurance Company Inc. HDHP. Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan. See *Availability of funds* below for information on when funds are available in the HRA. See IRS Publication 502 for a list of eligible medical expenses. Physician prescribed over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable. Over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.
• **Non-medical**	If you are under age 65, withdrawal of funds for non-medical expenses will create a 20% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds.When you turn age 65, distributions can be used for any reason without being subject to the 20% penalty, however they will be subject to ordinary income tax.	Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.
Availability of funds	Funds are not available for withdrawal until all the following steps are completed: • Your enrollment in the UnitedHealthcare Insurance Company Inc. High Deductible Health Plan is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • The UnitedHealthcare Insurance Company Inc. High Deductible Health Plan receives record of your enrollment and provides information to the fiduciary (OptumHealth Bank) to initiate the HSA account set-up.	The entire amount of your HRA will be available to you upon your enrollment in the UnitedHealthcare Insurance Company, Inc. High Deductible Health Plan. (The amount of your HRA will be prorated based on the effective date of coverage.)

	• You must complete and send the HSA application to OptumHealth Bank . You may find the application on our web site, www.uhcfeds.com. If the application is not received prior to the receipt of your enrollment by the Plan, the fiduciary (OptumHealth Bank) will send you the **mandatory** HSA paperwork which includes an HSA Application, HSA Custodial Agreement, Beneficiary Form, Privacy Policy and an HSA Fee Schedule for you to complete. The fiduciary (OptumHealth Bank) receives the completed paperwork back from you and your HSA is completely established.	
Account owner	FEHB enrollee	UnitedHealthcare Insurance Company Inc. High Deductible Health Plan
Portable	You can take this account with you when you change plans, separate or retire. If you do not enroll in another HDHP, you can no longer contribute to your HSA. See "HSA eligibility" .	If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA. If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

If You Have an HSA

If you have an HSA

- **Contributions**

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

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

- **Catch-up contributions**

  If you are age 55 or older, the IRS permits you to make additional "catch-up" contributions to your HSA. The allowable catch-up contribution is $1,000. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury website at www.ustreas.gov/offices/public-affairs/hsa/

- **If you die**

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

- **Qualified expenses**

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

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

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

- **Non-qualified expenses**

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

- **Tracking your HSA balance**

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

- **Minimum reimbursements from your HSA**

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

If You Have an HRA

- **Why an HRA is established**

  If you don't qualify for an HSA when you enroll in this HDHP, or later become ineligible for an HSA, we will establish an HRA for you. If you are enrolled in Medicare, you are ineligible for an HSA 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 the chart on page 28 which details the differences between an HRA and an HSA. The major differences are:

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

Section 5. Preventive care

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay
Preventive care, adult	
Routine annual physicial which includes: Routine preventive screenings such as: • Blood tests • Urinalysis • Total Blood Cholesterol • Routine Prostate Specific Antigen (PSA) test — one annually for men age 50 and older • Colorectal Cancer Screening, including - Fecal occult blood test yearly starting at age 50 - Sigmoidoscopy screening — every five years starting at age 50 - Double contrast barium enema — every five years starting at age 50 - Routine Colonoscopy screening — every 10 years starting at age 50 • Routine annual digital rectal exam (DRE) for men age 40 and older	In-Network: Nothing at a network provider Out-of-network:100%
• Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	In-Network: Nothing at a network provider Out-of-network:100%
Well woman care; including, but not limited to: • Routine Pap test • Human papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections. • Annual counseling and screening for human immune-deficiency virus. • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence	In-Network: Nothing at a network provider Out-of-network:100%.
Routine Prostate Specific Antigen (PSA) test - one annually for men age 40 and older	In-Network: Nothing at a network provider Out-of-network:100%
• Routine mammogram — covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period	In-Network: Nothing at a network provider Out-of-network:100%

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	
• From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	In-Network: Nothing at a network provider Out-of-network:100%
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm and HHS at https://www.healthcare.gov/preventive-care-benefits/	
One annual biometric screening to include: • Body Mass Index (BMI) • Blood Pressure • Lipid/cholesterol levels • Glucose/hemoglobin A1C measurement Note: services must be coded by your doctor as preventive to be covered in full Members can access the Health Risk Assessment on www.myuhc.com	In-Network: Nothing at a network provider Out-of-network: 100%
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.	In-Network: Nothing at a network provider Out-of-network: 100%
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel* • *Immunizations, boosters, and medications for travel or work-related exposure*	*All Charges.*
Preventive care, children	
Professional services, such as: • Well-child visits for routine examinations, immunizations and care (up to age 22) Examinations, such as: • Eye exam through age 17 to determine the need for vision correction • Hearing exams through age 17 to determine the need for hearing correction	In-Network: Nothing at a network provider Out-of-network:100%
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org and HHS at https://www.healthcare.gov/preventive-care-benefits/	
Not covered:	*All Charges.*

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	
• *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel* • *Immunizations, boosters, and medications for travel .*	*All Charges.*

Section 5. Traditional medical coverage subject to the deductible

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network preventive care is covered at 100% (see page 34) and is not subject to the calendar year deductible.
- The deductible is $1500 self only ($3,000 per Self Plus One enrollment, or $3,000 per 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 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 $4,000 self only, $6,850 per Self Plus One enrollment or $6,850 per 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 $6,850 self only, $10,000 per Self Plus One or $10,000 per 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	You pay After the calendar year deductible…
Deductible before Traditional medical coverage begins	
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 $1,500 for in-network and $2,500 out-of-network for Self Only coverage, and $3,000 for in-network and $5,000 out-of-network for Self Plus One and 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.	In-network: 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.

