UnitedHealthcare Insurance Company, Inc.

www.uhcfeds.com

Customer Service: 877-835-9861

United Healthcare®

2025

Choice Plus Primary Postal East

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 7 for details. This plan is accredited. See page 13.

Serving: Alabama, Arkansas, District of Columbia, Florida, Georgia (Atlanta area), Illinois, Iowa, Kentucky, Louisiana, Maryland, Mississippi, Missouri (St. Louis), North Carolina, Pennsylvania, Tennessee, Texas and Virginia

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

Only Postal Employees and Annuitants may enroll in this plan.

IMPORTANT
- Rates: Back Cover
- Changes for 2025: Page 16
- Summary of Benefits: Page 112

Enrollment codes for this Plan:

JYA - Self Only
JYC - Self Plus One
JYB - Self and Family

PSHB

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 73-931

Important Notice

Important Notice for Medicare-eligible Active Employees from UnitedHeathcare Insurance Company, Inc. About Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the UnitedHealthcare Insurance Company Inc.'s prescription drug coverage for active employees 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 active employees and their covered family members do not need to enroll in an open market Medicare Part D plan 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 PSHB coverage as an active employee.

However, if you (as an active employee and your covered Medicare Part D-eligible family members) choose to enroll in an open market Medicare Part D plan, you can keep your PSHB coverage and your PSHB plan will coordinate benefits with Medicare.

Please be advised

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

Medicare's Low Income Benefits

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

Additional Premium for Medicare's High Income Members
Income-Related Monthly Adjustment Amount (IRMAA)

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

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

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

Table of Contents

Introduction

This brochure describes the benefits of UnitedHeathcare Insurance Company, Inc. under contract (CS 2964 PS) between UnitedHeathcare Insurance Company, Inc. and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits (FEHB) law, as amended by the Postal Service Reform Act, which created the Postal Service Health Benefits (PSHB) Program. Customer service may be reached at 1-877-835-9861 or through our website: www.uhcfeds.com. The address for UnitedHealthcare Insurance Company, Inc. administrative offices is:

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

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. If you are a Postal Service annuitant and you are eligible for Medicare Part D, or a covered Medicare Part D-eligible family member of a Postal Service annuitant, your prescription drug benefits are provided under our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP) unless you choose to opt in to the UnitedHealthcare Retiree Advantage plan which includes Part D prescriptions drugs. You do not have a right to benefits that were available before January 1, 2025, under the FEHB Program unless those benefits are also shown in this PSHB Plan brochure.

OPM negotiates benefits and rates for each plan annually. Benefits are effective January 1, 2025. Rates are shown at the end of this brochure.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee and each covered family member, “we” means UnitedHealthcare Insurance Company.
- We limit acronyms to ones you know. OPM is the United States Office of Personnel Management. The FEHB Program is the Federal Employees Health Benefits Program administered by OPM and established under 5 U.S.C. chapter 89. The PSHB Program is the Postal Service Health Benefits Program established within the FEHB Program under 5 U.S.C. section 8903c. PSHB Plan means a health benefits plan offered under the PSHB Program. PSHB means Postal Service Health Benefits. If we use others, we tell you what they mean.
- Our brochure and other PSHB plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of healthcare for everyone and increases your Postal Service Health Benefits Program premium.

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

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

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your healthcare providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 1-877-835-9861 and explain the situation.

If we do not resolve the issue:

CALL - THE HEALTHCARE FRAUD HOTLINE
877-499-7295
OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/
The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.
You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

Do not maintain family members on your policy:

- Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
- Your child age 26 or over (unless they are disabled and incapable of self-support prior to age 26)

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

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

Discrimination is Against the Law

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

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

Preventing Medical Mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

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

3. Get the results of any test or procedure.

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

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

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

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

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.

- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.

- www.ahrq.gov/patients-consumers. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.

- https://psnet.ahrq.gov/issue/national-patient-safety-foundation The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.

- www.bemedwise.org The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medication.

- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

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

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

PSHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

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

- **Minimum value standard**

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

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

  See https://health-benefits.opm.gov/PSHB/ for enrollment information as well as:

  - Information on the PSHB Program and plans available to you
  - A health plan comparison tool

  Note: Contact the USPS for information on how to enroll in a PSHB Program Plan through the PSHB System.

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

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

  We do not determine who is eligible for coverage. You will be responsible for making changes to your enrollment status through the PSHB System. In some cases, your employing or retirement office may need to submit documentation. For information on your premium deductions, you must also contact your employing or retirement office.

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

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

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

  If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member.

You enroll in a PSHB Program Plan and make enrollment changes in the PSHB System located at https://health-benefits.opm.gov/PSHB/. For assistance with the PSHB System, call the PSHBP Helpline at (844) 451-1261. 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 request. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

Use the PSHB System if you want to change from Self Only to Self Plus One or Self and Family, and to add or remove a family member.

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

If you or one of your family members is enrolled in one PSHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another PSHB or 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 PSHB Program, change your enrollment, or cancel coverage using the PSHB System. For a complete list of QLEs, visit the PSHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, personnel/payroll office, or retirement office.

- **Family Member Coverage**

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

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

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

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

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

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

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

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

- **Children's Equity Act**

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

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

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

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

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

For annuitants who are required to be enrolled in Medicare Part B as a condition to continue PSHB coverage in retirement: If you enroll in Medicare Part B and continue PSHB coverage in retirement, the child equity law applies to you and you cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your child(ren) live as long as the court/administrative order is in effect. You cannot be compelled to enroll or remain enrolled in Medicare Part B to maintain your PSHB enrollment as a condition to satisfy a court/administrative order. However, if you do not enroll (or remain enrolled) in Medicare Part B as required to continue your PSHB coverage in retirement (notwithstanding an existing court/administrative order), you will not be able to continue your PSHB coverage in retirement.

- **Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP)**

Our PDP EGWP is only available to Postal Service annuitants who are Medicare Part D-eligible and their covered Medicare Part D-eligible family members. Our PDP EGWP is not an open market Medicare Part D Plan. If you are an active Postal Service employee, or covered family member, and become eligible to enroll in Medicare Part D, you are not eligible to enroll in our PDP EGWP. Please contact CMS for assistance at 800-MEDICARE (800-633-4227), TTY: 877-486-2048.

As a part of the PSHBP (Postal Service Health Benefits Program), you will be automatically enrolled into the UnitedHealthcare MedicareRx (PDP) Part D prescription drug plan for your prescription drug benefits unless you choose to opt into the UHC Feds PSHB Retiree Advantage (PPO) plan, which includes Part D prescription drugs. If you elect to enroll in the Retiree Advantage plan it will take over as the primary and only payer so you will not need to coordinate benefits, however, you must remain enrolled in the Choice Plus Primary PSHB plan and continue to pay that plan premium if you elect the Retiree Advantage plan. Do not suspend or cancel your coverage with OPM or you will also be terminated from the Retiree Advantage plan. Please contact us at 1-844-481-8821, TTY 711 for assistance.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage and premiums begin on January 1. If you joined at any other time during the year, your employing or retirement office will tell you the effective date of coverage.

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

- **When you retire**

When you retire, you can usually stay in the PSHB Program. Generally, you must have been enrolled in the FEHB and/or PSHB 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 PSHB 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.

If you are eligible for coverage under spouse equity, you are only eligible to enroll in the FEHB Program. If you are not eligible for coverage under spouse equity and you are otherwise eligible for Temporary Continuation of Coverage (TCC), then you could enroll in TCC under the PSHB Program.

- **Upon divorce**

If you are an enrollee and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You **must** enter the date of the divorce or annulment and remove your ex-spouse in the PSHB System. We may ask for a copy of the divorce decree as proof. If you need to change your enrollment type, you must use the PSHB System. A change will not automatically be made.

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). Former spouses eligible for coverage under the spouse equity law are not eligible to enroll in the PSHB Program. However, former spouses eligible for coverage under the spouse equity law may enroll in the FEHB Program. (Former Spouses seeking but not yet adjudicated as eligible for Spouse Equity may be entitled to TCC under a PSHB plan in the interim).

Former spouses not meeting the spouse equity requirements may be eligible for TCC under the PSHB Program provided you otherwise meet the eligibility requirements for TCC. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get information about your coverage choices. You can also visit OPM's website at https://www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

- **Medicare PDP EGWP**

When a Postal Service annuitant who is Medicare Part D-eligible or their covered Medicare-eligible family member opts out of or disenrolls from our PDP EGWP, they will not have our prescription drug coverage under this plan. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for additional information at (844) 481-8821.

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

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

You may not elect TCC if you are fired from your Federal 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 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 PSHB Program coverage.

- **Converting to individual coverage**

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

Your benefits and rates will differ from those under the PSHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 1-866-546-0510 or visit our website at www.uhcfeds.com.

- **Health Insurance Marketplace**

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

Section 1. How This Plan Works

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

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

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

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

OPM requires that PSHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Unitedhealthcare hold accreditation from the National Committee for Quality Assurance (NCQA). To learn more about this plan's accreditation(s), please visit the following websites: National Committee for Quality Assurance (www.ncqa.org).

General features of our High Option Plan

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

We have Open Access benefits

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

We have Point of Service (POS) benefits

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

How we pay providers

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

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

Annual deductible

The annual medical deductible must be met before Plan benefits are paid for many services other than preventive care services or services specifically designed as not requiring the deductible. Your deductible for this plan is $500 for Self only and $1,000 for Self Plus One or Self and Family for In-Network and $3,000 Self Only and $6,000 Self Plus One or Self and Family Out-of-network. Information on how this deducible works can be found in Section 4 *Your Cost for Covered Services.*

Health education resources and accounts management tools

myuhc.com gives you the ability to:

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

myHealthcare Cost Estimator

Changing the way you access health care information for the better, 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 path allows you to see the appointments, tests and follow up care involved, from the first consult to last follow up visit. You can also learn about estimated costs ahead of time to help you plan. Create a custom estimate based on your own plan details and selected treatments or procedures.

Your rights and responsibilities

OPM requires that all PSHB plans provide certain information to their PSHB members. You may get information about us, our networks, and our providers. OPM's PSHB 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 Inc. has been in existence since 1972.
- UnitedHealthcare Insurance Company Inc. is a for-profit organization.

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

If you want more information about us, call 877-835-9861, or write to UnitedHealthcare, 10175 Little Patuxent Parkway, Ste 200 Columbia, MD 21044. You may also visit our website at www.uhcfeds.com.

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

Your medical and claims records are confidential

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

Service Area

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

Entire states of: Alabama, Arkansas, Florida, Illinois, Iowa, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Pennsylvania, Tennessee, Texas and Virginia

District of Columbia

Atlanta - including counties of Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Forsyth, Fulton, Gwinnett, Haralson, Heard, Henry, Jasper, Morgan, Newton, Paulding, Rockdale, Spalding and Walton

Georgia counties of Houston and Putnam

St. Louis - including counties of Bollinger, Butler, Cape Girardeau, Clark, Clinton, Crawford, Dent, Dunklin, Franklin, Gasconade, Greene, Howell, Iron, Jefferson, Lewis, Lincoln, Madison, Marion, Mississippi, Monroe, Montgomery, New Madrid, Oregon, Pemiscot, Perry, Phelps, Pike, Ralls, Randolph, Reynolds, Ripley, Scott, Shannon, St. Charles, St. Clair, St. Francois, St. Louis, St. Louis City, Ste. Genevieve, Stoddard, Texas, Warren, Washington and Wayne

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2025

This is the first year for the Postal Service Health Benefits Program (PSHBP). This Section is not an official statement of benefits. For that, go to Section 5. Benefits.

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 PSHBSystem enrollment confirmation.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 877-835-9861 or write to us at UnitedHealthcare Insurance Company, Postal Service Health Benefits (PSHB) Program, P.O. Box 30432, Salt Lake City, UT 84130-0432. You may also request replacement cards through our website: www.myuhc.com.

Note - Members with prescription drug coverage through the EGWP (PDP) will receive a separate ID card for pharmacy benefits.

Where you get covered care

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

Balance Billing Protection

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

- **Plan providers**

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

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

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

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

This plan provides Care Coordinators for complex conditions and can be reached at 877-835-9861 for assistance.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website. This plan allows you to save money by choosing a lower cost place of service.

	A freestanding facility is an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims as a freestanding entity and not as a hospital. You will have a lower out of pocket expense when you use a freestanding facility instead of a hospital for outpatient services. Outpatient services are health services or treatments that do not require an overnight hospital stay. Outpatient care received in a hospital will typically cost you more. Talk to your doctor about the options available to you for these services.
• **Non-network providers and facilities**	You can access care from any licensed provider or facility. Providers and facilities not in the UnitedHealthcare Choice Plus network are considered non-network providers and facilities.
What you must do to get covered care	It depends on the type of care you need. You can go to any provider you choose to but it will cost you less to get care from our Premium designated providers and in network providers. We must approve some care in advance.
• **Primary care**	Your visits to your primary care provider (PCP) are paid at 100% for all ages and all visits whether they are for preventive care or treatment for an illness. Your primary care provider may be a family practitioner, an internist or pediatrician. Your primary care provider will provide most of your healthcare.
• **Specialty care**	Here are some other things you should know about specialty care: If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan. If you are seeing a specialist and your specialist leaves the Plan, call your primary care provider, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else. • If you have a chronic and disabling condition and - lose access to your specialist because your coverage changed from the FEHB to the PSHB and your health plan does not participate in the PSHB; - lose access to your specialist because we drop out of the Postal Service Employees Health Benefits (PSHB) Program and you enroll in another PSHB program plan; or - lose access to your specialist because terminate our contract with your specialist for other than cause; - lose access to your specialist because we reduce our service area and you enroll in another PSHB plan you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan. If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.
• **Hospital care**	Your Plan primary care provider or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.
• **If you are hospitalized when your enrollment begins**	We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 877-835-9861. If you are new to the PSHB 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 this PSHB plan, your former plan will pay for the hospital stay until:

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

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the PSHB 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

The pre-approval processes for inpatient hospital admissions (called precertification) and for other services, are detailed in this Section.

