Compass Rose Health Plan

www.compassrosebenefits.com

888-438-9135

2021

A Fee-for-Service Plan (High Option) with a Preferred Provider Organization

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 12 for details.

Who may enroll in this Plan: Civilian Active and Retired employees of the following organizations:

Central Intelligence Agency (CIA)
Defense Intelligence Agency (DIA)
Department of Defense/ Civilian and Civilian Retirees (DOD)
Department of Energy, Office of Intelligence and Counterintelligence
Department of Homeland Security, Office of Intelligence and Analysis
Department of State
Department of Treasury, Office of Intelligence and Analysis
Drug Enforcement Administration, Intelligence Division
Federal Bureau of Investigation (FBI)
National Geospatial-Intelligence Agency (NGA)
National Reconnaissance Office (NRO)
National Security Agency (NSA)
Office of DNI (ODNI) and Affiliated Centers
Office of Naval Intelligence
United States Agency for International Development (USAID)
United States Coast Guard (USCG)

Membership dues: There are no membership dues.

IMPORTANT
- Rates: Back Cover
- Changes for 2021: Page 14
- Summary of Benefits: Page 108

Enrollment codes for this Plan:

421 - Self Only
423 - Self Plus One
422 - Self and Family

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 72-007

Important Notice from the Compass Rose Health Plan About Our Prescription Drug Coverage and Medicare

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

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

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

Please Be Advised

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

Medicare's Low Income Benefits

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

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

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

Table of Contents

Introduction

This brochure describes the benefits of the Compass Rose Health Plan under contract (CS 1065) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 888-438-9135 or through our website: www.compassrosebenefits.com. The address for the Compass Rose Health Plan claims office is:

UMR
P.O. Box 8095
Wausau, WI 54402-8095

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2021, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2021, and changes are summarized on page 14. Rates are shown at the end of this brochure.

Plain Language

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

• Except for necessary technical terms, we use common words. For instance, "you" means the enrollee and each covered family member; "we" means the Compass Rose Health Plan.

• We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.

• Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

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

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

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

• Do not give your plan identification (ID) number over the phone or to people you do not know, except for your health care provider, 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 explanation of benefits (EOBs) statements that you receive from us.

• Periodically review your claims history for accuracy to ensure we have not been billed for services you did not receive.

• Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.

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

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

- If the provider does not resolve the matter, call us at 888-438-9135 and explain the situation.

- If we do not resolve the issue:

CALL – THE HEALTH CARE FRAUD HOTLINE

877-499-7295

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

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

You can also write to:

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

• Do not maintain as a family member on your policy:

- Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or

- Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26). A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

• If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).

• Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain FEHB benefits, trying to or obtaining services or coverage for yourself or for someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.

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

Discrimination is Against the Law

The Compass Rose Health Plan complies with all applicable Federal civil rights laws, including Title VII of the Civil Rights Act of 1964.

You can also file a civil rights complaint with the Office of Personnel Management by mail at: Office of Personnel Management Healthcare and Insurance Federal Employee Insurance Operations, Attention: Assistant Director FEIO,1900 E Street NW, Suite 3400-S, Washington, D.C. 20415-3610.

Preventing Medical Mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medication or give your doctor and pharmacist a list of all the medication and dosages 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 the pharmacist about your medicine 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?
- Do not assume the results are fine if you do not get them when expected. Contact your health care 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 health care you need.

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

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

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

Patient Safety Links

For more information on patient safety, please visit:

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

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

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

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

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

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

Preventable Health Care 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 health care facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error. The Compass Rose Health Plan utilizes The Centers for Medicare and Medicaid Services policy for Never Events. Claims must be submitted for Never Events using specific codes. There is no financial responsibility for the Plan or the member.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

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

- **Minimum value standard**

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

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

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

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

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

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

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

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

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

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

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

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

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

- **Family Member Coverage**

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

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

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

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

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

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

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

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2021 benefits of your prior plan or option**. If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2020 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

You may be eligible for spouse equity coverage or assistance with enrolling in a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

If you are divorced from a Federal employee, or an annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the Spouse Equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices. You can also visit OPM's website, www.opm.gov/healthcare-insurance/healthcare/plan-information/guides. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

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

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 26, regardless of marital status, etc.

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/healthcare/plan-information/guides. It explains what you have to do to enroll.

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

- **Finding Replacement Coverage**

  We will provide you with assistance in finding a non-group contract available inside or outside the Marketplace if:

  - Your coverage under TCC or the spouse equity law ends;
  - You decide 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.

  You must contact us in writing within 31 days after you are no longer eligible for coverage. For assistance in finding coverage, please contact us at 866-368-7227 option 3 or visit our website at www.compassrosebenefits.com.