Deductible before Traditional medical coverage begins - continued on next page

Benefit Description	You pay After the calendar year deductible…
Deductible before Traditional medical coverage begins (cont.)	
	Out-of-network: 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 health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The deductible is $1,500 for in-network and $2,500 out-of-network for Self Only enrollment, and $3,000 for in-network and $5,000 out-of-network 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 deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible…
Diagnostic and treatment services	
Professional services of physicians • In physician's office • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical opinion	In-Network: PCP copayment $15 per visit, Specialist $30 copayment per visit Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Virtual Visits - • A virtual visit lets you see and talk to a doctor from your mobile device or computer without an appointment. Most visits take about 10-15 minutes and doctors can write a prescription*, if needed that you can pick up at your local pharmacy • Log in to **myuhc.com®** and choose from provider sites where you can register for a virtual visit. You will pay your copayment. **Important note:** Access/ coverage to virtual visits and prescription services may not be available in all states due to state regulations.	$15 copayment per visit

Benefit Description	You pay After the calendar year deductible…
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG	In-Network: $50 copayment per visit Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Major Diagnostic tests: • Computed Tomography (CT) scans • Pet Scans • Magnetic resonance imaging (MRI) • Magnetic resonance angiogram (MRA) • Nuclear Medicine Preauthorization may be required for these tests	In-network: 150 copayment per visit Out-of-network : 30% of our Plan allowance and any difference between our allowance and the billed amount
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk. • Delivery • Postnatal care • Breastfeeding support, supplies and counseling for each birth Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 62 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary.	In-network: $15 PCP copayment , $30 specialist copayment - applies to first visit only for routine services Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.

Maternity care - continued on next page

Benefit Description	You pay After the calendar year deductible…
Maternity care (cont.)	
• We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury	In-network: $15 PCP copayment , $30 specialist copayment - applies to first visit only for routine services Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Family planning	
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Administration of injectable contraceptive drugs (such as Depo Provera) • Insertion and removal of Intrauterine Devices (IUDs) • Diaphragms and fitting of diaphragms • Genetic Counseling Note: We cover oral and injectable contraceptives under the prescription drug benefit.	In-Network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Contraceptive counseling on an annual basis	In network you pay nothing Out of network : 30% of our Plan allowance and any difference between our allowance and the billed amount
Not covered: Reversal of voluntary surgical sterilization	*All Charges.*
Infertility services	
COVERED: Diagnosis and treatment of the underlying cause of infertility, **except** for the Reproductive services listed as **Not Covered:**	In-Network: $15 PCP copayment per visit; $30 copayment specialist per visit Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: *The services listed below are **not covered** as treatments for infertility or as alternatives to conventional conception:* • *Assisted reproductive technology (ART) and assisted insemination procedures, including but not limited to:*	*All Charges.*

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Infertility services (cont.)	
- *Artificial insemination (AI) ; In vitro fertilization (IVF)* - *Embryo transfer and Gamete Intrafallopian Transfer (GIFT) ; Zygote Intrafallopian Transfer (ZIFT)* - *Intravaginal insemination (IVI) ; Intracervical insemination (ICI)* - *Intracytoplasmic sperm injection (ICSI)* - *Intrauterine insemination (IUI)* • *Services, procedures, and/or supplies that are related to ART and/or assisted insemination procedures* • *Cryopreservation or storage of sperm (sperm banking), eggs, or embryos* • *Preimplantation diagnosis, testing, and/or screening, including the testing or screening of eggs, sperm, or embryos* • *Drugs used in conjunction with ART and assisted insemination procedures (see Prescription Drug section)* • *Services, supplies, or drugs provided to individuals not enrolled in this Plan*	*All Charges.*
Allergy care	
• Testing and treatment • Allergy injections • Allergy serum	In-Network: $15 copayment per PCP visit, $30 copayment per specialist visit Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Provocative food testing and sublingual allergy desensitization	*All Charges.*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 54. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit.	In-Network: $15 copayment per PCP visit; $30 copayment per specialist visit Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.

Treatment therapies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Treatment therapies (cont.)	
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.	In-Network: $15 copayment per PCP visit; $30 copayment per specialist visit Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Habilitative / Rehabilitative Therapies	
Rehabilitative Services Outpatient Therapy when performed by qualified physical therapists and occupational therapists • Physical therapy- up to 20 visits per year • Occupational therapy- up to 20 visits per year • Cardiac rehabilitation is provided for up to 36 visits per year per condition • Pulmonary rehabilitation - up to 20 visits per year • Cognitive rehabilitation - up to 20 visits per year • Post cochlear implant rehabilitation and aural therapy up to 30 visits per year Note: we only cover therapy when a provider orders the care	In-Network: $30 copayment per specialist visit Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Habilitative services for children under age 19 with congenital or genetic birth defects. Treatment is provided to enhance the child's ability to function. Services include: • Speech therapy • Occupational therapy; and • Physical therapy **Includes medically necessary habilitative services coverage for children with Autism, an Autism Spectrum disorder, or Cerebral Palsy** **Note:** No day or visits apply to these services. A congenital disorder means a significant structural or functional abnormality that was present from birth	$30 copayment per specialist visit
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All Charges.*

Benefit Description	You pay After the calendar year deductible…
Speech therapy	
Up to 20 visits per year per condition	In-Network: $30 copayment per specialist visit Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: *Exercise programs , gyms, or pool memberships* *work hardening/functional capacity programs or evaluations*	*All Charges.*
Hearing services (testing, treatment, and supplies)	
• Hearing exams for children through age 17(refer to preventive care -children) • For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an MD; DO or audiologist .	In-Network: $15 copayment per vist to PCP, $30 copayment per visit to specialist Out-of-network: 30% of our 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.	Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.*
Not covered: • *All other hearing testing*	*All Charges.*
Vision services (testing, treatment, and supplies)	
• Initial pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	In-Network: 20% of eligible expenses Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Diagnosis and treatment of diseases of the eye	$15 copayment per visit to PCP $30 copayment per visit to specialist Out of network: 30% of our Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All Charges.*
Routine eye examination - Eye refraction every two years to provide a written lens prescription *Note: See Preventive care, children for eye exams for children*	$30 copayment per visit