- **Inpatient hospital admission**

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

- **Other services**

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

- Angioma/Hemangioma (with pictures)
- Applied Behavioral Analysis
- Air Ambulance (non-emergent)
- Blepharoplasty (with pictures)
- Breast implant removal, breast reconstruction for non-cancer diagnosis, breast reduction
- Certain out of network services
- Dental procedures in a facility
- Certain Durable Medical Equipment supplies over $1000
- Clinical trials
- Coronary artery bypass graft
- Congenital anomaly repair
- Computed Tomography (CT) scans (brain, chest, heart)
- Dialysis
- Discectomy/fusion
- Gender Affirming Surgical Procedures
- Genetic testing
- Gynecomastia surgery
- Human Growth hormone
- Hysterectomy
- Iatrogenic infertility services
- Infertility Services
- Implanted spinal cord stimulators
- Inpatient hospitalization
- Intensive Outpatient Treatment

- Joint replacement
- Morbid obesity surgery
- Magnetic resonance imaging (MRI) (brain, chest, heart, musculoskeletal)
- Magnetic resonance angiogram (MRA)
- Partial Hospitalization
- PET scans (non- cancer diagnosis)
- Pulmonary rehabilitation
- Radiation therapy
- Reconstructive surgery
- Sclerotherapy
- Sleep apnea (surgery & appliance) with sleep studies,(polysomnography) attended
- Tempromandibular Joint (TMJ) Dysfunction surgery
- Transplants
- Therapeutic services: such as physical therapy, occupational therapy and speech therapy after the 8th visit
- Uvulopalatopharyngoplasty
- Vein Ablation
- Ventricular assist device

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

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

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

Next, provide the following information:

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

- **Non-urgent care claims**

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

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

- **Urgent care claims**

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

  If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide 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 Postal Service Insurance Operations (PSIO) at (202) 936-0002 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 877-835-9861. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

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

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

- **Emergency inpatient admission**

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

- **Maternity care**

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

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

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

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

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

If you fail to obtain authorization/precertification 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 your claim is in reference to a contraceptive, call 877-835-9861.

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

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

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

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

1. Precertify your hospital stay or, if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information.
   - You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.
   - If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

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

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.

Note: If you are enrolled in our Medicare PDP EGWP and do not agree with our benefit coverage decision you have the right to appeal. See Section. 8(a) for information about the PDP EGWP appeal process.

Section 4. Your Cost 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 a Specialist, you pay a copayment of $60 per visit, and when you go to Urgent Care, you pay $50 per visit.

Deductible

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

- The calendar year deductible is $500 Self Only and $1,000 Self Plus One or Self and Family. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $500. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $1,000. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $1,000. The Out-of-network deductible is $3,000 Self Only and $6,000 Self Plus One or Self and Family.
- We also have a separate deductible for:
  - Pharmacy - Tier 3 and 4 prescriptions only. Prescription paid under the pharmacy benefit are not subject to the medical deductible. There is however, a pharmacy deductible which only applies to Tier 3 and Tier 4 prescription drugs. That deductible is $250 Self Only, $500 Self Plus One or Self and Family.
- There are in-network benefits that are paid prior to your deductible being satisfied, such as Primary Care visits, Specialist Visits, Virtual/Telemedicine visits - please refer to the benefits section of this brochure.

Note: If you change PSHB plans during Open Season, the effective date of your new PSHB plan is January 1 of the next year, and a new deductible starts on January 1. If you change plans at another time during the year, you must begin a new deductible under your new plan.

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

Coinsurance

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

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

Differences between our Plan allowance and the bill

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

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

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

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

Your catastrophic protection out-of-pocket maximum

After your (copayments and coinsurance) total $7,350 for Self Only, or $14,700 for a Self Plus One or Self and Family enrollment in any calendar year, or out-of-network $15,000 per Self Only or $30,000 for Self Plus One or Self and Family you do not have to pay any more for covered services. However, copayments and coinsurance, if applicable for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services:

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

For members enrolled in our Plan's associated MA-PD or PDP EGWP, we are required to accumulate all members' actual out-of-pocket costs for Medicare-covered drugs, services and supplies toward the PSHB catastrophic maximum(s), unless specifically excluded below.

- Part D prescription drug coverage, whether your Part D coverage is through the Retiree Advantage Plan (MAPD) or MedicareRx PDP (PDP EGWP), your Part D prescription drug coverage does not accumulate towards the PSHB catastrophic out-of-pocket maximum, however, once your True Out of Pocket (TROOP) reaches $2,000 for your Part D prescription coverage, you enter the Catastrophic Coverage level and will have no copay for all covered medications.

If you are enrolled in our Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP), the prescription drug out-of-pocket maximum is $2,000. After this maximum is met, we pay 100% of all eligible covered prescription drug benefits.

Carryover

If you changed to this PSHB Plan during Open Season from a plan with a catastrophic protection benefit the effective date of the change is January 1, and covered expenses that apply to this plan's catastrophic protection benefit starts on January 1.

Note: If you change PSHB plans during Open Season the effective date of your new PSHB plan is January 1 of the next year, and a new catastrophic protection accumulation starts on January 1. If you change plans at another time during the year, you must begin a new catastrophic protection accumulation under your new plan.

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

When Government facilities bill us

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

Important Notice About Surprise Billing – Know Your Rights

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

A surprise bill is an unexpected bill you receive for:

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

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

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

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

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

Section 5. High Option Benefits

Page 112 has a benefits summary for this plan.

Section 5. High Option Benefits Overview

This Plan is a High Option plan. The benefits are described in Section 5. Make sure that you review the benefits that are available. Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about benefits, contact us at 1-877-835-9861 or on our website at www.uhcfeds.com.

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

Benefits	You pay
Medical Services Provided by Physicians: Routine Preventive Care	In-network: $0 Out-of-network: you pay all charges
Medical Services Provided by Physicians: Diagnostic and treatment services provided in office	Primary care physician - In-network: $0 copayment all ages (not subject deductible); Out-of-network: 40% after deductible has been met and any difference between our allowance and the billed amount Specialist: $60 copayment in-network (not subject deductible); Out-of-network: 40% after deductible has been met and any difference between our allowance and the billed amount
Urgent Care	In-network: $50 copayment (deductible does not apply) Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Services provided by a hospital: Inpatient	In-network: 20% coinsurance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Services provided by a hospital: Outpatient Surgical	In-network: 20% coinsurance Out-of-network: 40% of the plan allowance and any difference between our allowance and the billed amount
Emergency Benefits: Emergency room	In-network: 20% coinsurance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Mental Health and Substance Use Disorder Treatment	Regular cost sharing
Prescription Drugs:	Retail - 30-day supply: Tier 1 - $10 Tier 2 - $50 Tier 3 - $100 Tier 4 - $200 Mail Order - 90-day supply:

	Tier 1 - $25 Tier 2 - $125 Tier 3 - $250 Tier 4 - $500 Note: Tier 3 and Tier 4 drugs are subject to a pharmacy deductible of $250 Self Only / $500 Self Plus One or Self and Family Out-of-network: you pay all charges
Pharmacy - Specialty Medications (30-day supply)	Tier 1 - $10 Tier 2 - $150 Tier 3 - $350 Tier 4 - $500 Available through in-network designated Specialty Pharmacy Only

UnitedHealthcare Retiree Advantage Health Plan

Medical Benefit: Deductible
Member Pays: No Deductible; Brochure Section 9

Medical Benefit: Primary Care Provider Visit
Member Pays: Nothing; Brochure Section 9

Medical Benefit: Preventive Care
Member Pays: Nothing; Brochure Section 9

Medical Benefit: Specialist Visit
Member Pays: Nothing; Brochure Section 9

Medical Benefit: Virtual Visit
Member Pays: Nothing; Brochure Section 9

Medical Benefit: Urgent Care
Member Pays: Nothing; Brochure Section 9

Medical Benefit: Emergency Room
Member Pays: Nothing; Brochure Section 9

Medical Benefit: Pharmacy (30-day supply)
Member Pays: Tier 1 - $5, Tier 2 - $25, Tier 3 - $60, Tier 4 - $90; Brochure Section 9

*Note: You must have Medicare Part A and Part B, and Medicare must be primary for you to enroll in the UnitedHealthcare Retiree Advantage Plan. This plan reduces your costs by eliminating your cost sharing for covered medical services.

Please see Section 9 in this brochure for additional information on how to enroll in this plan and for details on a reimbursement of $150.00 of your Medicare Part B premium.

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

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.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- The calendar year deductible is: $500 Self Only, $1,000 Self Plus One and Self and Family in-network and $3,000 Self Only, $6,000 Self Plus One and Self and Family out-of-network. The calendar year deductible may apply to some benefits in this Section. We added - "Not subject to deductible" to show when the calendar year deductible does not apply.
- If you enroll in UnitedHealthcare Choice Plus Primary Plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our PSHB members. This plan enhances your PSHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a $150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.)
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description	You pay	
Diagnostic and treatment services	**In-Network**	**Out-of-Network**
Professional services of physicians: • In Provider's office / telehealth visit • Primary care / Optum Primary care • Office Medical consultations • Second surgical opinion • Advanced care planning	Primary care Provider (PCP) $0 - Not subject to deductible Specialist $60 copayment - Not subject to deductible	Primary care Provider (PCP) visit - 40% of the Plan allowance and any difference between our allowance and the billed amount
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations • In an emergency room • At home • Advance care planning	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Benefit Description	You pay	
Virtual Visits	**In-Network**	**Out-of-Network**
Use virtual visits through our designated virtual visit network provider groups when: • Your doctor is not available • You become ill while traveling • Conditions such as: cold, flu, bladder infection, bronchitis, diarrhea, fever, pink eye, rash, sinus problem, sore throat, stomach ache Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at 1-877-835-9861. Access to Virtual Visits and prescription services may not be available in all states due to state regulations. You can pre-register with a group. After registering and requesting a visit you will pay your portion of service costs and then you enter a virtual waiting room.	$0 Not subject to deductible	*All charges*
Lab, X-ray and other diagnostic tests	**In-Network**	**Out-of-Network**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap test • Pathology • X-ray • Non-routine mammogram • CT/CAT Scan • MRI • Ultrasound • Electrocardiogram and EEG	20% coinsurance of plan allowance	*All charges*
Major Diagnostic tests • CT scans/MRI • PET Scans • Nuclear Medicine Pre-authorization is required	20% coinsurance of plan allowance	*All charges*

Benefit Description	You pay	
Preventive care, adult	**In-Network**	**Out-of-Network**
Routine physical every year: **The following preventive services are covered at the time interval recommended at each of the links below:** • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks • Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women go to the Health and Human Services (HHS) website at https://www.hrsa.gov/womens-guidelines • To build your personalized list of preventive services go to https://health.gov/myhealthfinder	$0	*All charges*
• Routine mammogram	$0	*All charges*
• Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. For a complete list of endorsed immunizations go to the Centers for Disease Control (CDC) website at www.cdc.gov/vaccines/schedules/ Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	$0	*All charges*
Annual preventive biometric screening in your physician's office to include: • Body mass index (BMI) • Blood pressure • Lipid/cholesterol levels • Glucose/hemoglobin AIC measurement	$0	*All charges*

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**In-Network**	**Out-of-Network**
Services subject to age and frequency recommendations and must be coded by your physician as preventive to be covered in full.	$0	*All charges*
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy. • Family centered programs when medically identified to support obesity prevention and management by an in-network provider.	$0	*All Charges*
• When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) for cost share requirements for anti-obesity medications.		
• When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See section 5(b) for Surgery requirements and cost share.		
BRCA genetic counseling and evaluation is covered as preventive when a woman's family history is associated with an increased risk for deleterious mutations in BRCA1 and BRCA2 genes and medical necessity criteria has been met. Preauthorization required	$0	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*	*All charges*
Preventive care, children	**In-Network**	**Out-of-Network**
Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org	$0	*All charges*

Preventive care, children - continued on next page

Benefit Description	You pay	
Preventive care, children (cont.)	**In-Network**	**Out-of-Network**
Children's immunization's endorsed by the Centers for Disease Control (CDC) including DTaP/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the website at https://www.cdc.gov/vaccines/schedules/index.html	$0	*All charges*
You can also find a complete list of U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	$0	*All charges*
Obesity counseling, screening, and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy. • Family centered programs when medically identified to support obesity prevention and management by an in-network provider.	$0	*All charges*
• When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) for cost share requirements for anti-obesity medications.		
• When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share.		
Maternity care	**In-Network**	**Out-of-Network**
Complete maternity (obstetrical) care, such as: • Prenatal and Postpartum care • Screening for gestational diabetes • Delivery • Screening and counseling for prenatal and postpartum depression Note: Here are some things to keep in mind:	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Maternity care - continued on next page

Benefit Description	You pay	
Maternity care (cont.)	**In-Network**	**Out-of-Network**
• You do not need to precertify your vaginal delivery; see page 59 for other circumstances, such as extended stays for you or your baby. • As part of your coverage, you have access to in-network certified nurse midwives, and board-certified lactation specialists during the prenatal and post-partum period. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b).Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Breastfeeding and lactation support, supplies and counseling for each birth	$0	$0
Not covered: *Routine sonograms to determine fetal age, size or sex*	*All charges*	*All charges*
Family planning	**In-Network**	**Out-of-Network**
Contraceptive counseling on an annual basis	$0	40% of the Plan allowance and any difference between our allowance and the billed amount
A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories on the HRSA list. This list includes: • Voluntary female sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera)	$0	40% of the Plan allowance and any difference between our allowance and the billed amount

Family planning - continued on next page

Benefit Description	You pay	
Family planning (cont.)	**In-Network**	**Out-of-Network**
• Intrauterine devices (IUDs) • Diaphragms Note: See additional Family Planning and Prescription drug coverage Section 5(f). Note: Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below. Contraceptive products that are not already available at $0 cost-share can be provided at $0 member cost-share if the provider determines that a particular contraceptive is medically necessary for that member. The cost-share waiver process requires that providers attest the product is needed for contraceptive purposes and this can be submitted electronically by the provider. To request an exemption, members should call customer service at 877-835-9861. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov.	$0	40% of the Plan allowance and any difference between our allowance and the billed amount
Voluntary male sterilization	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling unless medically necessary* • *Interruption of pregnancy unless the life of the mother is at risk*	*All charges*	*All charges*
Infertility services	**In-Network**	**Out-of-Network**
Diagnosis and treatment of infertility	20% coinsurance of the plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)	**In-Network**	**Out-of-Network**
Infertility: A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. It is defined by the failure to achieve a successful pregnancy after 12 months or more of unprotected intercourse or artificial insemination for individuals under age 35. Earlier evaluation and treatment for those individuals actively looking to achieve a conception may be justified based on medical history and diagnostic testing and is warranted after six (6) months for individuals aged 35 years or older. Diagnosis and treatment of infertility specific to • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) Fertility drugs see Section 5(f) • Oral and injectable drugs associated with artificial insemination and IVF (3 cycles annually) procedures Note: Prior Authorization required	50% coinsurance of plan allowance	50% of the Plan allowance and any difference between our allowance and the billed amount
Iatrogenic Infertility Services	**In-Network**	**Out-of-Network**
Coverage is available for fertility preservation for medical reasons that cause irreversible infertility such as surgery, including surgical treatment of gender dysphoria, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes. Covered benefits include the following procedures: • Collection of sperm • Cryo-preservation of sperm • Oocyte cryo-preservation • Embryo cryo-preservation • Ovarian stimulation, retrieval of eggs and fertilization Benefits are not available for: • Embryo transfer • Long-term storage costs (greater than 1 year) • Elective fertility	20% coinsurance of plan allowance; $60 per specialist visit	40% of the Plan allowance and any difference between our allowance and the billed amount