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

- **Health Insurance Marketplace**

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

Section 1. How This Plan Works

This Plan is a fee-for-service (FFS) Plan. OPM requires that FEHB plans be accredited to validate the plan operations and/or care management meet nationally recognized standards. The Compass Rose Health Plan is accredited by the Accreditation Association for Ambulatory Health Care (AAAHC). For information on the Compass Rose Health Plan's accreditation, please contact us at 866-368-7227 option 3. Vendors that support the Compass Rose Health Plan have programs that hold accreditation from URAC (Express Scripts and UMR) and National Committee for Quality Assurance (NCQA) (Express Scripts and UMR). You can choose your own physicians, hospitals, and other health care providers.

We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

We have a Preferred Provider Organization (PPO)

Our fee-for-service Plan offers services through a PPO. This means that certain hospitals and other health care providers are "preferred providers." When you use our PPO providers, you will receive covered services at a reduced cost. The Plan uses the UnitedHealthcare Choice Plus network in all states. Contact us for the names of PPO providers and to verify their continued participation.

To access the electronic directory visit www.compassrosebenefits.com/UHC. A page titled "Find a Provider" will appear. Click on the link for "Search for a medical provider." If you are searching for a behavioral health provider, click on "View directory of behavioral health providers." Also, when you make an appointment, please verify that your physician is still a PPO provider. Contact 888-438-9135 for information concerning your PPO.

PPO benefits apply only when you use a PPO provider. **You must present your PPO identification (ID) card confirming your PPO participation to be eligible for PPO benefits.** Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply. If they are not, they will be paid as non-PPO providers. When you use a PPO hospital, keep in mind that the health care professionals who provide services to you in the hospital, such as radiologists, emergency room physicians, anesthesiologists, and pathologists, may not be preferred providers in our PPO. We will provide the PPO benefit level for the non-PPO providers, however their respective charges will be subject to the Plan allowance as defined in Section 10. Non-PPO providers may bill you for any difference between the Plan allowance and the billed amount.

If you reside in the PPO network area and no PPO provider is available, or if you do not use a PPO provider, non-PPO benefits apply.

The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply.

How we pay providers

Our participating providers are generally reimbursed according to an agreed-upon fee schedule and are not offered additional financial incentives based on care provided or not provided to you. Our standard provider agreements do not contain any contractual provisions that include incentives to restrict a provider's ability to communicate with and advise patients of any appropriate treatment options. In addition, the Plan has no compensation, ownership, or other influential interests that are likely to affect provider advice or treatment decisions.

We may, through a negotiated agreement with some non-PPO health care providers, apply a discount to covered services that you receive from these providers.

We use Milliman Care Guidelines and UnitedHealthcare (UHC) guidelines with support from the UHC medical directors in making determinations regarding hospital stay precertification and extended stay reviews, observation stay reviews, and reviews of procedures that require precertification or authorization. (See *How You Get Care* in Section 3.) These determinations can affect what we pay on a claim.

We apply the National Correct Coding Initiative (NCCI) edits published by the Centers for Medicare and Medicaid Services (CMS) in reviewing billed services and making Plan benefit payments for them.

Your rights and responsibilities

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

- Started in 1948
- Non-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, Compass Rose Health Plan at www.compassrosebenefits.com. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 866-368-7227 option 3 or write to Compass Rose Health Plan P.O. Box 8095, Wausau, WI 54402-8095. You may also visit our website at www.compassrosebenefits.com.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website Compass Rose Health Plan at www.compassrosebenefits.com/PHI 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.

Section 2. Changes for 2021

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

Changes to this Plan

- Your share of the non-Postal premium will increase for Self Only, increase for Self Plus One, and increase for Self and Family.
- The Plan decreased the maximum amount and percentage of coinsurance on specialty generic medications. See page 74.
- The Plan increased Level 2 and Level 3 prescription copays for Network Retail. See page 74.
- The Plan increased Level 2 and Level 3 prescription copays for Network Retail when Medicare Part B is primary. See page 74.
- The Plan increased Level 2 and Level 3 prescription copays for Network Home Delivery. See page 74.
- The Plan increased Level 2 and Level 3 prescription copays for Network Home Delivery when Medicare Part B is primary. See page 74.
- The Plan has decreased Voluntary Smart90 copays to match Mail Network Home Delivery copays. See page 74.
- The Plan states you will be subject to the Brand/Generic Cost Differential when requesting a brand name medication with a DAW (Dispense As Written) 2 if a generic substitution is available. See page 74.
- The Plan requires members currently purchasing certain specialty medications from their prescriber, outpatient facility or another pharmacy to fill their prescription through Accredo after two courtesy fills in order to obtain coverage. See page 71.
- The Plan has added antiretroviral pre-exposure prophylaxis (PrEP) therapy for persons who are at high risk of HIV acquisition will be covered at 100% as preventative care. See page 74.
- The Plan has set its out-of-network plan allowance to the 80th percentile amount of prevailing health care charges from FAIR Health (or its successor). See page 104.
- The Plan requires prior authorization after the 12th physical, occupational or speech therapy visit. See page 40.
- The Plan requires prior authorization for advanced imaging. See page 32.
- The Plan does not apply the calendar year deductible to outpatient imaging services received at a PPO free-standing imaging center. See page 32.
- The Plan does not apply member cost-sharing for regular diagnostic imaging received at a PPO free-standing imaging center. Normal be See page 32.
- The Plan pays hospital observation care that exceeds 24 hours under the inpatient hospital benefit. See page 60.
- The Plan covers diagnostic testing for temporomandibular joint (TMJ) dysfunction. See page 32.
- The Plan removed the difference between how PPO and Non-PPO claims are paid under the infertility services benefit. See page 37.
- The Plan removed the prior authorization requirement for CPAP and BiPAP machines. See page 43.
- The Plan covers B12 injections under the treatment therapies benefit. See page 38.
- The Plan covers tobacco cessation aids under UMR's Tobacco Cessation Program. See page 45.
- The Plan covers autologous transplants for the following autoimmune diseases: systemic sclerosis and scleroderma-SSc (severe, progressive). See page 52.