Benefit Description	You pay After the calendar year deductible…
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	In-Network:$15 copayment per visit to PCP $30 copayment per visit to specialist Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All Charges.*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes • Stump hose • 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 • 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. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) *Surgical and anesthesia services.* For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) *Services provided by a hospital or other facility, and ambulance services*	In-Network: 20% of eligible expenses Out-of-network: 30% of our 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	In-Network: 20% of eligible expenses Out-of-network: 30% of Plan allowance and difference between allowance and the billed amount.
Not covered: • *Orthopedic and corrective shoes* • *Arch supports*	*All Charges.*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible…
Orthopedic and prosthetic devices (cont.)	
• *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than 3 years after the last one we covered (except as needed to accommodate growth in chidren or socket replacement for members with significant residual limb volume or weight changes)* • *External penile devices* • *Speech prosthetics except electrolarynx* • *Carpal tunnel splints* • *Deodorants, filters, lubricants, tape, appliance cleansers, adhesive and adhesive removers related to ostomy supplies*	*All Charges.*
Durable medical equipment (DME)	
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen and the rental of equipment to administer oxygen including tubing, connectors and masks • Dialysis equipment • Standard Hospital beds • Standard Wheelchairs • Crutches • Walker • Blood glucose monitors • Insulin pumps and insulin pump supplies • Surgical dressings not available over the counter • Therapeutic shoes for diabetics • Braces including necessary adjustments to shoes to accommodate braces, which are used for the purpose of supporting a weak or deformed body part • Braces restricting or eliminating motion in a diseased or injured part of the body Note: Most DME items must be preauthorized. Call us at 877-835-9861 (TTY: 301-360-8111) 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.	In-Network: 20% of eligible expenses Out-of-network:30% of our Plan allowance and any difference between our allowance and the billed amount.

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible…
Durable medical equipment (DME) (cont.)	
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.	In-Network: 20% of eligible expenses Out-of-network:30% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Motorized wheelchairs and other power operated vehicles unless meeting ACA requirements and medical necessity* • *Duplicate or backup equipment* • *Parts and labor costs for supplies and accessories replaced due to wear and tear such as wheelchair tires* • *Educational, vocational, or environmental equipment* • *Deluxe or upgraded equipment and supplies* • *Home or vehicle modifications, seat lifts* • *Activities of daily living aids (such as grab bars)* • *Paraffin baths, whirlpools, and cold therapy* • *Infertility monitors* • *Physical fitness equipment* • *Orthotic devices* • *Personal comfort or hygiene items* • *Air conditioners, air purifiers and filters* • *Batteries and battery chargers* • *Dehumidifiers and humidifiers* • *Augmentative communication devices* • *Continuous pulse oximetry unless skilled nursing is involved in home care and it is part of their medically necessary equipment*	*All Charges.*
Home health services	
• 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: - 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	In-Network: $30 copayment per visit Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount

Home health services - continued on next page

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

Benefit Description	You pay After the calendar year deductible…
Chiropractic	
• Diagnosis and related services for the manipulation of the spine and extremities to remove nerve interference or its effects. Limited to one treatment per day up to 24 visits per calendar year. **Note:** The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.	In-Network: 20% of eligible expenses Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Alternative treatments	
Acupuncture – up to 12 visits per year for the following: • Anesthesia, • Pain relief when aAnother method of pain management has failed • Nausea that is related to surgery, pregnancy or chemotherapy. • Acupuncture services must be performed in an office setting. by one of the following, either practicing within the scope of his/her license (if state licensing is available) or who is certified by a national accrediting body. - Doctor of medicine - Doctor of osteopathy - Chiropractor - Acupuncturist	In-Network: 20% of eligible expenses Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback* • *Acupressure* • *Aroma therapy* • *Massage therapy* • *Rolfing*	*All Charges.*
Educational classes and programs	
• Diabetes self management (must be prescribed by a licensed health care professional	In-Network::$15 copayment per visit to PCP $30 copayment per visit to specialist; Out-of-network: 30% of Plan allowance and difference between allowance and billed amount.

Educational classes and programs - continued on next page

Benefit Description	You pay After the calendar year deductible…
Educational classes and programs (cont.)	
- Outpatient self-management training for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insuling using diabetes. 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 managementof 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.	In-Network::$15 copayment per visit to PCP $30 copayment per visit to specialist; Out-of-network: 30% of Plan allowance and difference between allowance and billed amount.
• Tobacco Cessation program, including individual / group/ telephonic counseling and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence	In-Network: Nothing for counseling for up to two quit attempts per year with up to four counseling sessions per attempt. Prescription and Over the Counter, FDA approved drugs to treat tobacco dependence, are covered with no copayment provided they are obtained with a written prescription. Out of network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Childhood obesity education	In-Network: nothing Out-of-network::30% of our Plan allowance and any difference between our allowance and the billed amount.