Iatrogenic Infertility Services - continued on next page

Benefit Description	You pay	
Iatrogenic Infertility Services (cont.)	**In-Network**	**Out-of-Network**
Note: There is a benefit limit of $20,000 for medical services and $5,000 for pharmacy benefits. The preimplantation genetic testing and fertility preservations are one combined maximum. Prior authorization is required. Benefits are further limited to one cycle of fertility preservation for iatrogenic infertility per covered person during the period of time he or she is enrolled for coverage under the policy.	20% coinsurance of plan allowance; $60 per specialist visit	40% of the Plan allowance and any difference between our allowance and the billed amount
Allergy care	**In-Network**	**Out-of-Network**
• Testing and treatment • Allergy injections - including serum	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*	*All charges*
Treatment therapies	**In-Network**	**Out-of-Network**
• 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 53. • Respiratory and inhalation therapy (pulmonary rehabilitation) is provided for up to 20 sessions • Cardiac rehabilitation following qualifying event/ condition is provided for up to 36 sessions • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services* on page 19.	20% coinsurance of the plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Benefit Description	You pay	
Habilitative/Rehabilitative therapies	**In-Network**	**Out-of-Network**
Habilitative/Rehabilitative Services Outpatient Therapy when performed by qualified physical therapists and occupational therapists: • Physical Therapy/ Occupational therapy - up to 60 visits per year combined • Cognitive Rehabilitation up to 20 visits per year • Post cochlear implant rehabilitation and aural therapy up to 30 visits per year Note: We only cover therapy when a physician: • Orders the care • Identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • Indicates the length of time the services are needed.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*	*All charges*
Speech therapy	**In-Network**	**Out-of-Network**
Up to 20 visits per year for speech therapy	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Exercise programs, gyms or pool memberships* • *Work hardening/functional capacity programs or evaluations* • *Voice therapy*	*All charges*	*All charges*
Hearing services (testing, treatment, and supplies)	**In-Network**	**Out-of-Network**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
• External hearing aids Limit of $2,500 per ear and limited to a single purchase (including repair/replacement) per hearing impaired ear every three (3) years. Repair and replacement of a hearing aid would apply to this limit in the same manner as a purchase.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

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

Benefit Description	You pay	
Hearing services (testing, treatment, and supplies) (cont.)	**In-Network**	**Out-of-Network**
• Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, see Section 5(a) Orthopedic and prosthetic devices. Note: For therapy associated with cochlear implants please refer to the rehabilitative treatment therapy section of this brochure.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: *Hearing services that are not shown as covered*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**In-Network**	**Out-of-Network**
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) Note: See Preventive care, children for eye exams for children.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Diagnosis and treatment of diseases of the eye	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Routine Eye Examination - Eye refraction every two years to provide a written lens prescription Note: Eye examinations for children follow the Bright Futures Guidelines (American Academy of Pediatrics) at no charge	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*	*All charges*
Foot care	**In-Network**	**Out-of-Network**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
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*	*All charges*	*All charges*

Foot care - continued on next page

Benefit Description	You pay	
Foot care (cont.)	**In-Network**	**Out-of-Network**
• *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**In-Network**	**Out-of-Network**
• Artificial limbs and eyes • Prosthetic sleeve or sock • 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 • Enteral equipment and supplies • 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 • Orthotic braces and splints not available over the counter that straighten or change the shape of a body part • Bone anchored hearing aids (BAHA) limited to one per member per lifetime, when the member has either of the following - Craniofacial anomalies in which abnormal or absent ear canals preclude the use of a wearable hearing aid - Hearing loss of sufficient severity that it cannot be adequately remedied by a wearable hearing aid • Single purchase of each type of prosthetic device every three (3) years (in-network). Prior authorization is required for prosthetic devices in excess of $1,000. Note: Most orthopedic and prosthetic devices must be preauthorized. Call us at 1-877-835-9861 if your plan physician prescribes this and you need assistance locating a health care physician or health care practitioner to sell or rent you orthopedic or prosthetic equipment. You may also call us to determine if certain devices are covered.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
Orthopedic and prosthetic devices (cont.)	**In-Network**	**Out-of-Network**
Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than 5 years after the last one (except as needed to accommodate growth in children or socket replacement for members with significant residual limb volume or weight changes)* • *External penile devices* • *Speech prosthetics (except electrolarynx)* • *Carpal tunnel splints* • *Deodorants, filters, lubricants, tape, appliance cleansers, adhesive and adhesive removers related to ostomy supplies*	*All charges*	*All charges*
Durable medical equipment (DME)	**In-Network**	**Out-of-Network**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • A single purchase of a type of durable medical equipment (including repair and replacement) every three (3) years. This limit does not apply to wound vacuums. Prior authorization is required for durable medical equipment in excess of $1,000. - Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks) - Dialysis equipment - Standard hospital beds - Wheelchairs - Crutches - CPAP - Walkers - Blood glucose monitors/continuous glucose monitors	20% coinsurance of plan allowance	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	**In-Network**	**Out-of-Network**
- Insulin pumps. and insulin pump supplies - Surgical dressings not available over-the-counter - Burn garments - Braces, including necessary adjustments to shoes to accommodate braces, which are used for the purpose of supporting a weak or deformed body part - Braces restricting or eliminating motion in a diseased or injured part of the body - Hair prosthesis (wigs for hair loss due to cancer treatment) - limited to $350 per years Note: Many DME items must be preauthorized. Call us at 1-877-835-9861 as soon as your Plan physician prescribes this equipment. We will arrange with a healthcare provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	20% coinsurance of plan allowance	*All charges*
Not covered: • *Power operated vehicles unless medically necessary based upon diagnosis* • *Duplicate or back up equipment* • *Parts and labor costs for supplies and accessories replaced due to wear and tear such as tires and tubes* • *Educational, vocational or environmental equipment* • *Deluxe or upgraded equipment or supplies* • *Home or vehicle modifications; seat lifts* • *Over-the-counter medical supplies* • *Activities of daily living aids (such as grab bars and utensil holders)* • *Personal hygiene equipment* • *Paraffinbaths, whirlpoolsand cold therapy* • *Augmentative communication devices* • *Physical fitness equipment* • *Continuous pulse oximetry unless skilled nursing is involved in home care and it is part of their medically necessary equipment* • *Out-of-network purchases*	*All charges*	*All charges*

Benefit Description	You pay	
Home health services	**In-Network**	**Out-of-Network**
• Medically necessary Home healthcare ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true: - It must be delivered or supervised by a licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for safety of the patient - It is ordered by a physician - It is not delivered for the purpose of assisting with the activities of daily living including dressing, feeding, bathing or transferring from a bed to a chair - It requires clinical training in order to be delivered safely and effectively - It is not custodial care • We will determine if benefits are available by reviewing both the skill nature of the service and the need for the Physician directed medical A service will not be determined to be skilled simply because there is not an available caregiver. • Services include the administration of: oxygen therapy, intravenous therapy and medications. • Limited to 60 visits per year • Prescription foods covered when the following criteria have been met: - 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 Note: medications delivered will be subject to pharmacy charges.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family*	*All charges*	*All charges*

Home health services - continued on next page

Benefit Description	You pay	
Home health services (cont.)	**In-Network**	**Out-of-Network**
• *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Private duty nursing* • *Foods that can be obtained over the counter (without a prescription) even if prescribed by your physician*	*All charges*	*All charges*
Chiropractic	**In-Network**	**Out-of-Network**
• Manipulation of the spine and extremities up to 20 visits per year • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Alternative treatments	**In-Network**	**Out-of-Network**
Acupuncture – by a doctor of medicine or osteopathy, or licensed or certified acupuncture practitioner Up to 12 visits per year Dry Needling – by a licensed or certified practitioner	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Naturopathic services* • *Hypnotherapy* • *MassageTherapy* • *Herbal medicine* • *Rolfing* • *Ayurveda* • *Homeopathy* • *Other alternative treatments unless specifically listed as covered*	*All charges*	*All charges*
Educational classes and programs	**In-Network**	**Out-of-Network**
Outpatient self-management training for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin using diabetes and designated chronic conditions. Diabetes outpatient self- management training, education and medical nutrition therapy services must be prescribed by a licensed health care professional who has appropriate state licensing authority. Outpatient self-management training includes, but is not limited to, education and medical nutrition therapy. The training must be given by a certified registered or licensed health care professional trained in the care and management of diabetes. Coverage includes:	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Educational classes and programs - continued on next page

Benefit Description	You pay	
Educational classes and programs (cont.)	**In-Network**	**Out-of-Network**
• Initial training visit, up to 10 hours, after you are diagnosed with diabetes, for the care and management of diabetes, including but not limited to: Counseling in nutrition, the use of equipment and supplies, training and education, up to four hours, as a result of a subsequent diagnosis by a Physician of a significant change in your symptoms or condition which require modification of your program of self-management of diabetes. Also included is training and education, up to four hours, because of the development of new techniques and treatments.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Coverage is provided for: Tobacco Cessation program "Quit for Life" which includes online learning, Quit Coach, Nicotine Replacement Therapy Coaching and over the counter and prescription drugs approved by the FDA (subject to age and treatment therapy recommendations) to treat tobacco dependence. Learn more about this program in Section 5(h) Wellness and other Special Features.	$0	$0

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Physicians must provide or arrange your care.
- The calendar year deductible is: $500 Self Only, $1,000 Self Plus One and Self and Family in-network and $3,000 Self Only, $6,000 Self Plus One and Self and Family out-of-network. The calendar year deductible applies to most benefits in this Section. We indicate "Not subject to deductible" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other healthcare professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SERVICES AND/OR PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.
- If you enroll in UnitedHealthcare Choice Plus Primary Plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our PSHB members. This plan enhances your PSHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a $150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.)

Benefit Description	You pay	
Surgical procedures	**In-Network**	**Out-of-Network**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of severe obesity (see Bariatric surgery) • Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Treatment of burns	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**In-Network**	**Out-of-Network**
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. Physician charges for Scopic Procedures such as: • Endoscopy • Colonoscopy (Diagnostic) • Sigmoidscopy Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery.* Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Note: For female surgical family planning procedures see Family Planning Section 5(a) Note: For male surgical family planning procedures see Family Planning Section 5(a)	see Family Planning Section 5 (a)	see Family Planning Section 5 (a)
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; (see Foot care)*	*All charges*	*All charges*
Bariatric Surgery	**In-Network**	**Out-of-Network**
Surgical treatment of severe obesity (Bariatric surgery) when the following criteria has been met: • Eligible members must be age 18 or older or for adolescents, have achieved greater than 95% of estimated adult height AND a minimum Tanner Stage of 4 • A Body Mass Index (BMI) above 40 kg/m2 without co-morbidity; or • A BMI of 35 kg/m2 or greater with obesity-related co-morbid medical conditions including: - Hypertension - Cardiopulmonary condition - Sleep apnea - Diabetes - Any life threatening or serious medical condition that is weight induced • Must enroll in the Bariatric Resource Services Program (BRS)	20% coinsurance of plan allowance	*All charges*

Bariatric Surgery - continued on next page

Benefit Description	You pay	
Bariatric Surgery (cont.)	**In-Network**	**Out-of-Network**
• Must use a designated Bariatric Resource Services (BRS) provider and facility • Documentation that dietary attempts at weight control have been ineffective through completion of a structured diet program, such as Weight Watchers or Jenny Craig. Either of the following in the two-year period that immediately precedes the request for the surgical treatment of morbid obesity meets the indication: 1. One structured diet program for six consecutive months; or 2. Two structured diet programs for three consecutive months • A carrier or a private review agent acting on behalf of a carrier shall use flexibility with regard to defining a structured diet program • Completion of a psychological examination of the member's readiness and fitness for surgery and the necessary postoperative lifestyle changes • This benefit must be coordinated by UnitedHealthcare Bariatric and Bariatric Centers of Excellence Facility	20% coinsurance of plan allowance	*All charges*
Revisional Bariatric Surgery due to a technical failure or major complication from the initial procedure; potential failure/complications include but are not limited to the following: • Bowel perforation (including adjustable gastric band erosion) • Adjustable gastric band migration (slippage) that cannot be corrected with manipulation or adjustment (records must demonstrate that manipulation or adjustment to correct band slippage has been attempted) • Leak • Obstruction (confirmed by imaging studies) • Staple-line failure • Mechanical adjustable gastric band failure • Uncontrollable reflux related to sleeve gastrectomy when all the following criteria are met: - Maximum nonpharmacological medical management failure (e.g., positional, dietary modification and behavioral changes); and - Maximum pharmacological medical management failure (e.g., at least one month of double dose PPI, H2 blocker, and/or sucralfate); and	20% coinsurance of plan allowance	*All charges*

Bariatric Surgery - continued on next page

Benefit Description	You pay	
Bariatric Surgery (cont.)	**In-Network**	**Out-of-Network**
- Severe esophagitis (grade C or D) confirmed by endoscopy despite maximum medical management **and** • The individual must also meet the following criteria: - Completion of a preoperative evaluation that includes a detailed weight history along with dietary and physical activity patterns; and - Psychosocial-behavioral evaluation by an individual who is professionally recognized as part of a behavioral health discipline to provide screening and identification of risk factors or potential postoperative challenges that may contribute to a poor postoperative outcome	20% coinsurance of plan allowance	*All charges*
Reconstructive surgery	**In-Network**	**Out-of-Network**
Physician charges for : • 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; birthmarks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts; - Treatment of any physical complications, such as lymphedemas; - Breast prostheses and surgical bras and replacements (see *Prosthetic devices)* Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. • Gender Affirming Surgery	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Reconstructive surgery - continued on next page