We have clarified the following

- The Plan has added language to distinguish between the retail 30-day and 90-day supply copay. See page 74.
- The Plan has added language clarifying that members will be reimbursed for the amount approved, not necessarily the amount submitted for post-service claims. See page 87.
- The Plan has added language on how to reach an Express Scripts Specialist Pharmacist for questions on medications. See page 71.
- The Plan has added language clarifying that we have a six-tier prescription drug benefit. See page 71.
- The Plan has added language clarifying that medical foods are not covered. See page 74.
- The Plan has updated language removing "retail" from the description of the specialty medications requirement. See page 109.
- The Plan has added information clarifying that 90-day supplies of covered medications are covered at CVS and Walgreens. See page 71.
- The Plan has added language clarifying the website for locating a network pharmacy. See page 71.
- The Plan has added language clarifying that a Level 2 or Level 3 copay will apply when no generic medication is available. See page 109.
- The Plan has added copays for Smart90 and specialty medications to the *Summary of Benefits for the Compass Rose Health Plan - 2021*. See page 109.
- The Plan has added language clarifying that specialty drugs received under the medical benefit that are available under Section 5(f) must be obtained through Accredo after two courtesy fills. See pages 38, 60, and 61.
- The Plan has added clarification that services, drugs, or supplies received as the result of injury or illness resulting from taking part in the commission of an assault or felony are excluded. See page 85.
- The Plan has added language clarifying that clinic visits are subject to a copay for PPO providers. See page 31.
- The Plan has added language clarifying that the $200 emergency room copay for dental care after an accidental injury is not included in out-of-pocket expenses. See page 26.
- The Plan has added language clarifying that Doctor On Demand offers medication management through psychiatrists. See pages 68 and 83.
- The Plan has added language clarifying instructions on using Doctor On Demand for members with Medicare B. See page 83.
- The Plan has updated the mailing address for disputed claims. See page 89.
- The Plan has added a website for Non-FEHB benefits. See page 84.

Section 3. How You Get Care

Identification Cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 888-438-9135 or write to us at Compass Rose Health Plan, P.O. Box 8095, Wausau, WI 54402-8095.

Where you get covered care

You can get care from any "covered provider" or "covered facility". How much we pay – and you pay – depends on the type of covered provider or facility you use. If you use our preferred providers, you will pay less.

- **Covered Providers**

We provide benefits for the services of covered professional providers, as required by 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.

Covered professional providers are medical practitioners who perform covered services when acting within the scope of their license or certification under applicable state law and who furnish, bill, or are paid for their health care services in the normal course of business. Covered services must be provided in the state in which the practitioner is licensed or certified.

We consider the following physicians to be primary care physicians: family practitioner, general practitioner, internal medicine, pediatrician, OBGYN, nurse practitioner, physician assistant and certified nurse midwife. Mental health visits are also considered primary care. We consider other all other types of providers to be specialists.

Physician: Doctors of medicine or psychiatry (M.D.), osteopathy (D.O.), dental surgery (D.D.S.), medical dentistry (D.M.D.), podiatric medicine (D.P.M.), chiropractic (D.C.), and optometry (O.D.) when acting within the scope of their license or certification.

Qualified Clinical Psychologist: An individual who has earned either a Doctoral or Master's Clinical Degree in psychology or an allied discipline and who is licensed or certified in the state where services are performed. This presumes a licensed individual has demonstrated to the satisfaction of state licensing officials that he/she, by virtue of academic and clinical experience, is qualified to provide psychological services in that state.

Nurse Midwife: A person who is certified by the American College of Nurse Midwives or is licensed or certified as a nurse midwife in states requiring licensure or certification.

Nurse Practitioner/Clinical Specialist: A person who 1) has an active R.N. license in the United States, 2) has a baccalaureate or higher degree in nursing, and 3) is licensed or certified as a nurse practitioner or clinical nurse specialist in states requiring licensure or certification.