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is $1,500 for in-network and $2,500 out-of-network for Self Only enrollment, and $3,000 for in-network and $5,000 out-of-network 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 deductible applies to all benefits in this Section unless we indicate differently. After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare. .
- The amounts listed below are for the charges billed by a physician or other health care 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 PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay After the calendar year deductible…
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies • Insertion of internal prosthetic devices . See 5(a) *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns	In-Network: 20% of eligible expenses Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year 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.	In-Network: 20% of eligible expenses Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
• Surgical treatment of morbid obesity (bariatric surgery) • Eligible members must be age 18 or over; and • have a minimum Body Mass Index (BMI) of 40 or 35 (with at least 2 co-morbid conditions present), and • you must have completed a 6 month Plan physician supervised weight loss program; and • you must complete a pre-surgical psychological evaluation • This benefit must be coordinated by UnitedHealthcare Bariatric Surgery Program and in a Bariatric Center of Excellence Facility (Coverage for members under 18 is limited to individuals who meet guidelines established by the National Heart, Lung and Blood Institute)	In-Network: 20% of eligible charges Out-of-Network: 100%
Physician charges for Scopic Procedures such as : Endoscopy Colonscopy (Diagnostic) Sigmoidscopy Please note that benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under Surgery. Examples of surgical scopic prcedures are arthroscopy, laparoscopy, brochoscopy and hysteroscopy.	In Network: 20% Out of network: 30% of our Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All Charges.*

Benefit Description	You pay After the calendar year deductible…
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) **Note:** If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. .	In-Network: 20% of eligible expenses Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All Charges.*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures	In-Network: 20% of eligible expenses Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay After the calendar year deductible…
Oral and maxillofacial surgery (cont.)	
• Other surgical procedures that do not involve the teeth or their supporting structures	In-Network: 20% of eligible expenses Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All Charges.*
Organ/tissue transplants (Transplants must be provided in a Plan Designated Center of Excellence for Transplants)	
These **solid organ transplants** are covered. Solid organ transplants are limited to: • 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 • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	In-Network: 20% of eligible expenses Out-of-network: 100%

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

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (Transplants must be provided in a Plan Designated Center of Excellence for Transplants) (cont.)	
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, 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 - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia	In-Network: 20% of eligible expenses Out-of-network:100%

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

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (Transplants must be provided in a Plan Designated Center of Excellence for Transplants) (cont.)	
- 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 - Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	In-Network: 20% of eligible expenses Out-of-network:100%
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - 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	In-Network: 20% of eligible expenses Out-of-network: 100%

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

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (Transplants must be provided in a Plan Designated Center of Excellence for Transplants) (cont.)	
- Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	In-Network: 20% of eligible expenses Out-of-network: 100%
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. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma	In-Network: 20% of eligible expenses Out-of-network: 100%

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

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (Transplants must be provided in a Plan Designated Center of Excellence for Transplants) (cont.)	
- Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MDDs) - Myelodysplasia/Myelodysplastic Syndromes - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyosarcoma - Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - 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	In-Network: 20% of eligible expenses Out-of-network: 100%
Not covered:	*All Charges.*

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

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (Transplants must be provided in a Plan Designated Center of Excellence for Transplants) (cont.)	
• *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered* • *All services related to non-covered transplants* • *All services associated with complications resulting from the removal of an organ from a non-member*	*All Charges.*
National Transplant Program (NTP) OptumHealth Care Solutions used for organ tissue transplants **Limited Benefits:** Treatment for breast cancer, multiple myeloma and epithelial ovarian cancer may be provided in a National Cancer Institute or National Institutes of Health approved clinical trial at a Plan designated center of excellence and if approved by the Plan's medical director in accordance with Plan protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient. **Transplants must be provided in a Plan Designated Center for transplants. These centers do a large volume of these procedures each year and have a comprehensive program of care. Call 1-877-835-9861 for information.**	
Not Covered: • *Donor screening tests and donor search expenses except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered - and all services related to these non-covered transplants* • *All services associated with complications resulting from the removal of an organ from a non-member*	All charges
Donor testing for bone marrow /stem cell transplants for up to 4 potential donors whether family or non-family	In-Network- 20% of eligible expenses Out of Network:100%

Benefit Description	You pay After the calendar year deductible…
Anesthesia	
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	In-Network: 20% of eligible expenses Out-of-network: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 deductible is $1,500 for in-network and $2,500 out-of-network for Self Only enrollment, and $3,000 for in-network and $5,000 out-of-network 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
- 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 PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You Pay
Inpatient hospital	
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. We will pay benefits for an inpatient stay of at least 48 hours following a mastectomy or lymph node dissections. If your hospital stay is elective, please notify us within five business days prior to your admission. For non-elective admissions, please notify us within one business day or the same day of admission. For emergency admissions, please notify us within one business, the same day of admission, or as soon as it is reasonably possible. If you fail to notify us in a timely manner, your benefits will be reduced by $100 per occurrence.	In-Network: $500 per admission Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced	In-Network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.

Inpatient hospital - continued on next page

Benefit Description	You Pay
Inpatient hospital (cont.)	
• 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 (Note: calendar year deductible applies.)	In-Network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All Charges.*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts , and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service **Note:** We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	In-Network: $250 copayment per surgery Out-of-network:30% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Blood and blood derivatives not replaced by the member	*All Charges.*
Extended care benefits/Skilled nursing care facility benefits	
• Room and board in a semi-private room • General nursing	In-Network: no copayment if admitted from inpatient hospital setting, otherwise $500 copayment per admission Out-of-network::30% of our Plan allowance and any difference between our allowance and the billed amount.

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

Benefit Description	You Pay
Extended care benefits/Skilled nursing care facility benefits (cont.)	
• 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	In-Network: no copayment if admitted from inpatient hospital setting, otherwise $500 copayment per admission Out-of-network::30% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Custodial care* • Rest cures, domicillary or convalescent care • Personal comfort items such as telephone, barber services, guest meals and beds	*All charges.*
Hospice care	
Hospice care that is recommended by a physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for the immediate family members while the Covered person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency. • Outpatient care • Family counseling • Supportive and palliative care for a terminally ill member is covered in the home or hospice facility	In-Network:: 20% of eligible expenses Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Independent nursing, homemaker services	*All charges.*
Ambulance	
Medically Necessary emergency ground or air ambulance	In-Network: 20% of eligible expenses Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.

Section 5(d). Emergency services/accidents

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is $1,500 for in-network and $2,500 out-of-network for Self Only enrollment, and $3,000 for in-network and $5,000 out-of-network 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 deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- 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.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** See the instructions after the benefits description below.