Benefit Description	You pay	
Reconstructive surgery (cont.)	**In-Network**	**Out-of-Network**
- Surgical treatment for Gender Dysphoria may be indicated for individuals who meet the medical criteria and persistent, well-documented diagnostic criteria A disorder characterized by the following diagnostic criteria (Diagnostic and Statistical Manual of Mental Disorders, 5th edition [DSM-5]). **Requirements:** • Must be 18 years of age or older • Favorable psychosocial-behavioral evaluation to provide screening and identification of risk factors or potential postoperative challenges • Persistent, well-documented Gender Dysphoria • Capacity to make a fully informed decision and to consent for treatment • Complete at least 12 months of successful continuous full-time real-life experience in the desired gender • Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated) • Treatment plan that includes ongoing follow-up and care by a Qualified Behavioral Health Provider experienced in treating Gender Dysphoria **Gender reconstructive surgeries for (male to female) include:** • Laser or electrolysis hair removal in advance of genital reconstruction • Orchiectomy: removal of testicles • Penectomy: removal of penis • Vaginoplasty: creation of vagina • Clitoroplasty: creation of clitoris • Labiaplasty: creation of labia • Prostatectomy: removal of prostate • Urethroplasty: creation of urethra • Tracheal shave • Voice modification surgery • Voice modification lessons and therapy • Chest and breast surgery including bilateral mastectomy • Breast reduction and Breast augmentation • Gender Affirming Facial Surgeries • Travel and Lodging ($2000 maximum)	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Reconstructive surgery - continued on next page

Benefit Description	You pay	
Reconstructive surgery (cont.)	**In-Network**	**Out-of-Network**
Gender reconstructive surgeries for (female to male) include: • Laser or electrolysis hair removal in advance of genital reconstruction • Salpingo-oophorectomy: removal of fallopian tubes and ovaries • Vaginectomy: removal of vagina • Vulvectomy: removal of vulva • Metoidioplasty: creation of micro-penis using the clitoris • Phalloplasty: creation of penis, with or without urethra • Hysterectomy: removal of uterus • Urethroplasty: creation of urethra within penis • Scrotoplasty: creation of scrotum • Testicular prosthesis: implantation of artificial testes • Penile prosthesis • Voice modification surgery • Voice modification lessons and therapy • Chest and breast surgery including bilateral mastectomy • Breast reduction and Breast augmentation • Gender Affirming Facial Surgeries • Travel and Lodging ($2000 maximum) Note: Prior Authorization is required	20% coinsurance of plan allowance	40% of the 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*	*All charges*	*All charges*
Oral and maxillofacial surgery	**In-Network**	**Out-of-Network**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay	
Oral and maxillofacial surgery (cont.)	**In-Network**	**Out-of-Network**
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*	*All charges*
Temporomandibular Joint Dysfunction (TMJ)	**In-Network**	**Out-of-Network**
Services for the evaluation and treatment of TMJ and associated muscles • Diagnosis: Exam, radiographs and applicable imaging studies and consultation. • Non-surgical treatment including: Clinical exams, Oral appliances (orthotic splints), Arthrocentesis, Trigger- point injections Benefits are provided for surgical treatment if the following criteria are met: • There is radiographic evidence of joint abnormality • Non-surgical treatment has not resolved the symptoms • Pain or dysfunction is moderate or severe Benefits for surgical services include: • Arthrocentesis • Arthroscopy • Arthroplasty • Arthrotomy • Open or closed reduction of dislocations $3,000 limit for all services pertaining to TMJ	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Organ/tissue transplants	**In-Network**	**Out-of-Network**
These **solid organ transplants** are covered. Solid organ transplants are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas	20% coinsurance of plan allowance	*All charges*

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**In-Network**	**Out-of-Network**
• Kidney • Kidney-pancreas • Liver • Lung: single/bilateral/lobar • Pancreas These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	20% coinsurance of plan allowance	*All charges*
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hematopoietic stem cell - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy)	20% coinsurance of plan allowance	*All charges*

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**In-Network**	**Out-of-Network**
- 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 - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Hematopoietic stem cell - Medulloblastoma - Multiple myeloma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	20% coinsurance of plan allowance	*All charges*
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed)	20% coinsurance of plan allowance	*All charges*

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**In-Network**	**Out-of-Network**
- Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	20% coinsurance of plan allowance	*All charges*
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence 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	20% coinsurance of plan allowance	*All charges*

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**In-Network**	**Out-of-Network**
- Multiple myeloma - Multiple sclerosis - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myelodysplasia/Myelodysplastic Syndromes - Myeloproliferative disorders (MDDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma)	20% coinsurance of plan allowance	*All charges*

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**In-Network**	**Out-of-Network**
- Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	20% coinsurance of plan allowance	*All charges*
National Transplant Program (NTP) – Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members. **Transplants must be provided in a Plan designated Center of Excellence for Transplants. These centers do a large volume of these procedures each year and have a comprehensive program of care.** **Limited Benefits** – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols.	20% coinsurance of plan allowance	*All charges*
Donor testing for bone marrow/stem cell transplants for up to 4 potential donors whether family or non-family	20% coinsurance of plan allowance	*All charges*
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered* • *All services related to non-covered transplants* • *All services associated with complications resulting from the removal of an organ from a non member*	*All charges*	*All charges*
Anesthesia	**In-Network**	**Out-of-Network**
Professional services provided in – • Hospital (inpatient) • Hospital (outpatient) • Skilled nursing facility • Ambulatory surgical center • Office	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $500 Self Only, $1,000 Self Plus One and Self and Family in-network and $3,000 Self Only, $6,000 Self Plus One and Self and Family out-of-network. The calendar year deductible applies to almost all benefits in this We indicate "Not subject to deductible" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your Costs for Covered Services* for valuable information about how cost sharing works. Also read Section 9, C*oordinating 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 such as physician charges are in Sections 5(a) or (b).
- If you enroll in UnitedHealthcare Choice Plus Primary Plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our PSHB members. This plan enhances your PSHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a $150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.)
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SERVICES AND/OR PROCEDURES.** Please refer to the preauthorization information shown in Section 3 or call customer service to be sure which services require preauthorization.

Benefit Description	You pay	
Inpatient hospital	**In-Network**	**Out-of-Network**
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.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood products, derivatives and components, artificial blood products and biological serum. Blood products include any product created from a component of blood such as, but not limited to, plasma, packed red blood cells, platelets, albumin, Factor VIII, immunoglobulin, and prolastin	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**In-Network**	**Out-of-Network**
• Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthesia services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home • Take-home items	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as phone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**In-Network**	**Out-of-Network**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, x-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Blood and blood derivatives not replaced by the member*	*All charges*	*All charges*

Benefit Description	You pay	
Extended care benefits/Skilled nursing care facility benefits	**In-Network**	**Out-of-Network**
Services and supplies provided during a stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for up to 60 days per year when full- time nursing care is medically necessary as determined by the Plan. Services include: • Room and board in a Semi-private Room (a room with two or more beds), and general nursing care • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a physician.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Custodial care* • *Rest cures, domiciliary or convalescent care* • *Personal comfort items, such as phone, barber services, guest meals and beds*	*All charges*	*All charges*
Hospice care	**In-Network**	**Out-of-Network**
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 • Respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care • Benefits are available when hospice care is received from a licensed hospice agency.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Independent and private duty nursing, homemaker services*	*All charges*	*All charges*

Benefit Description	You pay	
Ambulance	**In-Network**	**Out-of-Network**
Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities only when the transport meets one of the following: • From an Out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required. • To the closest Network Hospital that provides the required Covered Health Care Services that were not available at the original Hospital, including transportation costs of a newborn to the nearest appropriate facility to treat the newborn's condition. The Physician must certify that such transportation is necessary to protect the health and safety of the newborn. • From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub- acute facility where the required Covered Health Care Services can be delivered. • **Prior Authorization Requirement** In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency air ambulance services, you **must** obtain authorization as soon as possible before transport. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid. For the purpose of this Benefit the following terms have the following meanings: • "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting. • "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness. • "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.	20% coinsurance of plan allowance	40% coinsurance of the Plan allowance and any difference between our allowance and the billed amount
Not Covered: • *International Transportation*	*All charges*	*All charges*

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $500 Self Only, $1,000 Self Plus One and Self and Family in-network and $3,000 Self Only, $6,000 Self Plus One and Self and Family out-of-network. The calendar year deductible applies to almost all benefits in this We indicate "Not subject to deductible" to show when the calendar year deductible does not apply..
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost sharing works. Also read Section 9, C*oordinating benefits with other coverage*, including with Medicare.
- If you enroll in UnitedHealthcare Choice Plus Primary Plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our PSHB members. This plan enhances your PSHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a $150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.)

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within or outside our service area

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

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

Benefit Description	You pay	
Emergency Care	**In-Network**	**Out-of-Network**
Emergency care at a Provider's office **(PCP)**	Primary care Provider (PCP) $0 - Not subject to deductible	Primary care physician (PCP) 40% of the Plan allowance and any difference between our allowance and the billed amount
Emergency care at a doctor's office - **Specialist**	$60 copayment specialist visit - Not subject to deductible	Specialist per visit - 40% of the Plan allowance and any difference between our allowance and the billed amount
Emergency care at an urgent care center	$50 copayment - Not subject to deductible	40% of the Plan allowance and any difference between our allowance and the billed amount
Emergency care as an outpatient at a hospital, including providers' services	20% coinsurance of plan allowance (waived if admitted)	40% of the Plan allowance and any difference between our allowance and the billed amount (waived if admitted)
Not covered: • *Elective care or non-emergency care at hospital emergency room*	*All charges*	*All charges*
Ambulance	**In-Network**	**Out-of-Network**
Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance or water vehicle) to the nearest Hospital where the required Emergency Health Care Services can be performed.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between allowance and the billed amount
Not Covered: • *International Transportation*	*All charges*	*All charges*

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

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- The calendar year deductible is: $500 Self Only, $1,000 Self Plus One and Self and Family in-network and $3,000 Self Only, $6,000 Self Plus One and Self and Family out-of-network. The calendar year deductible applies to almost all benefits in this Section. We indicate "Not subject to deductible" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost sharing works. Also read Section 9 *Coordinating benefits with other coverage,* including with Medicare.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.
- If you enroll in UnitedHealthcare Choice Plus Primary Plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our PSHB members. This plan enhances your PSHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a $150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.)
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SERVICES AND/ OR PROCEDURES**. Please refer to the preauthorization information shown in Section 3 or call customer service to be sure which services require preauthorization.

Benefit Description	You pay	
Professional services	**In-Network**	**Out-of-Network**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes	$0 copayment - Not subject to deductible	40% of the Plan allowance and any difference between our allowance and the billed amount

Professional services - continued on next page

Benefit Description	You pay	
Professional services (cont.)	**In-Network**	**Out-of-Network**
• Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of substance use disorders including detoxification, treatment and counseling Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy • Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	$0 copayment - Not subject to deductible	40% of the Plan allowance and any difference between our allowance and the billed amount
Autism Spectrum Disorder for children with autism spectrum disorder • Assessments, evaluations, or tests by a licensed physician or licensed psychologist to diagnose whether an individual has an autism spectrum disorder; • Treatment of autism spectrum disorders when it is determined by a licensed physician or licensed psychologist that the treatment is medically necessary health care. A licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity	$0 copayment - Not subject to deductible	40% of the Plan allowance and any difference between our allowance and the billed amount
Diagnostics	**In-Network**	**Out-of-Network**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility.	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount

Benefit Description	You pay	
Inpatient hospital or other covered facility	**In-Network**	**Out-of-Network**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Partial day treatment • Residental Treatment Note: Prior authorization is required	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Outpatient hospital or other covered facility	**In-Network**	**Out-of-Network**
Outpatient services provided and billed by a hospital or other covered facility • Facility based intensive outpatient treatment programs	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by the Plan physician to be necessary and appropriate* • *Methadone Maintenance for substance use unless it is part of an approved treatment program* • *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*	*All charges*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page. Some injectable medications may be covered under your medical benefit.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage. Prior approval/authorizations must be renewed periodically.
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing Also, read Section 9 about coordinating benefits with other coverage, including with Medicare. sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9, C*oordinating benefits with other coverage*, including with Medicare.
- The calendar year medical deductible is: $500 Self Only, $1,000 Self Plus One and Self and Family in-network and $3,000 Self Only $6,000, Self Plus One and Self and Family out-of-network. Prescription drugs payable under the pharmacy benefit are not subject to the medical deductible.
- Your pharmacy deductible which is applicable only for Tier 3 and Tier 4 drugs for Self Only is $250 and for Self Plus One or Self and Family is $500. This deductible does not apply to any Tier 1 or Tier 2 drugs or specialty pharmacy medications.
- Federal law prevents the pharmacy from accepting unused medications.
- If you enroll in UnitedHealthcare Choice Plus Primary Plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our PSHB members. This plan enhances your PSHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a $150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.)

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

- **Who can write your prescription**. A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice, must prescribe your medication.
- **Where you can obtain them**. You may fill the prescription at a Plan retail or mail order pharmacy. Specialty Pharmacy drugs are only filled at our Specialty Pharmacy. Some drugs are only available at the retail pharmacy for safety or other reasons. To locate the name of a Plan pharmacy near you, refer to your Directory of Health Care Professionals, call our Customer Service Department 1-877-835-9861 or visit our website, www.uhcfeds.com.
- **We use a Prescription Drug List (PDL) called the Advantage PDL.** Our PDL Management Committee creates this list that includes FDA approved prescription medications, products, or devices. Our Plan covers all prescription medications written in accordance with FDA guidelines for a particular therapeutic indication except for prescription medications or classes of medications listed under “Not Covered” in this section of the brochure. The PDL Management Commitee decides the tier placement based upon clinical information from the UnitedHealthcare Pharmacy and Therapeutics (P&T) Committee as well economic and financial considerations. You will find important information about our PDL as well as other Plan information on our web site, 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 mail order), and includes select generic medications, as well as select preferred medications. Brand medications in Tier 1 include select insulin products, select inhalers for asthma, and select medications for migraine headaches for which no generic alternative(s) are available. For the lowest out-of-pocket expense, you should always consider Tier 1 medications if you and your provider decide they are appropriate for your treatment.