Clinical Social Worker: A social worker that 1) has a Master's or Doctoral degree in social work, 2) has at least two years of clinical social work practice, and 3) in states requiring licensure, certification or registration, is licensed, certified, or registered as a social worker where the services are rendered.

Speech, Occupational and Physical Therapists: A professional who is licensed or meets state requirements where the services are performed to provide Speech, Occupational or Physical therapy services.

Physician Assistant: A person who is licensed, registered, or certified in the state where services are performed.

Licensed Professional Counselor or Master's Level Counselor: A person who is licensed, registered, or certified in the state where services are performed.

Audiologist: A person who is licensed, registered, or certified in the state where services are performed.

Licensed Acupuncturist (L.A.C.): A person who has completed the required schooling and licensure to perform acupuncture in the state where services are performed (see definition of acupuncture benefits, Section 5(a)).

Christian Science Practitioner: If you choose to visit a Christian Science practitioner instead of a physician, the charges are still considered allowable expenses. To qualify for benefits, you must make this choice annually. The benefits will then apply to all subsequent expenses incurred during the year. You can change your mind only at the time of your first claim each year. The practitioner you choose must be listed as such in the *Christian Science Journal* that is current at the time the service is provided. Your choice will not apply to, or prevent payment of, a physician's maternity charges.

Lactation Consultant: A person who is licensed as a Registered Nurse in the United States (or appropriate equivalent if providing services overseas) and is licensed or certified as a lactation consultant by a nationally recognized organization.

- **Covered Facilities**

Covered facilities include:

Hospital

1) An institution that is accredited as a hospital under the hospital accreditation program of the Joint Commission; or

2) Any other institution that is operated pursuant to law, under the supervision of a staff of doctors with 24-hour-a-day nursing service, and that is primarily engaged in providing:

a) General patient care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities, all of which facilities must be provided on its premises or under its control; or

b) Specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including X-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital (as defined above) or with a specialized provider of those facilities.

3) For inpatient and outpatient treatment of mental health and substance abuse, the term hospital also includes a freestanding residential treatment center facility approved by the Joint Commission or Commission on Accreditation of Rehabilitation Facilities (CARF).

In no event shall the term hospital include a convalescent nursing home or institution or part thereof that:

- is used principally as a convalescent facility, rest facility, nursing facility or facility for the aged;
- furnishes primarily domiciliary or custodial care including training in the routines of daily living;
- or is operated as a school.

Nursing School Administered Clinic: A clinic that is

- licensed or certified in the state where the services are performed, and

- provides ambulatory care in an outpatient setting—primarily in rural or inner city areas where there is a shortage of physicians. Services billed for by these clinics are considered outpatient 'office' services rather than facility charges.

Skilled Nursing Facility: An institution, or the part of an institution that provides skilled nursing care 24 hours a day and is classified as a skilled nursing facility under Medicare.

Birthing Center: A licensed facility that is equipped and operated solely to provide care, to perform uncomplicated spontaneous deliveries and to provide immediate postpartum care.

Hospice: A provider that meets all of the following:

1) primarily provides inpatient and outpatient hospice care to terminally ill persons;

2) is certified by Medicare as such, or is licensed or accredited as such by the jurisdiction it is in;

3) is supervised by a staff of M.D.'s or D.O.'s, at least one of whom must be on call at all times;

4) provides 24-hour nursing services under the direction of an R.N. and has a full-time administrator; and

5) provides an ongoing quality assurance program.

Freestanding Ambulatory Facility: A facility which is licensed by the state as an ambulatory surgery center or has Medicare certification as an ambulatory surgical center, has permanent facilities and equipment for the primary purpose of performing surgical and/or renal dialysis procedures on an outpatient basis, provides treatment by or under the supervision of doctors and nursing services whenever the patient is in the facility, does not provide inpatient accommodations, and is not, other than incidentally, a facility used as an office or clinic for the private practice of a doctor or other professional.

- **Transitional Care**

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

- terminate our contract with your specialist for reasons other than cause;

- drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Program plan; or

- reduce our Service Area and you enroll in another FEHB plan;

you may be able to continue seeing your specialist and receiving any PPO benefits 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 and your PPO benefits continue until the end of your postpartum care, even if it is beyond the 90 days.

- **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 888-438-9135. If you are new to the FEHB Program, we will reimburse you for your covered expenses while you are in the hospital beginning with the effective date of your coverage.

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

• You are discharged, not merely moved to an alternative care center;

• The day your benefits from your former plan run out; or

• The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB 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-service claim approval processes for inpatient hospital admissions (called precertification) and for other services, are detailed in this Section. A **pre-service claim** is any claim, in whole or in part, that requires approval from us in advance of obtaining medical care or services. In other words, a pre-service claim for benefits (1) requires precertification, prior approval or a referral and (2) will result in a reduction of benefits if you do not obtain precertification, prior approval or a referral.

You must get prior approval for certain services. Failure to do so will result in a maximum $500 penalty.