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 telephone 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	You pay After the calendar year deductible…
Emergency within or outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital	In-Network: PCP $15 copayment, Specialist $30 copayment Urgent Care: 35 copayment Emergency Room: $150 copayment per visit Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All Charges.*
Ambulance	
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	In-Network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.

Section 5(e). Mental health and substance abuse 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 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 deductible is $1,500 for in-network and $2,500 out-of-network for Self Only enrollment, and $3,000 for in-network and $5,000 out-of-network 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. You must pay your deductible before your Traditional medical coverage may begin.
- 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.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay After the calendar year deductible…
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. 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.
Diagnosis and treatment of psychiatric conditions, mental illness or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication evaluation and management • Treatment and counseling including therapy visits	In-Network: $30 specialist copayment per visit Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
• Diagnostic tests	In-Network:: $50 copayment Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay After the calendar year deductible…
Mental health and substance abuse benefits (cont.)	
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	In-Network: $500 copayment per admission Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Services we have not approved and /or not a part of a preauthorized treatment plan* • *Psychiatric evaluation or therapy on court order or as a condition of parole or probation unless determined by the plan physician to be necessary and appropriate* • *Methadone maintenance* • *Services and supplies when paid for directly or indirectly by a local State or Federal Government Agency* • *Room and board at a therapeutic boarding school* • *Services rendered or billed by schools* • *Services that are not medically necessary* *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All Charges.*

Preauthorization	To be eligible to receive these benefits you must contact the Plan preauthorization of most mental health and substance abuse benefits.
Limitation	We may limit your benefits if you do not obtain a treatment plan and obtain prior authorization.

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.
- You are responsible for the entire negotiated cost of prescriptions prior to satisfying your deductible when using a network pharmacy. You are responsible for the entire retail cost of prescriptions when using a non-network pharmacy.
- The deductible is $1,500 for Self Only enrollment, and $3,000 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 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 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.
- Certain medications require your health care provider to request approval from us in order for these to be payable under the Pharmacy Plan. The Pharmacy Plan requires approval for these prescription medications to make sure that they are being prescribed and used according to the Food and Drug Administration (FDA)-approved indications and dosing schedules and meet the definition of a covered service. If your pharmacist tells you that your prescription medication requires approval, ask your pharmacist or physician to contact the Plan at the number on your Member ID card for further instructions.
- 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 health care provider licensed to write the prescription.

• **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(TTY 301-360-8111), or visit our website at www.uhcfeds.com.

• **We use a Prescription Drug List (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 Commitee decides the tier placement 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 Prescription Drug List as well as other Plan information on our web site at 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 all generic medications, as well as select preferred brand medications. Brand medications in Tier 1 include select insulin products, select inhalers for asthma, and select medications for migraine headaches for which no generic alternative(s) are available. For the lowest out-of-pocket expense, you should always consider Tier 1 medications if you and your provider decide they are appropriate for your treatment.

• **Tier 2** is your **middle** copayment option ($40 for up to a 30-day supply or $100 for up to a 90-day supply through our mail order program) and contains all 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 (50% with a minimum of $25 for up to a 30-day supply or 50% with a minumum of $62.50 for up to a 90-day supply through our mail order program) and consists of only 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 (50% with a minimum of $100 for up to a 30-day supply or 50% with a minumum of $250 for up to a 90-day supply through our mail order program) and consists of only non-preferred brand medications 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. 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).

In rare cases, you will pay the full copayment amount for a medication when the actual cost of that medication is less than the discounted ingredient cost of the drug. This means if the medication you have filled costs $6, you may have to pay the full copayment of $10 if it is a Tier 1 medication. You will never pay more than the appropriate copayment for a medication. Contact our Member Services Department at 1-877-835-9861 (TTY 301-360-8111) with questions.

These 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 next page 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.

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.

Injectable medications - Medications typically covered under the pharmacy benefit and received through a retail or mail order pharmacy are those that are self-administered by you or a non-skilled caregiver. However, injectable medications that are typically administered by a health care professional are covered under your medical benefit and need to be accessed through your provider or Specialty pharmacy. Contact the Health Plan at 877-835-9861 (TTY 301-360-8111) 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 (TTY: 301-360-8111) for additional information

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.

Refill Frequency - A process that allows you to receive a refill 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.

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

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 After the calendar year deductible…
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines 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	Network retail pharmacy for up to a maximum of a 30-day supply: Tier 1- $ 10 copayment Tier 2- $ 40 copayment Tier 3- 50% / minimum $25 copayment Tier 4- 50% / minimum 100 copayment Plan mail order pharmacy for up to a 90-day supply: Tier 1- $ 25 copayment Tier 2- $ 100 copayment Tier 3- 50% minimum $ 62.50 copayment Tier 4 - 50% minimum $250 copayment Out-of-network: 100%

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	
Note: Intravenous fluids and medications for home use, implantable drugs, and some injectable drugs are covered under Section (5a) Medical services and supplies or Section (5b) Surgical and anesthesia services.	Network retail pharmacy for up to a maximum of a 30-day supply: Tier 1- $ 10 copayment Tier 2- $ 40 copayment Tier 3- 50% / minimum $25 copayment Tier 4- 50% / minimum 100 copayment Plan mail order pharmacy for up to a 90-day supply: Tier 1- $ 25 copayment Tier 2- $ 100 copayment Tier 3- 50% minimum $ 62.50 copayment Tier 4 - 50% minimum $250 copayment Out-of-network: 100%
• 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	In-Network: 20% of eligible expenses Out-of-network:100%
Women's Tier 1 Contraceptive drugs and devices • 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.	In network covered at 100%. Not subject to deductible. Out-of-network: 100%
Smoking cessation medications are covered as follows: • Prescription medications • Over the counter smoking cessation medications purchased with a prescription from physician	In Network - not subject to deductible . You pay nothing Out of Network - You pay 100%
Not covered: • *Medications drugs and supplies used for cosmetic purposes* • *Any product dispensed for the purpose of appetite suppression and other weight loss products* • *Drugs to enhance athletic performance* • *Medical supplies such as dressings and antiseptics* • *Fertility drugs for assisted reproductive services* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies*	*All charges.*