- **Tier 2** is your **middle** copayment option (**$50** for up to a 30-day supply or $125 for up to a 90-day supply through mail order), and contains most preferred brand medications not included in Tier 1. Preferred medications placed in Tiers 1 and 2 are those the PDL Management Committee has determined to provide better overall value than those in Tier 3. If you are currently taking a medication in Tier 2, ask your provider whether there are Tier 1 alternatives that may be appropriate for your treatment.
- **Tier 3** is your **higher** copayment option (**$100** for up to a 30-day supply or $250 for up to a 90-day supply through mail order), and consists of non-preferred medications. Sometimes there are alternatives available in Tier 1 or Tier 2. If you are currently taking a medication in Tier 3, ask your provider whether there are Tier 1 or Tier 2 alternatives that may be appropriate for your treatment. **This tier is subject to the pharmacy deductible described above.**
- **Tier 4** is your **highest** copayment (**$200** for up to a 30-day supply or $500 for up to a 90-day supply through mail order), and consists of non-preferred medications that do not add clinical value over their covered Tier 1, Tier 2, or Tier 3 alternatives. Some medications on Tier 4 may also have an over-the-counter alternative which can be purchased without a prescription. **This tier is subject to the pharmacy deductible described above.**

Specialty Pharmacy medications are dispensed at 30-day supply. The copayments for these medications are on a separate tier. Tier 1 -$10; Tier 2- $150; Tier 3 - $350; Tier 4 - $500. **The pharmacy deductible does not apply for specialty medications.**

Mandatory Specialty Pharmacy Program - Our Specialty Pharmacy Program includes medications for rare, unusual or complex diseases. Members must obtain these medications through our designated specialty pharmacy. For costs associated with these prescriptions please see below. You will receive up to a maximum of a consecutive 30-day supply of your prescription medication. Our specialty pharmacy providers will give you superior assistance and support during your treatment. This Program offers the following benefits to members:

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

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

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

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

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

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

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

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

Day Supply - "Day supply" means consecutive days within the period of prescription. Where a prescription regimen includes "on and off days" when the medication is taken, the off days are included in the count of the day supply.

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

Injectable medications - Some injectable medications may be covered under the medical policy. Medications typically covered under the pharmacy benefit and received through a retail or mail order pharmacy are those that are self-administered by you or a non-skilled caregiver. However, injectable medications that are typically administered by a health care professional are covered under your medical benefit and need to be accessed through your provider or Specialty pharmacy. Contact the Health Plan at 1-877-835-9861 for more information on these medications.

Special dispensing circumstances - UnitedHealthcare will give special consideration to filling prescription medications for members covered under the PSHB if:

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

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

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

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

Benefit Description	You pay	
Preventive medications	**In-Network**	**Out-of-Network**
The following are covered: Preventive Medications with USPSTF A and B recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to http://www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations The following drugs and supplements are covered without cost- share, even if over-the-counter, are prescribed by a health care professional, and filled at a network pharmacy. • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 & 800 mcg • Liquid iron supplements for children age 0-1 year • Pre-natal vitamins for pregnant women	$0	*All charges*

Preventive medications - continued on next page

Benefit Description	You pay	
Preventive medications (cont.)	**In-Network**	**Out-of-Network**
• Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 • Certain statins to treat cardiovascular disease for adults age 40 to 75 will be covered without a copayment as recommended by the United States Preventive Services Task force (USPSTF) when the following criteria is met: - one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); - and a calculated 10-year risk of a cardiovascular event of 10% or greater	$0	*All charges*
Opioid rescue agents such as naloxone are covered under this Plan with no cost sharing when obtained from a network pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/.	$0	*All charges*
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Nonprescription medications*	*All charges*	*All charges*
Covered medications and supplies	**In-Network**	**Out-of-Network**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medications that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin with a copayment charge applied every 2 vials • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction are limited. Contact the plan for dosage limits. • Drugs to treat gender dysphoria* - Estradiol	Non-maintenance medications at a retail pharmacy: Up to a 30-day supply • Tier 1: $10 copayment • Tier 2: $50 copayment • Tier 3: $100 copayment • Tier 4: $200 copayment Maintenance medications from the Plan mail order pharmacy for up to a maximum of a 90-day supply • Tier 1: $25 copayment	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**In-Network**	**Out-of-Network**
- Testosterone - Leuprolide • Medications prescribed to treat obesity* - Saxenda - Wegovy - Zepbound • Oral and injectable contraceptive drugs • Oral and injectable drugs associated with artificial insemination and IVF (3 cycles annually) procedures • Some drugs may require prior authorization Note: Intravenous fluids and medications for home use, implantable drugs, and some injectable drugs are covered under Medical services and supplies Section (5a) or Surgical and anesthesia services Section (5b). *For a complete list of drugs and medications, visit www.uhcfeds.com or call our Customer Service Department 877-835-9861	Non-maintenance medications at a retail pharmacy: Up to a 30-day supply • Tier 1: $10 copayment • Tier 2: $50 copayment • Tier 3: $100 copayment • Tier 4: $200 copayment Maintenance medications from the Plan mail order pharmacy for up to a maximum of a 90-day supply • Tier 1: $25 copayment • Tier 2: $125 copayment • Tier 3: $250 copayment • Tier 4: $500 copayment Specialty Medications (per 30-day supply) • Tier 1 $10 copayment • Tier 2 $150 copayment • Tier 3 $350 copayment • Tier 4 $500 copayment	*All charges*
COVID-19 Over The Counter (OTC) Test Kits • 8 Tests per member per month	Tier 3 -$12 Capped	*All charges*
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to PSHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. • Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy.	$0	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**In-Network**	**Out-of-Network**
• Members may have a clinical review for contraceptives that are excluded. They should reach out to their prescribing provider. Contraceptive products that are not already available at $0 cost- share can be provided at $0 member cost-share if the provider determines that a particular contraceptive is medically necessary for that member. The cost-share waiver process requires that providers attest the product is needed for contraceptive purposes and this can be submitted electronically by the provider. Providers or prescribers may contact Optum Rx Prior Authorization department at 1-800-711-4555 for expedited review. • If you have difficulty accessing contraceptive coverage or other reproductive healthcare you can contact contraception@opm.gov. • Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7. • The "morning after pill" (tier 1) is provided at no cost if prescribed by a physician and purchased at a network pharmacy. Note: For additional Family Planning benefits see Section 5(a)	$0	*All charges*
Smoking cessation medications are covered as follows: • Prescription medications for smoking cessation • Over-the-counter smoking cessation medications with a prescription from physician as part of our smoking cessation program Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Educational Classes and programs in Section 5(a)	$0	*All charges*
Not covered • *Medications, drugs and supplies used for cosmetic purposes* • *Medical Marijuana* • *Drugs to enhance athletic performance* • *Medical supplies such as dressings and antiseptics* • *Artificial insemination fertility drugs other than used for the iatrogenic services* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies*	*All charges*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**In-Network**	**Out-of-Network**
• *Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed* • *Nonprescription medications unless specifically indicated elsewhere* • *Drugs for sexual performance for patients that have undergone genital reconstruction* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them* • *Drugs available over-the-counter that do not require a prescription order by federal or state law before being dispensed* • *Alcohol swabs and bio-hazard disposable containers* • *Compound drugs that do not contain at least one covered ingredient that requires a prescription order to fill*	*All charges*	*All charges*

Section 5(f)(a). PDP EGWP Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- These prescription drug benefits are for members enrolled in our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP).
- If you are a Postal Service annuitant and their covered Medicare-eligible family member, you will be automatically group enrolled in our PDP EGWP. Contact us for additional information at (844) 481-8821.

Note: Notify us as soon as possible if you or your eligible family member is already enrolled in a Medicare Part D Plan. Enrollment in our PDP EGWP will cancel your enrollment in another Medicare Part D plan.

There are advantages to being enrolled in our PDP EGWP:

- In our PDP EGWP, your cost-share for covered drugs, medications, and supplies will be equal to or better than the cost-share for those enrolled in our standard non-PDP EGWP Prescription Drug Program.
- In our PDP EGWP, you have a pharmacy network that may include pharmacies that are **out-of-network or excluded** for those enrolled in our standard non-PDP EGWP Prescription Drug Program. For assistance locating a PDP EGWP network pharmacy, call us at 1-844-481-8821, TTY 711 or visit our website at: www.retiree.uhc.com/postal
- Our PDP EGWP, UnitedHealthcare MedicareRx (PDP) has $0 deductible and $2,000 annual out-of-pocket maximum.

We cover drugs, medications, and supplies as described below and on the following pages.

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused drugs, medications, and supplies.
- The Medicare Part D calendar year deductible is: $0 per person.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage.
- If you choose to opt out of or disenroll from our PDP EGWP, see Section 9 for additional PDP EGWP information and for our opt-out and disenrollment process. Contact us for assistance with the PDP EGWP opt out and disenrollment process at 1-844-481-8821, TTY 711.

Warning:If you opt out of or disenroll from our PDP EGWP, you will not have any PSHB Program prescription drug coverage. However, you can enroll in our MAPD during Open Season or for a **qualifying life event (QLE)** and receive PSHB Program Prescription Drug Coverage. To learn more about our UnitedHealthcare Retiree Advantage (MAPD) and how to enroll, call us at 1-844-481-8821, 8 a.m. to 8 p.m., local time 7 days per week, For TTY for the deaf, hard of hearing, or speech impaired, call 711.

Note:If you choose to opt out of or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll during Open Season or for a QLE. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for assistance at 1-844-481-8821, TTY 711.

		Each new enrollee will receive a description of our PDP EGWP Summary of Benefits, a prescription drug plan identification card, a mail order form/patient profile and a preaddressed reply envelope. For assistance or questions, please contact us at 1-844-481-8821, TTY 711. We are available Monday through Friday, 8 a.m. - 8 p.m. local time.		

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

- **Who can write your prescription**. A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication. Your prescribers must have Medicare-approved prescriptive authority.
- **Where you can obtain prescription drugs.** You may fill prescriptions at any network pharmacy. For assistance locating a PDP EGWP network pharmacy, visit our website at https://www.retiree.uhc.com/postal, or call us at 1-844-481-8821, TTY 711.
- **We have a managed formulary.** Your provider may prescribe drugs that are subject to additional review to determine they are medically necessary. You may view our formulary on our website at https://www.retiree.uhc.com/postal, or call us at 1-844-481-8821, TTY 711.
- **Our Prescription Drug List (PDL)** consists of 4 tiers:
  - **Tier 1 Preferred Generic** - All covered generic drugs
  - **Tier 2 Preferred Brand** - Many common brand name drugs, called preferred brands
  - **Tier 3 Non preferred Drug** - Non preferred brand name drugs. In addition, Part D eligible compound medications are covered in tier 3.
  - **Tier 4 Specialty Tier** - Unique and/or very high cost brand drugs
- **These are the dispensing limitations**
  - **Quantity limits** - The plan will only cover a certain amount of this drug for 1 copay/coinsurance or over a certain number of days. These limits can help ensure safe and effective use of the drug. If you are prescribed more than this amount or your doctor or prescriber thinks the limit is not right for your situation, you or your doctor or prescriber can ask the plan to cover the additional quantity.
  - **Morphine Milligram Equivalent** - Additional quantity limits may apply to all opioid drugs used to treat pain. This additional limit is called a cumulative Morphine Milligram Equivalent (MME). It's designed to monitor safe dosing levels of opioids for people who may be taking more than 1 opioid drug for pain management. If your doctor or prescriber prescribes more than this amount or thinks the limit is not right for your situation, you or your doctor or prescriber can ask the plan to cover the additional quantity.
  - **7-day limit** - An opioid drug used to treat pain may be limited to a 7-day supply if you don't have a recent history of using opioids. This limit helps minimize long-term opioid use. If you are new to the plan and have a recent history of using opioids, the pharmacy may override the limit when appropriate.
  - Dispensing limits may apply to certain drugs limiting to a 1-month supply per prescription.
- **We may require Utilization Management strategies including:**
  - **Prior authorization** - The plan requires you or your doctor or prescriber to get prior approval for certain drugs. This means the plan needs more information from your doctor or prescriber to make sure the drug is being used and covered correctly by Medicare for your medical condition. Certain drugs may be covered by either Medicare Part B (doctor and outpatient health care) or Medicare Part D (prescription drugs) depending on how it is used. If you don’t get prior approval, the plan may not cover the drug.
  - **Step therapy** - There may be effective, lower-cost drugs that treat the same medical condition as this drug. You may be required to try 1 or more of these other drugs before the plan will cover your drug. If you have already tried other drugs or your doctor or prescriber thinks they are not right for you, you or your doctor or prescriber can ask the plan to cover this drug.
- **You may request a Formulary Exception -** Sometimes you may need to ask for drug coverage that’s not normally provided by your plan. This is called asking for an exception. When you do, the plan will review your request and give you a coverage decision known as a coverage determination. You, your authorized representative, doctor or prescriber can ask for an exception by calling Customer Service at 1-844-481-8821, TTY 711. Your doctor or prescriber must give us a supporting statement with the reason for the exception.

- Types of exceptions you can ask for:
  - **Drug List exception:** Ask the plan to cover your drug even if it's not on the Drug List. If approved, this drug will be covered at a pre-determined cost-sharing level. You will not be able to ask us to provide the drug at a lower cost-sharing level.
  - **Utilization exception:** Ask the plan to revise the coverage rules or limits on your drug. For example, if your drug has a quantity limit, you can ask the plan to change the limit and cover more.
  - **Tiering exception:** Ask the plan to cover your drug on our list at a lower cost-sharing level if this drug is not on the Specialty Tier. The plan may approve your request for an exception if the covered alternative drugs wouldn't be as effective in treating your condition or would cause adverse medical effects.