- **Inpatient hospital admission**

Precertification is the process by which —prior to your hospital admission —we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition. Unless we are misled by the information given to us, we will not change our decision on medical necessity.

In most cases, your physician or hospital will take care of requesting precertification. Because you are still responsible for ensuring that your care is precertified, you should always ask your physician or hospital whether or not they have contacted us.

- **WARNING:**

We will reduce our benefits for the inpatient hospital stay by $500 if no one completes a precertification. If the stay is not medically necessary, we will only pay for any covered medical services and supplies that are otherwise payable on an outpatient basis. You are held harmless when PPO hospitals do not contact the Plan for precertification for inpatient hospitalizations.

- **Exceptions**

You do not need precertification in these cases:

•You are admitted to a hospital outside the United States.

•You have another group health insurance policy that is the primary payer for the hospital stay.

•Medicare Part A is the primary payer for the hospital stay. Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then we will become the primary payer and you do need precertification.

- **Other services**

Your primary care physician has authority to refer you for most services. For certain services, however, prior approval must be obtained from us. Because you are still responsible for ensuring that your care is precertified, you should always ask your physician if they have contacted us. Call UMR at 888-438-9135 for prior authorization for services such as:

Section 5(a)

• Applied Behavior Analysis

• Chemotherapy

• Dialysis

• Durable medical equipment over $500 for rental or $1,500 for purchase

• Genetic testing - all genetic testing must be prior authorized through eviCore at 888-209-5761, option 1

• Home health care

• Infusion therapy

• Orthotic and prosthetic devices over $2,000

• Pain management injections (such as epidural or facet)

• Physical, occupational and speech therapy - after your 12th visit

• Private duty nursing

• Radiation

• Sleep studies - all sleep studies must be prior authorized through eviCore at 888-209-5761, option 2

Section 5(b)

• Bariatric surgery

• Biopsy procedures

• Oral maxillofacial surgeries

• Surgical procedures performed outside a doctor's office (screening colonoscopies do not require prior authorization)

• Transgender surgical and non-surgical treatments and procedures

• Transplants

• Varicose vein surgery

Section 5(c)

• Chemotherapy

• Dialysis

• Hospice care

• Inpatient hospital treatment

• Non-emergency air ambulance - all non-emergency air ambulance transportation must be prior authorized through Sentinel at 877-542-8828

• Radiation

• Skilled nursing facilities

Section 5(e)

• Inpatient mental health and substance abuse treatment

• Partial hospitalization

• Residential treatment services

Section 5(f)

• Some prescription drugs

Note: We will reduce our benefits for any outpatient services requiring prior approval by $500 if no one completes a review prior to your receiving the services. In most cases, your physician or provider will take care of requesting prior approval. **Because you are still responsible for ensuring that your care is prior approved, you should always ask your physician or provider if they have contacted us**.

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

First, you, your representative, your physician, or your hospital must call 800-808-4424 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

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

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim.

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

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

- **Urgent care claims**

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

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of 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 888-438-9135. You may also call OPM's FEHB 2 at 202-606-3818 between 8 a.m. and 5 p.m. Eastern Standard 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 888-438-9135. 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 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.

- - **The Federal Flexible Spending Account Program-** ***FSAFEDS***

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

- **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. If you do not phone the Plan within two business days, penalties may apply - see *Warning* under *Inpatient hospital admissions* earlier in this Section and *If your hospital stay needs to be extended* below.

- **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 confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

- **If your hospital stay needs to be extended**

If your hospital stay – including for maternity care – needs to be extended, you, your representative, your doctor or the hospital must ask us to approve the additional days. If you remain in the hospital beyond the number of days we approved and did not get the additional days precertified, then

- For the part of the admission that was medically necessary, we will pay inpatient benefits, but
- For the part of the admission that was not medically necessary, we will only pay for medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits.

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

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

If you 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 accordance with the procedures detailed below.

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

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

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

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

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

2. Ask you or your provider for more information.

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

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

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

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

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

- **To file an appeal with OPM**

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

Section 4. Your Costs for Covered Services

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

Cost-sharing

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

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. You will only be responsible for one (1) copayment per day per provider.

Example: When you see your PPO physician you pay a copayment of $15 per day, and when you go in a PPO hospital, you pay a copayment of $200 per hospital stay.

Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than your copayment, you pay the lower amount.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments and coinsurance amounts, with the exception of Essential Health Benefits copayments, do not count toward any deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply counts toward the deductible.

The calendar year deductible for PPO is $350 per person and for non-PPO services it is $400 per person. 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 $350 for PPO and $400 for non-PPO. 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 $700 for PPO and $800 for non-PPO. 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 $700 for PPO and $800 for non-PPO services.

If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than the remaining portion of your deductible, you pay the lower amount.

Example: If the billed amount is $100, the provider has an agreement with us to accept $80, and you have not paid any amount toward meeting your deductible, you must pay $80. We will apply $80 to your deductible. We will begin paying benefits once the remaining portion of your calendar year deductible of $350 for PPO or $400 for non-PPO has been satisfied.