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	
• *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 that can be purchased without a prescription* (except pre-natal vitamins for pregnant women and prescription strenght vitamin D (for members 65 and older) that can be purchased without a prescription • *Nonprescription medicines 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* • *Compound drugs that do not contain at least one covered ingredient that requires a Prescription Order or Refill* • *Alcohol swabs and bio-hazard disposable containers* • Drugs for sexual performance for patients that have undergone genital reconstruction • Medical marijuana	*All charges.*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHBP Plan. See Section 9 *Coordinating benefits with other coverage*.
- The deductible is $1,500 for in-network and $2,500 out-of-network for Self Only enrollment, and $3,000 for in-network and $5,000 out-of-network 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 deductible applies to all benefits in this Section unless we indicate differently. You must pay your deductible before your Traditional medical coverage may begin.
- 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.

Benefit description	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. • Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry • The dental coverage is severe enough that the initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period provided you do so within 60 days of the injury and if extenuating circumstances exist (such as prolonged hospitalization or the presence of a fixation wire from fracture care.) • Benefits for treatment of the accidental injury are limited to the following: - Emergency examination - Necessary x-rays - Endodonic (root canal) treatment - Temporary splinting of teeth - Prefabricated post and core - Simple minimal restorative procedures (fillings) - Extractions	In-Network: 20% of eligible expenses Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.

Accidental injury benefit - continued on next page

Benefit description	You pay
Accidental injury benefit (cont.)	
- 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 injuryNote: A sound natural tooth is a atooth that has no active decay, has at least 50% bony support, has no filling on more than two surfaces, has no root canal treatment except as a result of the accident and functions normally in chewing and speech. (Crowns, bridges and dentures are not considered sound, natural teeth)	In-Network: 20% of eligible expenses Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Oral implants and related procedures, including bone grafts to support implants* • *Procedures that involve teeth or their supporting structures (such as periodontal membrane, gingival and aveolar bone).*	*All charges*
Dental benefits	
Please refer to the non-FEHB page for a description of our non-FEHB dental benefits provided to you under this plan.	

Section 5(h). Special features

Feature	Description
Feature	
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited 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 agreeement, 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.
Care24	For any of your health concerns you may call 1-888-887-4114, 24 hours a day, seven days a week and talk with a registered nurse with an average of 15 years of experience who will discuss treatment options and answer your health questions. Members may learn self-care for minor illnesses and injuries; understand diagnosed conditions; manage chronic diseases; discover and evaluate possible benefits and risks of various treatment options; learn about specific medications; prepare questions for doctor visits; develop and maintain healthful living habits; and connect with community support groups.
UnitedHealthcare Health4Me™	Health4Me – Your family's health care resources, in your hands. UnitedHealthcare Health4Me™ provides instant access to your family's critical health information – anytime and anywhere. Whether you want to find a physician near you, check the status of a claim or speak directly with a health car professional, Health4Me is a your go-to resource. Key features include: • Search for physicians or facilities by location or specialty • Store favorite physicians and facilities • Have an East Connect representative contact you to answer any questions • View and share health plan ID card information • Contact and experienced registered nurse 24/7 • Access and update your Personal Health Record • Check health-related financial account balanced • Locate nearby convenience clinics urgent care facilities and ER's • Check status of deductible and out-of-pocket spending • Complete confidentiality

Feature - continued on next page

Feature	Description
Feature (cont.)	
	Available on the App Store ; Android available in Google play
Virtual Visits:	Virtual Visits: See a doctor when you need a doctor NO driving; No crowded waiting rooms. A virtual visit lets you see a doctor from the comfort of your home or office using a smartphone, tablet or computer. There's no need to make an appointment. Doctors can even write a prescription *, if needed, that you can pick up at your local pharmacy. Talk to a doctor about non-emergency conditions including: allergies, bladder infection; bronchitis, cough/cold, pink eye and more. * May not be available in all states.
Healthy Pregnancy Program	With our Healthy Pregnancy Program, UnitedHealthcare enrollees receive personal support through all stages of pregnancy and delivery. Some features of the program include a pregnancy assessment to identify special needs, identification of pregnancy risk factors, a 24-hour toll-free phone number to experienced nurses and customized maternity educational materials. To enroll in the Healthy Pregnancy Program, simply call toll-free at 1-800-411-7984; or visit www.healthy-pregnancy.com.
Health and Wellness Education Information	You can find healthy living articles and general information on www.myuhc.com. Health and wellness topics and categories including addiction, family, fitness and nutrition, healthy aging, healthy pregnancy, preventive medicine, relationships and much more.
Cancer Clinical Trials	To be a qualifying clinical trial, a trial must meet all of the following criteria: • Be sponsored and provided by a cancer center that has been designated by the *National Cancer Institute (NCI)* as a *Clinical Cancer Center* or *Comprehensive Cancer Center* or be sponsored by any of the following: - *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI).*) - *Centers for Disease Control and Prevention (CDC).* - *Agency for Healthcare Research and Quality (AHRQ).* - *Centers for Medicare and Medicaid Services (CMS).* - *Department of Defense (DOD).* - *Veterans Administration (VA).* • The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals. Benefits are not available for preventive clinical trials. • The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.
Transplant Centers of Excellence	OptumHealth Care Solutions provides you access to one of the nation's leading transplant networks, managing more than 10,000 referrals each year. Centers of Excellence are selected through a process of quality measurement and cover all phases of patient health care from evaluation, pre-transplant, transplant, post-transplant and 12-month follow-up health care. Contact OptumHealth Care Solutions at 1-888-936-7246 to discuss information about transplants and physicians.