- **A generic equivalent will be dispensed if it is available** unless your physician specifically requires a brand name drug.
- **Why use generic drugs.** Generic drugs have the same active ingredients as brand name drugs. They usually cost less than brand name drugs and generally work just as well. They usually don't have well-known names. Generic drugs are approved by the Food and Drug Administration (FDA). There are generic drugs available for many brand name drugs. Depending on state laws, generic drugs usually can be substituted for brand name drugs at the pharmacy without a new prescription. Our plan covers both brand name and generic drugs. Talk with your doctor or prescriber to see if any of the brand name drugs you take have generic versions.
- **When you do have to file a claim.** You may request a reimbursement by mailing a completed Direct Member Reimbursement (DMR) form to the OptumRx Manual Claims Department. You need to include your proof of payment (your receipt) along with your request. To request a Direct Member Reimbursement (DMR) Form be mailed to you, please contact us at 1-844-481-8821, TTY 711.
- **If we deny your claim and you want to appeal,** you, your representative, or your prescriber must request an appeal following the process described in Section 8(a). Medicare PDP EGWP Disputed Claims Process. The PDP EGWP appeals process has 5 levels. If you disagree with the decision made at any level of the process, you can generally go to the next level. At each level, you'll get instructions in the decision letter on how to move to the next level of appeal.

PDP EGWP Catastrophic Maximum
If you are enrolled in our Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP), the prescription drug out-of-pocket maximum is $2,000. After this maximum is met, we pay 100% of all eligible covered prescription drug benefits.

Benefit Description	You pay	
Covered medications and supplies	**In-Network**	**Out-of-Network**
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 • Diabetic supplies limited to: - Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction - This plan covers select Erectile Dysfunction and Sexual Desire Disorder medications with quantity limits. Contact us at 844-481-8821 for more information. • Drugs to treat gender dysphoria - Estradiol - Testosterone	**Part D Retail** 1 month supply: Tier 1 - $10 Tier 2 - $45 Tier 3 - $100 Tier 4 - $100 2 month supply: Tier 1 - $20 Tier 2 - $90 Tier 3 - $200 Tier 4 - $200 3 month supply:	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**In-Network**	**Out-of-Network**
- Leuprolide • Medical foods which are determined to be the sole source of nutrition are covered under medical benefit, see Section 5 (a).	**Part D Retail** 1 month supply: Tier 1 - $10 Tier 2 - $45 Tier 3 - $100 Tier 4 - $100 2 month supply: Tier 1 - $20 Tier 2 - $90 Tier 3 - $200 Tier 4 - $200 3 month supply: Tier 1 - $30 Tier 2 - $135 Tier 3 - $300 Tier 4 - $300 **Part D Mail Order** 1 month supply: Tier 1 - $10 Tier 2 - $45 Tier 3 - $100 Tier 4 - $100 2 month supply: Tier 1 - $17.50 Tier 2 - $78.75 Tier 3 - $175 Tier 4 - $175 3 month supply: Tier 1 - $25 Tier 2 - $112.50 Tier 3 - $250 Tier 4 - $250 Note: If there is no generic equivalent available, you will still have to pay the brand name copay.	*All charges*
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines.	$0	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**In-Network**	**Out-of-Network**
Contraceptive coverage is available at no cost to PSHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can request a tiering exception described above. After we get the statement from your doctor or prescriber supporting your request for an exception, we'll give you a decision within 72 hours. You can ask for an expedited (fast) decision if you or your doctor or prescriber believes that your health could be seriously harmed by waiting 72 hours. If your request for an expedited review is approved, we'll give you a decision within 24 hours after we get your doctor's or prescriber's supporting statement. Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy. If you have difficulty accessing contraceptive coverage or other reproductive healthcare you can contact contraception@opm.gov. Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7. Note: For additional Family Planning benefits see Section 5(a) Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Educational Classes and Programs in Section 5(a)	$0	*All charges*
Not covered • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility Drugs* • *Medications prescribed to treat obesity* • *Medical foods* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Nonprescription medications*	*All charges*	*All charges*

Benefit Description	You pay	
Preventive medications	**In-Network**	**Out-of-Network**
The following are covered: • Preventive Medications with a USPSTF A and B recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations	Nothing: when prescribed by a healthcare professional and filled by a network pharmacy.	*All charges*
Opioid rescue agents such as naloxone are covered under this Plan with no cost sharing when obtained from a network pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/	$0	*All charges*
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Nonprescription medications*	*All charges*	*All charges*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your PSHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your PSHB Plan. See Section 9, *Coordinating benefits with other coverage.*
- The calendar year deductible is: $500 Self Only, $1,000 Self Plus One and Self and Family in-network and $3,000 Self Only, $6,000 Self Plus One and Self and Family out-of-network. The calendar year deductible applies to almost all benefits in this Section. We indicate "Not subject to deductible" to show when the calendar year deductible does not apply.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with other coverage,* including with Medicare.
- If you enroll in UnitedHealthcare Choice Plus Primary Plan and are covered by Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Retiree Advantage Plan to our PSHB This plan enhances your PSHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. It includes a $150.00 Part B reimbursement. The UnitedHealthcare Retiree Advantage Plan is subject to Medicare rules. (See Section 9 for additional details.)
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SERVICES AND/OR PROCEDURES.** Please refer to the preauthorization information shown in Section 3 or call customer service to be sure which services require preauthorization.

Benefit Description	You pay	
Accidental injury benefit	**In-Network**	**Out-of-Network**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. You may request an extension of this time period provided you do so within 60 days of the injury and if extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wire from fracture care). A sound natural tooth is defined as a tooth that: • has no active decay, has at least 50% bony support, • has no filling on more than two surfaces; • has no root canal treatment, is not an implant • is not in need of treatment except as a result of the accident, and • functions normally in chewing and	20% coinsurance of plan allowance	40% of the 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.)	**In-Network**	**Out-of-Network**
• Crowns, bridges, implants and dentures are not considered sound natural teeth. Benefits for treatment of accidental injury are limited to the following: • Emergency examination • Necessary X-rays /periapical and panoral radiographs • Endodontic (root canal) treatment • Emergency, temporary splinting of teeth • Prefabricated post and core • Simple minimal restorative procedures (fillings) • Emergency extractions • Post-traumatic crowns are covered if it is the only clinical treatment available • Replacement of tooth due lost due to accidental injury • Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry	20% coinsurance of plan allowance	40% of the Plan allowance and any difference between our allowance and the billed amount
Adjunctive dental services	**In-Network**	**Out-of-Network**
Benefits for dental care that is medically necessary and an integral part of the treatment of a sickness or condition for which covered health services are provided. Examples of adjunctive dental care are: • Extraction of teeth prior to radiation for oral cancer • Elimination of oral infection prior to transplant surgery • Removal of teeth in order to remove an extensive tumor Note: When alternate methods may be used, we will authorize the least costly covered health service provided that the service and supplies are considered by the profession to be an appropriate method of treatment and meet broadly accepted national standards of dental practice. You and the provider may choose a more expensive level of care, but benefits will be payable according to these guidelines.	20% coinsurance of plan allowance	40% of the 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 the teeth or their supporting structures (such as the periodontal membrane, gingiva and alveolar bone)*	*All charges*	*All charges*

Section 5(h). Wellness and Other Special Features

UnitedHealthcare's Digital Experience	At UnitedHealthcare, our mission is helping people live healthier lives®. We strive to make health care simpler and easier for you to understand with our suite of integrated consumer tools on myuhc.com®. For members who are on the go, digital resources are available on the UnitedHealthcare app — wherever and whenever they need to manage your health care. **Download the UnitedHealthcare app*** for access to health plan ID cards, benefits information and help answering questions. At home and on the go our digital resources can help you manage health and finances. You want to have the resources to make well informed financial and health care decisions. The mobile app is designed to help you manage different aspects of your health, like searching for providers and getting health care cost estimates for specific treatments and procedures. You will have access to your health plan ID card, claims information and real-time status on account balances, deductibles and out-of-pocket spending. You can find and receive care, estimate costs and pay bills directly from the app. Virtual visits can be scheduled and held from your mobile app. (24/7 virtual visits). Register with one of the UHC providers and visits are available when you are. You can reach out to an advocate from your mobile app as well. Download the UnitedHealthcare app from the App Store® or Google Play™ **Your online web portal** can assist to Find Care and Costs to help you find and price care, at the same time. Your personalized website, myuhc.com®, features tools designed to help you: • Find, price and save on care — you can save with Virtual Visits and other tools. You can save an average of 36% when you compare costs for providers and services • Get care from anywhere with Virtual Visits. A doctor can diagnose common conditions by phone or video 24/7 • Understand your benefits and the financial impact of care decisions • Find tailored recommendations regarding providers, products and services. You can even generate an out-of-pocket estimate based on your specific health plan status • Access claim details, plan balances and your health plan ID card quickly • Follow through on clinical recommendations and access wellness programs • Order prescription refills, get estimates and compare medication pricing • Check your plan balances, access financial accounts and more • Find a quality doctor, clinic, hospital or lab that helps meet their needs. • Use multiple search options to filter results by location, specialty, quality, cost, services offered and more. • See provider ratings created by patients.
Myuhc.com Behavioral Health Resources	With myuhc.com®, your personalized member website, behavioral health support services are available for you and your family to access anytime, anywhere — whether you're in a time of greater need or may want to work on personal growth. myuhc.com is available at no additional cost to you and your family.

	Find the right care for you Using the provider search tool, you can: • Locate therapists, psychiatrists or other behavioral health clinicians and facilities near you • Narrow your search by provider name, location, area of expertise and more • Schedule an in-person or virtual appointment with the provider you select Tap into behavioral health support See which benefits and programs you may be eligible for at myuhc.com. Once there, you can also visit your personalized emotional support page to explore the resources and tools that may help you with the ins and outs of everyday life — even if you might not have any pressing concerns. Tools and resources at your fingertips: Learn about a variety of behavioral health and well-being topics at myuhc.com Health Resources>Mental Health and Substance Use. You'll get access to: • Articles • Podcasts • Videos • Other tools To find behavioral health care, sign in or register on myuhc.com and then go to Find Care Behavioral Health Directory
Sanvello/ Self Care by Able To	Support for those looking to manage day-to-day stress or those who need but are not yet ready to seek treatment or are looking for an adjunct to treatment. This program delivers personalized, on-demand support that can be accessed anytime, anywhere to help you build resilience with new skills and daily habits. • Assessments and tracking • Mental health skills and tools – Cognitive Behavioral Therapy skills, mediations and mindful techniques and sleep tracking • Interactive activities and content to assist with specific needs such as parenting stress, work-related burnout or coping with social injustice • Community support – Peer to peer sharing and learning, see others' experiences.
Real Appeal - A Lifestyle and Weight Management Program	Real Appeal® provides tools and support to help members lose weight and prevent weight- related health conditions. Real Appeal is provided **at no additional cost** to eligible members as part of your medical benefit plan. The program can help motivate members to improve their health and reduce risk of developing costly, chronic conditions like cardiovascular disease and diabetes. The program combines clinically proven science with engaging content that teaches members how to eat healthier and be active, without turning their lives upside down, to help them achieve and maintain their weight-loss goals. Real Appeal includes: **Social community resources such as:** Real Appeal LinkedIn community; Facebook community; YouTube videos including getting started, workouts and success stories **A Success Kit** - After attending their first group coaching session, members receive a Success Kit with tools to help them kick-start their weight loss. The kit includes items such as:

	• Balanced Portion plate • Electronic food scale • Digital weight scale • Fitness guide **A personalized Health Coach** - Coaches guide members through the program step- by-step, customizing it to help fit their needs, personal preferences, goals and medical history. 24/7 online support and mobile app through our myuhc portal or directly through our myuhc mobile app. Staying accountable to goals may be easier than ever. • Customizable food, activity, weight and goal • Unlimited access to digital • An online lifestyle program to help you learn new ways to be your healthiest self
UHC Rewards and One Pass Select	Your health plan comes with a new way to earn up to $300. With UnitedHealthcare Rewards, you can earn up to $300 for tracking your steps or sleep, getting an annual checkup and more. The activities you go for are up to you. When you activate UHC Rewards, you can also get started with One Pass Select™, a fitness program that gives you unlimited access to a nationwide network of thousands of fitness centers. Plus, you can use your earnings to help pay for a One Pass Select membership. Start earning with UHC Rewards by: • Download the UnitedHealthcare® app and then: Sign in or register • Select UHC Rewards • Activate UHC Rewards • Select Redeem rewards to access One Pass Select **UnitedHealthcare Rewards** is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you. If any fraudulent activity is detected (e.g., misrepresented physical activity), you may be suspended and/or terminated from the program. If you are unable to meet a standard related to health factor to receive a reward under this program, you might qualify for an opportunity to receive the reward by different means. You may call us toll-free at 1-866-230-2505 or at the number on your health plan ID card, and we will work with you (and, if necessary, your doctor) to find another way for you to earn the same reward. Rewards may be limited due to incentive limits under applicable law. Components subject to change. This program is not available for fully insured members in Hawaii, Vermont and Puerto Rico. **One Pass Select** is a voluntary program featuring a subscription-based nationwide gym network, digital fitness and grocery delivery service. The information provided under this program is for general informational purposes only and is not intended to be nor should it be construed as medical advice. Individuals should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for them. Purchasing discounted gym and fitness studio memberships, digital fitness or grocery delivery services may have tax implications. Employers and individuals should consult an appropriate tax professional to determine if they have any tax obligations with respect to the purchase of these discounted memberships or services under this program, as applicable. One Pass Select is a program offered by Optum. Subscription costs are payable to Optum.

Smoking Cessation Program	Quit for Life provides our members with resources and support for tobacco cessation. Included are: • Portal and mobile app • Online learning with interactive and personalized content and a community support forum • Integrated online and telephonic experience • Live coaching sessions with coaches with degrees in counseling, addiction studies, and related fields • Nicotine replacement therapy counseling • 24/7 support for easier access to services • Nicotine replacement therapy both prescription medications and over the counter products (with prescription)
Maternity Health Solutions	Maternity Health Solutions is designed to help improve outcomes and lower costs by providing moms-to-be with personalized care for clinical, behavioral and other holistic needs. • Maternity-related courses available on com regarding course topics such as: - Preconception: Preparing for a healthy pregnancy - Pregnancy in the first trimester - Pregnancy in the second trimester - Pregnancy in the third trimester - The fourth trimester after pregnancy: Postpartum - Pregnancy nutrition and exercise - Exploring breastfeeding • Maternity risk assessment on www.myuhc.com • Additional support for high-risk cases
UnitedHealth Premium	Choosing a doctor is one of the most important health decisions you'll make. The UnitedHealth Premium® program can help you find doctors who are right for you and your family. You can find quality, cost-efficient care. Studies show that people who actively engage in their health care decisions have fewer hospitalizations, fewer emergency visits, higher utilization of preventive care and overall lower medical costs. The program evaluates physicians in various specialties using evidence-based medicine and national standardized measures to help you locate quality and cost- efficient providers. It's easy to find a UnitedHealth Premium Care Physician. Just go to **www.myuhc.com®**and click on Find a Doctor. Choose smart. Look for blue hearts. • **Premium Care Physician** meets UnitedHealth Premium program quality & cost efficient care criteria. • **Quality Care Physician** meets UnitedHealth Premium program quality care criteria, but does not meet the program's cost efficient care criteria or is not evaluated for cost-efficient care. Physician is not eligible for a Premium designation. • **Not Evaluated for Premium Care** physician's specialty is not evaluated and/or does not have enough claims data for program evaluation or the physician's program evaluation is in process.