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

Coinsurance

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

Example: You pay 10% coinsurance of our allowance for an X-ray at a PPO provider.

If your provider routinely waives your cost

Note: If your provider routinely waives (does not require you to pay) your copayments, deductibles, or coinsurance, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived.

For example, if your physician ordinarily charges $100 for a service but routinely waives your 10% coinsurance, the actual charge is $90. We will pay $81 (90% of the actual charge of $90).

Waivers

In some instances, a UnitedHealthcare provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether or not you are responsible for the total charge depends on the contracts that the Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at 888-438-9135.

Differences between our allowance and the bill

Our “Plan allowance” is the amount we use to calculate our payment for covered services. Fee-for-service plans arrive at their allowances in different ways, so their allowances vary. For more information about how we determine our Plan allowance, see the definition of Plan allowance in Section 10.

Often, the provider's bill is more than a fee-for-service plan's allowance. Whether or not you have to pay the difference between our allowance and the bill will depend on the provider you use.

When you live in the Plan’s PPO area, you should use a PPO provider. The following two examples explain how we will handle your bill when you go to a PPO provider and when you go to a non-PPO provider. When you use a PPO provider, the amount you pay is much less.

- **PPO providers** agree to limit what they will bill you. Because of that, when you use a preferred provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example using coinsurance: You see a PPO physician who charges $350, but our allowance is $300. If you have met your deductible, you are only responsible for your coinsurance. That is, you pay just 10% of our $300 allowance ($30). Because of the agreement, your PPO physician will not bill you for the $50 difference between our allowance and his/her bill.

Follow these steps when you use a PPO provider in order to receive PPO benefits:

- When you call for an appointment, verify that the physician or facility is still a PPO provider and;
- Present your PPO ID card confirming your PPO participation in order to receive PPO benefits.
- **Non-PPO providers,** on the other hand, have no agreement to limit what they will bill you. For instance, when you reside in the PPO network area and use a non-PPO provider, you will pay your deductible and coinsurance—plus any difference between our allowance and charges on the bill. Here is an example: You see a non-PPO physician who charges $350 and our allowance is again $300. Because you have met your deductible, you are responsible for your coinsurance, so you pay 30% of our $300 allowance ($90). Plus, because there is no agreement between the non-PPO physician and us, the physician can bill you for the $50 difference between our allowance and his/her bill.

The following table illustrates the examples of how much you have to pay out-of-pocket for services from a PPO physician vs. a non-PPO physician when you reside in the PPO network area. The table uses our example of a service for which the physician charges $350 and our allowance is $300. The table shows the amount you pay if you have met your calendar year deductible.

EXAMPLE	PPO physician	Non-PPO physician
Physician's charge	$350	$350
Our allowance	We set it at: $300	We set it at: $300
We pay	90% of our allowance: $270	70% of our allowance: $210
You owe: Coinsurance	10% of our allowance: $30	30% of our allowance: $90
+Difference up to charge?	No: 0	Yes: $50
TOTAL YOU PAY	**$30**	**$140**

Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments

For those benefits where coinsurance or deductibles apply, we pay 100% of the Plan allowance for the rest of the calendar year after your expenses total:

• Medical PPO and Pharmacy Network providers: $5,000 for Self Only and $7,000 for Self Plus One or Self and Family;

• Medical, Non-PPO providers: $7,000 for Self Only and $9,000 for Self Plus One or Self and Family;

Out-of-pocket expenses are:

• Your $350 Self/$700 Self Plus One/$700 Self and Family calendar year deductible for PPO and $400 Self/$800 Self Plus One/$800 Self and Family for non-PPO;

• The percentage you pay for covered services after you have met your deductibles;

• The percentage you pay for surgery, anesthesia and extended medical care after an accidental injury;

• Copayments for Essential Health Benefits;

• Your copayment for hospital stays;

The following **cannot** be included in your out-of-pocket expenses:

- Expenses in excess of the Plan allowance or maximum benefit limitations;
- Non-covered services and supplies;
- Expenses for dental care including the $200 copayment you pay for dental care after an accidental injury; or
- Any amounts you pay if benefits have been reduced because of noncompliance with our precertification, prior authorization or prior approval requirements.

Any expenses incurred that apply toward the catastrophic out-of-pocket maximum for PPO or Non-PPO apply toward both PPO and Non-PPO limits.

Carryover

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

If we overpay you

We will make diligent efforts to recover benefit payments we made in error, but in good faith. We may reduce subsequent benefit payments to offset overpayments.

When Government facilities bill us

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

Section 5. High Option Benefits

See page 14 for how our benefits changed this year. **Pages 109-110** are a benefits summary of our High Option.

High Option Overview

This Plan offers a High Option. Benefits are described in Section 5. Make sure that you review the benefits that are available under the Plan. For certain services, prior approval must be obtained. Please see Section 3 for details.