Section 5(i). Health education resources and account management tools

Special features	Description
Health education resources	Log on to 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. Use myuhc.com to: • Learn about health conditions, treatments, and procedures in easy-to understand language • Compare your costs for treatments • Find tools that help you make more informed health care decisions • Chat online with a registered nurse Use the Personal Health Manager, your health history, medical library, and customizable organizer that is secure, easy-to-use and interactive. Once you enter your preferences and needs, we'll automatically send you the information you want to browse at your leisure. You can use the site to estimate your treatment or plan costs, research health conditions, track your claims status and more.
Account management tools	Log on to myuhc.com to: Check the status of your claims • Search for network physicians and hospitals • Verify your benefits—your copayment amounts, deductible status, and more • 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. • Make payments to providers or reimbursements to yourself in any amount via your UnitedHealthcare Health Savings Account.
Consumer choice information	As a member of this HDHP, you may choose any provider. However, you will receive discounts when you see a network provider. Directories, pricing information for medical care and prescription drugs as well as educational materials for the HSA and HRAs are available online at myuhc.com.
Care support	Care24 gives you access to a registered nurse and master's level counselors who can answer questions about your health. UnitedHealthWellness is a customized, interactive health improvement program and discounts on related services. You can take a personalized health assessment, sign up for an online better health program (like stress management or smoking cessation), work to meet your wellness goals, get reminders for screenings, and much more. Care Coordination is clinical expertise to help you make sound decisions and help you get access to proper care. For each HSA and HRA account holder, we maintain a complete claims payment history online through myuhc.com.

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 301-360-8111).

PPO Dental Plan

UnitedHealthcare provides a preventive PPO Dental Plan to our enrolled Federal members. There is no additional premium for this benefit and enrollment is automatic. Each eligiblle member of your family receives preventive PPO dental services such as examinations and cleanings. Visit us on the web at www.uhcfeds.com. for more information.

UnitedHealth Wellness SM

As a comprehensive portfolio of wellness programs and services offered through UnitedHealthcare, UnitedHealth Wellness can help improve your total health and well-being. UnitedHealth Wellness is not insurance. Instead, it is our commitment to bring you more ways than ever to stay healthy. For more information, please also visit us on the web at www.unitedhealthwellness.com or call 1-888-848-9355. We are pleased to offer you the following portfolio of wellness programs and services:

Online Health Coach: Exercise Program

This program provides personalized exercise routines to help you meet the challenges of getting in shape. This staged approach to getting fit walks you through five program levels. Plus, you'll receive tips on nutrition, fitness articles and access to interactive tools to help you keep your exercise routine for life. Program features include:

- **Weight Tracker** to monitor your weight over the course of the program
- **Exercise Planner/Tracker** to create and view your personal exercise program
- **Body Mass Index (BMI) Calculator** to help you find your ideal weight
- **Calorie Burner Calculator**

To access this program, log on to www.myuhc.com, click 'Health & Wellness', then 'Your Personal Health Center'.

Discounts on wellness products and services

Receive discounts on wellness products and health care services not covered by you medical, dental or vision plans. From nutrition supplements and fitness gear, to LASIK procedures and teeth whitening, this is the place to go before you buy anything. Log on to www.myuhc.com and click 'Health&Wellness' to find the discount link.

Section 6. General exclusions – things we don't 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 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
- 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.
- Applied Behavioral Analysis

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 physicians, 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. Physicians 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 (TTY 301-360-8111).

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 physician 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 health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

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

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

Section 8. The disputed claims process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.myuhc.com.

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 byor calling 1-877-835-9861.

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

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

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

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

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

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

a) Write to us within 6 months from the date of our decision; and

b) Send your request to us atUnitedHealthcare's Federal Employee Health Benefits (FEHB) Program Appeals, P.O. Box 30573, Salt Lake City, Utah 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.

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

3

You must write to OPM within:

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

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

Send OPM the following information:

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

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

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

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

4

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

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

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

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

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

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

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 the NAIC website at www.NAIC.org.

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

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

- **TRICARE and CHAMPVA**

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

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

- **Workers' Compensation**

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.
- Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

- **Medicaid**

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

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

- **When other Government agencies are responsible for your care**

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

- **When others are responsible for injuries**

  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

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We *[plan specific]* offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure.

For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213, (TTY 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage.

It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10 % increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

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

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

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

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

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

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

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at ((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 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.

Benefit Description	Member Cost without Medicare (In network benfits)	Member Cost with Medicare Part B (in network benefits)
Deductible	$1,500 Self Only, $3,000 Self Plus One and Self and Family	$1,500 Self Only, $3000 Self Plus One and Self and Family
Out of Pocket Maximum	$4,000 self only, $6,850 Self Plus One and Self Plus Family	$4,000 self only, $6,850 Self Plus One and Self and family
Primary Care Physician	$15 copayment per visit	$15 copayment per visit
Specialist	$35 copayment per visit	$35 copayment per visit
Inpatient Hospital	$500 per admission	$500 per admission
Outpatient Hospital	$250 copayment per surgery	$250 copayment per surgery
Rx	Tier 1 30-day supply -$10 copayment Tier 2 30-day supply -$40 copayment Tier 3 30-day supply - 50% coinsurance minimum of $25 Tier 4 - 30-day supply -50% coinsurance minimum of $100	Tier 1 30-day supply -$10 copayment Tier 2 30-day supply-$40 copayment Tier 3 30-day supply- 50% coinsurance minimum of $25 Tier 4 – 30-day supply - 50% coinsurance minimum of $100
Rx – Mail Order (90 day supply)	2.5 x retail copay	2.5 x retail copay

- **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 health care choices (like HMOs and regional PPOs) in some areas of the country.