Specialty Pharmacy	**What are the benefits of using Optum Specialty Pharmacy?** Optum Specialty Pharmacy provides personalized support and resources at no extra cost to help you manage your condition. **How does Optum Specialty Pharmacy support you?** • Pharmacists to answer questions 24/7 • A clinical care team to help you understand your medication • 1-on-1 video chats with your care team • Helpful videos from other specialty patients • Supplies you may need to take your medication at no extra cost • Refill reminders • Talk with a nurse about infusion services, if applicable **Tips for working with our Optum Specialty Pharmacy care team.** • Tell your pharmacist or nurse about any side effects or issues you may be facing with your care, such as forgetting to take your medication. • We're here to help with more than your medication. Our pharmacists and nurses can help you find resources to stay on track with your health. We're here to help. Call Optum Specialty Pharmacy at 1-855-427-4682 to learn more and transfer your prescriptions. Or, call the number on the back of your member ID card to find a designated specialty pharmacy near you.
Flexible Benefits Option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Cancer Clinical Trials	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)* • *VeteransAdministration(VA)* The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals. Benefits are not available for preventive clinical trials. The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.
Medicare Part B Reimbursement for Retiree Advantage Members	Receive reimbursement for your Medicare Part B Premium • $150.00 will be paid on your behalf directly to Medicare • See a reduction in your quarterly Medicare bill, or an increase in your Social Security payment or annuity payment • Receive this benefit for every month you're enrolled in the plan
Renew Active Fitness Program for Retiree Advantage Members	Renew Active is a fitness benefit which is included in the Retiree Advantage plan which provides: • A free gym membership to participating facilities - To view participating facilities, please visit www.uhcrenewactive.com • Access to an extensive network of gyms and fitness locations near members • A personalized fitness plan • Access to a wide variety of fitness classes • An online brain health program, exclusively from AARP® Staying Sharp • Connecting with others at local health and wellness events, and through the Fitbit® Community for Renew Active
First Line Essentials for Retiree Advantage Members	Shop for hundreds of over-the-counter items such as toothpaste, vitamins, and personal care from the Health Products catalog. • Members will receive $40 allowance each quarter to spend on items from the provided catalog • Items are delivered directly to your door • Orders can be placed over the phone, by mail, or online
HouseCalls for Retiree Advantage Members	With the UnitedHealthcare® HouseCalls program, you get an annual in-home preventive care visit from one of our health care practitioners at no extra cost. What does HouseCalls include? • One 45 to 60-minute at-home visit from a health care practitioner, each year. • A head-to-toe exam, health screenings and plenty of time to talk about your health questions. • A custom care plan made just for you. • Help connecting you with additional care you may need.

Healthy at Home for Retiree Advantage Members	Healthy at Home provides the following benefits up to 30 days following all inpatient and skilled nursing facility discharges when referred by a UnitedHealthcare Advocate: • Home-Delivered Meals - Receive 28 home-delivered meals provided by Mom's Meals • Non-emergency transportation - Receive 12 one-way rides to medically related appointments and to the pharmacy provided by ModviCare • In-home Personal Care - Receive 6 hours of in-home personal care through our exclusive national provider CareLinx
Real Appeal for Retiree Advantage Members	Real Appeal is a weight loss program that can help members feel and look better. The program provides everything they need to lose weight and keep it off. The online program includes: • Personalized diabetes prevention coaching • 24/7 online support and mobile app • Customizable food, activity, weight and goal trackers • Success group support, which lets members chat with others who are doing the Real Appeal program • The weekly Real Appeal All-Star Show featuring healthy tips from celebrities, athletes and health experts After attending their first group coaching session, members receive a Success Kit with tools to help them kick-start their weight loss. Success Kit includes: • Program, nutrition, and fitness guides • Tools to help cook healthier, tasty meals
UnitedHealthcare Hearing for Retiree Advantage Members	UnitedHealthcare Hearing provides members with greater technology, choice and convenience • Rechargeable hearing aids, remote adjustments and other advanced feature devices are available at up to 80% less than standard industry prices through direct delivery, including top brands in multiple styles • 6,500+ locations nationwide • Chose home delivery or in person options • 3-minute online hearing test to assess hearing loss/need for in-person test • Members receive $1500 allowance every 36 months towards the purchase of hearing aids • Members must use a UHC hearing provider to use their hearing aid benefit

PERS (Personal Emergency Response System) for Retiree Advantage Members	**UnitedHealthcare®** works with Lifeline to provide a personal emergency response system at no cost for Retiree Advantage plan members Lifeline personal emergency response system (PERS) allows you to ask for help whenever you need it, anytime of day or night – 365 days of the year, 24/7. All you need to do is press the help button, worn as a wristband or pendant, and a Trained Care Specialist will assist you to make sure you quickly get the help you need. **Features include:** • Optional AutoAlert fall detection technology automatically provides access to help if it detects a fall – even if wearer is disoriented, immobilized or unconscious and cannot press their help button • Cellular or landline compatible, Lifeline works anywhere in the U.S., where current telephone service is provided • Lightweight, waterproof help button can be worn on the wrist or as a pendant
Quit For Life for Retiree Advantage Members	Quit For Life has helped 3.5 million members quit smoking or using tobacco. It provides the tools and one-on-one support to help you quit your way. And for UnitedHealthcare members, it's offered at $0 out of pocket. With a 95% satisfaction rate, Quit for Life provides: • Tools and support to help members quit cigarettes, e-cigarettes, vaping and tobacco • A personal, one-on-one Quit Coach to help you create a customized quit plan • The Quit for Life mobile app, which offers 24/7 urge management support • Text2Quit text messages for daily tips and encouragement • Quit medications – Such as nicotine gum or patches – for no charge, based on eligibility

Non-PSHB Benefits Available to Plan Members

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

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

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

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

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

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

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

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

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

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

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

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

We do not cover the following:

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

Section 7. Filing a Claim for Covered Services

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

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

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

Medical and hospital benefits

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

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

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

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

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

Prescription drugs

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

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

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

Other supplies or services

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

Deadline for filing your claim

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

When we need more information	Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond.
Post-service claims procedures	We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected. If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information. If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.
Authorized Representative	You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a healthcare professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.
Notice Requirements	If you live in a county where at least 10% of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as 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 healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website. If you are a Postal Service annuitant, or their covered Medicare-eligible family member, enrolled in our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP) and you disagree with our **pre-service or post-service** decision about your prescription drug benefits, please, follow Medicare's appeals process outlined in Section 8(a) Medicare PDP EGWP Disputed Claims Process.

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing UnitedHeathcare, Postal Service Health Benefits Program at P.O. Box 30432, Salt Lake City, UT 84130-0432 or by calling 1-877-835-9861.

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

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

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

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: UnitedHealthcare, Postal Service Health Benefit (PSHB) Program Appeals, P.O. Box 30573, Salt Lake City, UT 84130-0573; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

Step	Description
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or c) Ask you or your provider for more information You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Postal Service Insurance Operations (PSIO), 1900 E Street, room 3443, NW, Washington, DC 20415. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. • Your email address, if you would like to receive OPM’s decision via email. Please note that by providing your email address, you may receive OPM’s decision more quickly. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim. Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision or notify you of the status of OPM’s review within 60 days. There are no other administrative appeals. If you do not agree with OPM’s decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

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

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

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 877-835-9861. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's PSIO at 202-936-0002 between 8 a.m. and 5 p.m. Eastern Time.

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

Reminder: If you are a Postal Service annuitant, or their covered Medicare-eligible family member, enrolled in our Medicare Part D PDP EGWP you may appeal an adverse pre-service or post-service determination through Medicare's appeals process. See Section 8(a).

Section 8(a). Medicare PDP EGWP Disputed Claims Process

When a claim is denied in whole or in part, you may appeal the denial.

Our Plan follows the Medicare Part D appeals process.

How to appeal a decision about your prescription coverage

Appeal Level 1 - You may ask us to review an unfavorable coverage decision we've issued to you, even if only part of our decision is not what you requested. An appeal to the plan about a Medicare Part D drug is also called a plan "redetermination."

Appeal Level 2 – If we reviewed your appeal at "Appeal Level 1" and did not decide in your favor, you have the right to appeal to the Independent Review Entity (IRE).

When we receive your request to review the adverse coverage determination, we give the request to people at our organization not involved in making the initial determination. This helps ensure that we give your request a fresh look.

Note: The Redetermination Request Form can be found under Resources tab at: https://retiree.uhc.com/postal

To file an appeal:

Write a letter describing your appeal, and include any paperwork that may help in the research of your case. Provide your name, your member identification number, your date of birth, and the drug you need.

You may also request an appeal by downloading and mailing in the Redetermination Request Form or by secure email: topartd_ag@uhc.com.

Send the letter or the Redetermination Request Form to:

Medicare Part D Appeals and Grievance Department
PO Box 6106
M/S CA 124-0197
Cypress CA 90630-9948

You may also fax your letter of appeal to the Medicare Part D Appeals and Grievances Department at 1-866-308-6294.

You must mail your letter within 65 days of the date the adverse determination was issued, or within 65 days from the date of the denial of reimbursement request. If you missed the 65-day deadline, you may still file your appeal if you provide a valid reason for missing the deadline.

You can also submit an appeal online at https://memberforms.uhc.com/MR-AppealsandGrievance.html

Note: if you are requesting an expedited (fast) appeal, you may also contact Customer Service at 1-844-481-8821, TTY 711

The Medicare Part D Appeals and Grievance Department will look into your case and respond with a letter within 7 calendar days of receiving your request. You'll receive a letter with detailed information about the coverage denial.

To inquire about the status of an appeal, contact Customer Service at 1-844-481-8821, TTY 711.

How soon must you file your appeal?

You must file the appeal request within 65 calendar days from the date included on the notice of our initial determination. We may give you more time if you have a good reason for missing the deadline.

How soon will we decide on your appeal?

- For a standard decision regarding reimbursement for a Medicare Part D drug you have paid for and received and for standard appeal review requests for drugs you have not yet received:
  - We will give you our decision within 7 calendar days of receiving the appeal request. If we do not give you our decision within 7 calendar days, your request will automatically go to Appeal Level 2 (Independent Review Entity).
- For a fast decision about a Medicare Part D drug that you have not yet received.
  - We will give you our decision within 72 hours after receiving the appeal request. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2.

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

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

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

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

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

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

Please see Section 4, *Your Costs for Covered Services*, for more information about how we pay claims.

- **TRICARE and CHAMPVA**

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

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

- **Workers' Compensation**

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

We do not cover services that:

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

- **Medicaid**

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

Suspended PSHB coverage to enroll in Medicaid or a similar state-sponsored program of medical assistance: If you are an annuitant, you can suspend your PSHB coverage to enroll in one of these state programs, eliminating your PSHB premium. For information on suspending your PSHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the PSHB 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 PSHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your PSHB 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 PSHB plan so that your plans can coordinate benefits. Providing your PSHB information may reduce your out-of-pocket cost.

Clinical trials

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

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

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

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

When you have Medicare

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

Important Note: Subject to limited exceptions, Postal Service annuitants entitled to Medicare Part A and their eligible family members who are entitled to Medicare Part A are required to enroll in Medicare Part B to maintain eligibility for the PSHB Program in retirement.

If you are required to enroll in Medicare Part B and fail to do so at your first opportunity, you may be disenrolled (annuitants) and/or your family members removed from coverage.

For more information on these requirements, please contact us at 877-835-9861.

The Original Medicare Plan (Part A or Part B)

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

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

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

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

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

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 1-877-835-9861 or see our website at www.myuhc.com.

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

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

Benefit Description: Deductible
High Option You pay without Medicare: In Network - $500 Self Only; $1,000 Self Plus One or Self and Family
High Option You pay with Medicare Part B: In Network - $500 Self Only; $1,000 Self Plus One or Self and Family

Benefit Description: Catastrophic Protection Out-of-Pocket Maximum
High Option You pay without Medicare: In Network - $3,000 Self Only; $6,000 Self Plus One or Self and Family
High Option You pay with Medicare Part B: In Network - $3,000 Self Only; $6,000 Self Plus One or Self and Family

Benefit Description: Part B Premium Reimbursement Offered
High Option You receive without Medicare: NA
High Option You receive with Medicare Part B: NA

Benefit Description: Primary Care Provider
High Option You pay without Medicare: In Network - $0 copayment - not subject to deductible
High Option You pay with Medicare Part B: In Network - $0 copayment - not subject to deductible

Benefit Description: Specialist
High Option You pay without Medicare: In Network - $60 copayment - not subject to deductible
High Option You pay with Medicare Part B: In Network - $60 copayment - not subject to deductible

Benefit Description: Inpatient Hospital
High Option You pay without Medicare: In Network - 20% after deductible
High Option You pay with Medicare Part B: In Network - 20% after deductible

Benefit Description: Outpatient Hospital
High Option You pay without Medicare: In Network - 20% after deductible
High Option You pay with Medicare Part B: In Network - 20% after deductible

Benefit Description: Incentives offered
High Option You receive without Medicare: NA
High Option You receive with Medicare Part B: NA

- **Tell us about your Medicare coverage**

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

- **Medicare Advantage (Part C)**

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

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

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

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

You may enroll in the UnitedHealthcare Retiree Advantage Plan if:

- You are enrolled in this UnitedHealthcare PSHB plan and have both Medicare Part A and Part B
- You are retired and live in our geographic service area
- You are a United States citizen or are lawfully present in the United States
- You do NOT have End-Stage Renal Disease (ESRD), with limited exceptions
- You complete an application for enrollment in the UnitedHealthcare Retiree Advantage Plan.