The High Option Section 5 is divided into subsections. Please read **Important things you should keep in mind** at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about the Plan, contact us at 866-368-7227 option 3 or on our website at www.compassrosebenefits.com

Highlights of this Plan include, but are not limited to:

- $15 copayment for a physician per office visit
- $25 copayment for a specialist per office visit
- Annual routine physical exams, screenings and immunizations when you use a Preferred provider the Plan will pay 100%
- PPO benefit applies to providers used outside the 50 United States
- Tobacco Cessation Program covered at 100%
- No referral required to see a specialist
- United Healthcare Choice Plus network
- $5 generic drug copayments

See page 14 for how our benefits changed this year.

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

Important things you should keep in mind about these benefits:

• Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.

• The calendar year deductible is: $350 for PPO per Self enrollment and $400 for non-PPO services per Self enrollment ($700 for PPO per Self Plus One enrollment or per Self and Family enrollment and $800 for non-PPO services per Self Plus One enrollment or Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No Deductible)" to show when the calendar year deductible **does not** apply.

• PPO benefits apply only when you reside in the PPO network area and use a PPO provider or if a provider is used outside the 50 United States. When no PPO provider is available, non-PPO benefits apply.

• The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply. Please refer to Page 12 when utilizing non-PPO providers to review how coverage will apply.

• 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, or if you are age 65 or over.

• YOU MUST GET PRIOR APPROVAL FOR CERTAIN OUTPATIENT SERVICES; FAILURE TO DO SO WILL RESULT IN A MAXIMUM $500 PENALTY. Please refer to the prior approval information shown in Section 3 to be sure which services require prior approval.

Benefit Description	You Pay
Note: We say "(No Deductible)" when the deductible does not apply.	
Diagnostic and treatment services	
Professional services of physicians (not including surgery) • In physician's office or convenient care center - office visits - clinic visits - consultations (to include second surgical opinion) Note: No referral required to see a specialist. Note: Supplies provided by the physician are covered under Section 5(a).	PPO: $15 copayment **(No Deductible)** $25 copayment for Specialist **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount $15 copayment **(No Deductible)** $25 copayment for Specialist **(No Deductible)** for providers used outside the 50 United States
Professional services of physicians (not including surgery) • In a hospital (Inpatient or Outpatient) • In an urgent care center • In a skilled nursing facility • At home • Advance care planning including end-of-life counseling	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance for providers used outside the 50 United States

Benefit Description	You Pay
Telehealth services	
• Telehealth Note: Doctor On Demand physicians treat hundreds of conditions, including providing mental health counseling. For more information on telehealth benefits, please see Section 5(h) Wellness and other special features.	PPO and Doctor on Demand: Nothing **(No Deductible)** $25 copayment for Specialist **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Nothing **(No Deductible)** $25 copayment for Specialist **(No Deductible)** for providers used outside the 50 United States
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • Electrocardiogram and EEG • Sleep studies* • Genetic testing* • Genetic counseling* *Note: All sleep studies and genetic testing must be prior authorized through eviCore at 888-209-5761, or are subject to the maximum $500 not prior authorized penalty. See Section 3 for more details. Note: Genetic testing is covered when medically necessary. The test must not be considered experimental, investigational, or unproven. The test must be performed by a CLIA-certified laboratory. The test result must directly impact or influence the disease treatment of the Covered Person. Genetic testing must also meet at least one of the following: the patient has current signs and/or symptoms (i.e., the test is being used for diagnostic purposes), conventional diagnostic procedures are inconclusive, the patient has risk factors or a particular family history that indicates a genetic cause, the patient meets defined criteria that place him or her at high genetic risk for the condition. Note: Genetic counseling is covered when associated with a covered genetic test.	PPO services: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance for providers used outside the 50 United States Nothing for covered tests if LabCorp or Quest are used for Laboratory Services **(No Deductible)** Note: You may elect to go to a LabCorp or Quest facility and/or you must notify your provider to submit your lab work to LabCorp or Quest for processing to obtain the 100% benefit for allowable charges. Note: If your PPO provider uses a non-PPO lab or radiologist, we will pay non-PPO benefits for any lab and X-ray charges. Note: This benefit applies to non-routine tests and is separate from Preventive routine tests listed in Section 5(a).
Imaging, such as: • X-rays • Non-routine mammograms • Ultrasounds • Sonograms Note: The first mammogram of the calendar year is covered under preventive care.	PPO services **in free-standing imaging center**: Nothing **(No Deductible)** PPO services **outside free-standing imaging center**: 10% of the Plan allowance Non-PPO services: 30% of the Plan allowance and any difference between our allowance and the billed amount