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

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

This Plan and our Medicare Advantage plan:

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 office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area
• **Medicare prescription drug coverage (Part D)**	When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

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

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Clinical Trials Cost Categories

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

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 20.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 20.

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.

Covered services

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

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 20.

Experimental or investigational service

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

- Not approved by the *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.

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.

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.

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

Plan allowance

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

Post-Service Claims

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

Pre-Service Claims

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

Premium contributions to HSA/HRA

The amount of money we contribute to your HSA or HRA.

Reimbursement

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

Subrogation

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

Unproven

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

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)

- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

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

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

Urgent Care Claims

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

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

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether 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.

Section 11. Three Federal Programs complement FEHB benefits

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program - FSAFEDS

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,550 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

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

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

- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to out-of-pocket dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26).
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1, you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?	Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS, (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450

The Federal Employees Dental and Vision Insurance Program - FEDVIP

Important Information	The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment**. FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.
Dental Insurance	All dental plans provide a comprehensive range of services, including: • Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays. • Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments. • Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures. Class D (Orthodontic) services with up to a 12-month waiting period. **Most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.**
Vision Information	All vision plans provide comprehensive eye examinations and coverage for your choice of either lenses and frames or for contact lenses. Other benefits such as discounts on LASIK surgery may also be available
Additional Information	You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/dental and www.opm.gov/vision . These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.
How do I enroll	You enroll on the Internet at www.BENEFEDS.com . For those without access to a computer, call 1-877-888-3337, (TTY 1-877- 889-5680).

The Federal Long Term Care Insurance Program - FLTCIP

Its important protection	The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337), (TTY 1-800-843-3557), or visit www.ltcfeds.com

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

Summary of benefits for the HDHP of the UnitedHealthcare Insurance Company Inc. - 2016

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. 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 2016 for each month you are eligible for the HSA, we will deposit $62.50 per month for Self Only enrollment or $125 per month for Self Plus One or Self and Family enrollment to your HSA. Your Health Savings Account (HSA) funds can be used to meet your calendar year deductible. Once your calendar year deductible is satisfied, Traditional medical coverage begins.

HDHP Benefits	You Pay	Page
Medical services provided by physicians:		
In-network medical preventive care	Nothing	34
Diagnostic and treatment services provided in the office	In-network: $15 copayment per visit for PCP, $30 copayment per visit specialist Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount	39
Services provided by a hospital:		
• Inpatient	In-network: $500 copayment per admission Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount	61
• Outpatient Services	In-network: $50 copayment per visit non-surgical Outpatient Surgery: $250 copayment per visit Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount	62
Emergency benefits:		65
• In-area or Out-of-area	In-Network: $150 copayment per visit Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount	65
Mental health and substance abuse treatment:	Regular cost-sharing	66
Prescription drugs:		70
• Retail pharmacy (30-day supply) • Note In Network Pharmacy Benefits Only	Tier 1:$10 copayment Tier 2: $40 copayment Tier 3: $50% coinsurance with minimum of $25 Tier 4: 50% coinsurance with a minimum of $100	70

HDHP Benefits	You Pay	Page
• Mail order (up to a 90-day supply)	Tier 1: $25 copayment Tier 2: $100 copayment Tier 3: 50% coinsurance with a minimum of $62.50 Tier 4: 50% coinsurance with a minimum of $250	70
Dental care:	Please refer to page Non-FEHB benefits section for a description of our non-FEHB dental benefit.	79
Vision care:	One eye exam every other calendar year	73
Special features:	Care 24, Discount Purchasing Programs, Cancer Resource Services, Healthy Pregnancy Program, Health and Wellness Programs	75
Protection against catastrophic costs (out-of-pocket maximum)**:**	In-network: Nothing after $4,000/Self Only or $6,850 Self Plus One and Self and Family per year. Out-of-network: Nothing after $6,850/Self Only or $10,000 Self Plus One and Self and Family per year.	17

Notes

2016 Rate Information for UnitedHealthcare Insurance Company HDHP

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

Postal rates apply to United States Postal Service employees.

Postal Category 1 rates apply to career bargaining unit employees.

Postal Category 2 rates apply to career non-bargaining unit employees.

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center: 1-877-477-3273, option 5, (TTY: 1-866-260-7507)

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees.

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

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
Southeast Region: Alabama, Louisiana, Mississippi, Arkansas Knoxville, TN							
Basic Option Self Only	LS1	$ 176.02	$ 58.67	$ 381.38	$ 127.12	$ 48.70	$ 58.67
Basic Option Self Plus One	LS3	$ 343.75	$ 114.58	$ 751.32	$ 248.26	$ 95.10	$ 114.58
Basic Option Self and Family	LS2	$ 488.50	$ 169.55	$1,058.42	$ 367.36	$ 142.41	$ 169.55
Western Region: Denver, CO, Phoenix, AZ, Tucson, AZ							
Basic Option Self Only	LU1	$ 177.56	$ 59.19	$ 384.72	$ 128.24	$ 49.13	$ 59.19
Basic Option Self Plus One	LU3	$ 346.76	$ 115.59	$ 751.32	$ 250.44	$ 95.94	$ 115.59
Basic Option Self and Family	LU2	$ 488.50	$ 175.32	$1,058.42	$ 379.86	$ 148.18	$ 175.32
Central Region: Western Kentucky, Des Moines, Iowa							
Basic Option Self Only	N71	$ 177.47	$ 59.16	$ 384.53	$ 128.17	$ 49.10	$ 59.16
Basic Option Self Plus One	N73	$ 346.61	$ 115.53	$ 750.98	$ 250.32	$ 95.89	$ 115.53
Basic Option Self and Family	N72	$ 488.50	$ 175.02	$1,058.42	$ 379.21	$ 147.88	$ 175.02