As part of this process CMS will verify your Medicare Part B enrollment. If the PSHB subscriber and/or dependent enrolls in the Retiree Advantage plan, each family member will have to complete an application by calling into our Retiree Solutions team (1-844-481-8821).

I**f you enroll in the UnitedHealthcare Retiree Advantage Plan do not suspend or terminate your PSHB plan or all benefits will be termed in both PSHB and UnitedHealthcare Retiree Advantage and you will be without any coverage.** Members who are not eligible for Medicare Part A and B will remain on the PSHB plan. If, for any reason, you do not meet the enrollment requirements, you will no longer be eligible to participate in the Retiree Advantage plan. Your contributions will end and your regular PSHB benefits will resume. You may be required to repay any reimbursements paid to you in error.

We offer a plan designed:

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

The UnitedHealthcare Retiree Advantage plan provides monthly **reimbursement of $150.00 of your Medicare Part B monthly premium.** In addition, we cover benefits, including office visit copayments at ($0), for urgent care and emergency care plus coverage for hearing aid discounts and wellness programs.

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

This Plan and another plan's Medicare Advantage plan: You may enroll in another non-PSHB plan's Medicare Advantage plan and also remain enrolled in our PSHB 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 PSHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant, you can suspend your PSHB coverage to enroll in a Medicare Advantage plan, eliminating your PSHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your PSHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the PSHB 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.

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

Benefit Description: Deductible
Member Cost without Medicare (In Network): $500 Self Only; $1,000 Self Plus One and $1,000 Self and Family
Member Cost with Medicare Part B (In Network): $500 Self Only; $1,000 Self Plus One and $1,000 Self and Family
Member Cost with UnitedHealthcare Retiree Advantage Health Plan: No plan deductible

Benefit Description: Out-of-Pocket Maximum
Member Cost without Medicare (In Network): $7,350 Self Only; $14,700 Self Plus One and $14,700 Self and Family
Member Cost with Medicare Part B (In Network): $7,350 Self Only; $14,700 Self Plus One and $14,700 Self and Family
Member Cost with UnitedHealthcare Retiree Advantage Health Plan: You pay nothing for Medicare-covered service from any provider

Benefit Description: Primary Care Physician
Member Cost without Medicare (In Network): $0
Member Cost with Medicare Part B (In Network): $0
Member Cost with UnitedHealthcare Retiree Advantage Health Plan: $0

Benefit Description: Specialist
Member Cost without Medicare (In Network): $60 per visit
Member Cost with Medicare Part B (In Network): $60 per visit
Member Cost with UnitedHealthcare Retiree Advantage Health Plan: $0

Benefit Description: Virtual Visits
Member Cost without Medicare (In Network): $0
Member Cost with Medicare Part B (In Network): $0
Member Cost with UnitedHealthcare Retiree Advantage Health Plan: $0

Benefit Description: Urgent Care
Member Cost without Medicare (In Network): $50 per visit
Member Cost with Medicare Part B (In Network): $50 per visit
Member Cost with UnitedHealthcare Retiree Advantage Health Plan: $0

Benefit Description: Emergency
Member Cost without Medicare (In Network): 20% after deductible
Member Cost with Medicare Part B (In Network): 20% after deductible
Member Cost with UnitedHealthcare Retiree Advantage Health Plan: $0

Benefit Description: Inpatient Hospital
Member Cost without Medicare (In Network): 20% after deductible
Member Cost with Medicare Part B (In Network): 20% after deductible
Member Cost with UnitedHealthcare Retiree Advantage Health Plan: $0

Benefit Description: Outpatient Hospital
Member Cost without Medicare (In Network): $250 copayment after deductible
Member Cost with Medicare Part B (In Network): $250 copayment after deductible
Member Cost with UnitedHealthcare Retiree Advantage Health Plan: $0

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

When we are the primary payor, we process the claim first. If you (as an active employee eligible for Medicare Part D or their covered Medicare Part D-eligible family member) enroll in any open market Medicare Part D plan and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by that Medicare Part D plan and consider them for payment under the PSHB plan.

Note: If you are a Postal Service annuitant or their covered Medicare-eligible family member enrolled in our Medicare Part D PDP EGWP, this does not apply to you because you may not be enrolled in more than one Medicare Part D plan at the same time. If you opt out of or disenroll from our PDP EGWP you do not have our PSHB Program prescription drug coverage and we are not a secondary payor for prescription drug benefits.

- **Medicare Prescription Drug Plan (PDP) Drug Plan Employer Group Waiver Plan (EGWP)**

If you are enrolled in Medicare Part A and/or Part B, and are not enrolled in our Medicare Advantage Prescription Drug Plan (MAPD), you will be automatically group enrolled into our Medicare PDP EGWP. Our PDP EGWP is a prescription drug benefit for Postal Service annuitants and their covered Medicare-eligible family members. This allows you to receive benefits that will never be less than the standard prescription drug coverage that is available to members with non-PDP EGWP prescription drug coverage. But more often you will receive benefits that are better than members with standard non-PDP EGWP prescription drug coverage. **Note:You have the choice to opt out of or disenroll from our PDP EGWP at any time and may obtain prescription drug coverage outside of the PSHB Program.**

When you are enrolled in our Medicare PDP EGWP for your prescription drug benefits you continue to have our medical coverage.

Members with higher incomes may have a separate premium payment for their Medicare Part D Prescription Drug Plan (PDP) benefit. Please refer to the Part D-IRMAA section of the Medicare website: https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to an additional premium.

For people with limited income and resources, Extra Help is a Medicare program to help with Medicare prescription drug plan costs. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213 TTY 800-325-0778. Many people quality for Extra Help and don't know it. There's no penalty for applying, and you can re-apply every year.

The PDP EGWP opt out process:

If you were automatically group enrolled into our PDP EGWP and choose to opt out, you can opt out by contacting us (844) 481-8821, 8 a.m. to 8 p.m., local time 7 days per week, For TTY for the deaf, hard of hearing, or speech impaired, call 711.

The PDP EGWP disenrollment process:

When you are enrolled in our PDP EGWP, you may choose to disenroll at any time. To disenroll from MedicareRx (PDP) please contact us at (844) 481-8821, TTY 711.

Warning:If you opt out of or disenroll from our PDP EGWP, you will not have any PSHB Program prescription drug coverage. However, you can enroll in our MAPD during Open Season or for a QLE and receive PSHB Program Prescription Drug Coverage. For more information on how to enroll in the Retiree Advantage plan, contact us at (844) 481-8821, TTY 711.

Note:If you choose to opt out of or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll when and if you are eligible. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for assistance at 1-844-481-8821, TTY 711.

Once you become a MedicareRx (PDP) or Retiree Advantage plan member, you will receive a letter to confirm you have had continuous prescription drug coverage. If you had coverage through the UnitedHealthcare FEHB or PSHB health plan or another FEHB or PSHB plan since you became Medicare eligible, you had what is known as “creditable coverage” and a penalty will not apply. You simply need to respond to the letter as quickly as possible to avoid an unnecessary penalty.

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 PSHB coverage on your own as an active employee		✓
2) Have PSHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have PSHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Postal Service and your position is excluded from the PSHB (your employing office will know if this is the case) and you are not covered under PSHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Postal Service and your position is not excluded from the PSHB (your employing office will know if this is the case) and...		
• You have PSHB coverage on your own or through your spouse who is also an active employee		✓
• You have PSHB coverage through your spouse who is an annuitant	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a Postal employee receiving Workers' Compensation		✓*
8) Are a Postal employee receiving disability benefits for six months or more	✓	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30-month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30-month coordination period)**		✓
• Medicare based on ESRD **(after the 30-month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have PSHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have PSHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	

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

Section 10. Definitions of Terms We Use in This Brochure

Assignment

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

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

Calendar year

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

Clinical trials cost categories

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

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

Coinsurance

See Section 4, page 23

Copayment

See Section 4, page 23

Cost-sharing

See Section 4, page 23

Covered services

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

Deductible

See Section 4, page 23

Experimental or investigational services

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 (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational).
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Healthcare professional

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

Infertility

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

Medical necessity

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

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

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

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

Medicare Part A

Part A helps cover inpatient hospital stays, skilled nursing facility care, hospice care, and some health care.

Medicare Part B

Part B covers medically necessary services like doctors' services and tests, outpatient care, home health services, durable medical equipment, and other medical services.

Medicare Part C	Part C is a Medicare Advantage plan that combines the coverage of Medicare Part A and Part B. Part C typically also covers additional benefits like, dental, vision, and hearing services. Some Part C plans also include Medicare Part D coverage.
Medicare Part D	Medicare Part D plans provide coverage for prescription drugs. Private insurers contract with CMS on an annual basis for the right to offer Part D plans. Part D can be offered as a standalone Prescription Drug plan (PDP) or as part of a Medicare Advantage Prescription Drug plan (MAPD).
Medicare Part D EGWP	A Medicare Part D Employer Group Waiver Plan (EGWP) is a type of Medicare prescription drug plan that can be offered to employees and retirees of certain companies, unions, or government agencies, which allows for flexibility and enhanced coverage of traditional Medicare pharmacy benefits. Examples of Medicare Part D EGWPs are Medicare Advantage Prescription Drug (MAPD) plan EGWPs that include both health and drug benefits, as well as Prescription Drug Plan (PDP) EGWPs, which only cover the prescription drug benefit.
Plan allowance	Allowable expense (plan allowance) is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. You should also see Important Notice About Surprise Billing – Know Your Rights in Section 4 that describes your protections against surprise billing under the No Surprises Act.
Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.
Pre-service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
Surprise bill	An unexpected bill you receive for: • emergency care – when you have little or no say in the facility or provider from whom you receive care, or for • non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for • air ambulance services furnished by nonparticipating providers of air ambulance services.

Unproven service(s)

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

- Well-conducted randomized controlled (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 (Patients who receive study treatment are compared to a group of patients who receive standard therapy). The comparison group must be nearly identical to the study treatment group.

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

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

Urgent care claims

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

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

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

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

Us/We

Us and We refer to UnitedHealthcare Insurance Company, Inc.

You

You refers to the enrollee and each covered family member.

Index

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

Summary of Benefits - Choice Plus Primary Postal East - 2025

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this PSHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.uhcfeds.com.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- This plan has point of service benefits which allow you to see non Plan providers however; you will save money if you obtain your services from in network providers.
- All benefits are subject to deductible unless noted as not subject to deductible. The calendar year deductible is: $500 Self Only, $1,000 Self Plus One and Self and Family in-network and $3,000 Self Only, $6,000 Self Plus One and Self and Family out-of-network.
- All benefits are subject to deductible unless noted: Not subject to deductible.

High Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	In-network: Primary care provider (PCP) You pay nothing - not subject to deductible Out-of-network: 40% of the Plan allowance and any difference between the Plan allowance and the billed amount **Specialist:** In-network: $60 copayment - not subject to deductible Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount	30
Medical Services provided by physicians: Routine Preventive Care	In-network covered at 100% Out-of-Network you pay all charges	32
Services provided by a hospital: Outpatient Surgical	In-network: 20% coinsurance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount	60
Services provided by a hospital: Inpatient	In-network: 20% coinsurance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount	59
Emergency benefits: Ambulance - emergency services	In-network: 20% coinsurance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount	64
Emergency benefits: Emergency Room	In-network : 20% coinsurance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount	64

High Option Benefits	You pay	Page
Mental health and substance use disorder treatment**:**	Regular cost sharing	65
Prescription drugs: Retail Pharmacy	In-network benefits only: Up to 30-day supply at retail Tier 1: $10 copayment Tier 2: $50 copayment Tier 3: $100 copayment Tier 4: $200 copayment Subject to pharmacy deductible for Tier 3 and Tier 4. See "Deductible" below	71
Prescription drugs: Mail order	In-network benefits only: Up to 90-day supply through mail order Tier 1: $25 copayment Tier 2: $125 copayment Tier 3: $250 copayment Tier 4: $500 copayment Subject to pharmacy deductible for Tier 3 and Tier 4. See "Deductible" below.	71
Specialty drugs (30-day) supply:	Available through in-network designated Specialty Pharmacy Only Tier 1: $10 Tier 2: $150 Tier 3: $350 Tier 4: $500	71
Medicare PDP EGWP	In-network benefits only: Retail (up to 30 day supply) Tier 1: $10 Tier 2: $45 Tier 3: $100 Tier 4: $100 Mail Order (up to 90 day supply) Tier 1: $25 Tier 2: $112.50 Tier 3: $250 Tier 4: $250	77
Dental care: Accidental Injury	In-network : 20% coinsurance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount	81
Annual Deductible:	In-network • $500 Self Only, $1,000 Self Plus One and Self and Family Out-of-network:	23

	• $3,000 Self Only, $6,000 Self Plus One and Self and Family Pharmacy: • Applies only to Tier 3 and Tier 4, $250 Self Only; $500 Self Plus One and Self and Family - Does not apply to the specialty pharmacy	
Protection against catastrophic costs (out-of-pocket maximum):	You pay nothing after: In-network: • $7,350 Self Only • $14,700 Self Plus One and Self and Family Out-of-Network: • $15,000 Self Only • $30,000 Self Plus One and Self and Family	23
Vision Care:	Routine eye examination for children as described in the Bright Future Guidelines is covered at 100% In-network: 20% coinsurance Out-of-Network: 40% of the Plan allowance and any difference between our allowance and the billed amount	40
Wellness and Special features:	UnitedHealthcare mobile app, Smoking Cessation, Maternity Health Solutions, Orthopedic Health Support, UnitedHealth Premium, Real Appeal, Specialty Pharmacy, Flexible Benefits Option, Cancer Clinical Trials, UHC Rewards and One Pass	87
Non-PSHB Benefits Available to Plan Members	PPO Dental Plan, UnitedHealthcare Hearing, UHC Rewards and One Pass, SafeTrip and other individual insurance products	91

2025 Rate Information for UnitedHealthcare Insurance Company, Inc. - Choice Plus Primary Postal East

To compare your PSHB health plan options please go to https://health-benefits.opm.gov/PSHB/.

To review premium rates for all PSHB health plan options please go to **www.opm.gov/healthcare-insurance/pshb/premiums/**

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Self	JYA	$286.09	$112.85	$619.86	$244.51
Self Plus One	JYC	$618.40	$239.35	$1,339.87	$518.59
Self and Family	JYB	$672.95	$270.58	$1,458.06	$586.26