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

Benefit Description	You Pay
Lab, X-ray and other diagnostic tests (cont.)	
	Nothing **(No Deductible) in free-standing imaging center** and **10%** of the Plan allowance o**utside free-standing imaging center** for providers used outside the 50 United States
Advanced imaging, such as: • MRI • MRA • SPECT • CTA • PET • CT Note: Prior authorization is required for advanced imaging. See Section 3 for details. Failure to prior authorize a service may result in a non-prior authorization penalty of a maximum $500 per episode of care.	PPO services **in free-standing imaging center**: 10% of the Plan allowance **(No Deductible)** PPO services **outside free-standing imaging center**: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance **(No Deductible) in free-standing imaging center** and 10% of the Plan allowance **outside free-standing imaging center** for providers used outside the 50 United States
Not covered: *Some allergy tests, see Allergy care, Page 38.*	*All charges*
Preventive care, adult	
• Routine physical every year The **following** preventive services are covered at the time interval recommended at each of the links below. • Immunizations such as Pneumococcal, influenza, shingles, tetanus/DTaP, and human papillomavirus (HPV). For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ • Screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer screening. For a complete list of screenings go to the U. S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org • Individual counseling on prevention and reducing health risks • Well woman care 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 Well Women preventive care services go to the Health and Human Services (HHS) website at https://www.healthcare.gov/preventive-care-women/	PPO Services in physician's office: Nothing **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount **(No Deductible)** Nothing **(No Deductible)** for providers used outside the 50 United States
The following are paid in addition to the above benefit: • First mammogram of the calendar year • First colonoscopy of the calendar year (no age limit) • Immunizations required for travel • Exams and immunizations for work	PPO: Nothing **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount **(No Deductible)**

Preventive care, adult - continued on next page

Benefit Description	You Pay
Preventive care, adult (cont.)	
• Exams and immunizations for sports Note: **Your physician's bill must clearly state "Routine Physical Exam."** If a medical diagnosis is provided on the bill, those services will be paid under the medical benefit. Note: We cover related services under the applicable benefits section (i.e., for facility charge, see Section 5(c)).	PPO: Nothing **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount **(No Deductible)** Nothing **(No Deductible)** for providers used outside the 50 United States
Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule.	PPO: Nothing **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount **(No Deductible)** Nothing **(No Deductible)** for providers used outside the 50 United States
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.	
Preventive care, children	
• 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 Future Guidelines, go to https://brightfutures.aap.org • Immunizations such as DTaP, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/index.html • You may also find a complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) online at https://www.uspreventiveservicestaskforce.org Note: **Your physician's bill must clearly state "Routine Physical Exam."** If a medical diagnosis is provided on the bill, those services will be paid under the medical benefit.	PPO: Nothing **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount **(No Deductible**) Nothing **(No Deductible)** for providers used outside the 50 United States
• Examinations, limited to: - Examinations for amblyopia and strabismus - limited to one screening examination (ages 3 through 5) - Examinations done on the day of immunizations (ages 3 up to age 22)	PPO: Nothing **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount **(No Deductible**) Nothing **(No Deductible)** for providers used outside the 50 United States Note: PPO services outside physician's office Nothing **(No Deductible)**

Preventive care, children - continued on next page

Benefit Description	You Pay
Preventive care, children (cont.)	
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.	
Maternity care	
Complete maternity (obstetrical) care such as: • Prenatal care (to include laboratory tests) • Amniocentesis • Delivery • Initial, routine examination of your newborn infant covered under your family enrollment • Postnatal care • One routine sonogram - additional sonograms may be covered when medically necessary • Screening for Human Immunodeficiency Virus (HIV) • Counseling and interventions for pregnant and postpartum persons who are at risk of perinatal depression • Early screening for syphilis in all pregnant women • Screening for gestational diabetes for pregnant women • Preeclampsia screening • Breastfeeding support, pumps, supplies and counseling for each birth Note: For assistance locating a PPO provider, please call 888-438-9135.	PPO: Nothing **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Nothing **(No Deductible)** for providers used outside the 50 United States
Note: Here are some things to keep in mind • You do not have to precertify your vaginal delivery; see page 22 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary and precertified. • 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 if we cover the infant under a Self Plus One enrollment or Self and Family enrollment. If your baby stays in the hospital after your discharge and is covered under your Self Plus One enrollment or Self and Family enrollment, you must precertify the extended stay and pay a separate hospital stay copayment. See Section 5(c).	

Maternity care - continued on next page

Benefit Description	You Pay
Maternity care (cont.)	
• Surgical benefits, not maternity benefits, apply to circumcision. • Bassinet or nursery charges on which you and your baby are confined are considered your maternity expenses, not your baby's. • Sonograms and other related tests that are **not** included in your routine prenatal or postnatal care are covered in Lab, X-Ray, and other diagnostic tests, see page 32. • 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) for non-PPO providers. • Maternity care expenses incurred by the Plan member serving as a surrogate mother are covered by the Plan subject to reimbursement from the other party to the surrogacy contract or agreement. The involved Plan member must execute our Reimbursement Agreement against any payment she may receive under a surrogacy contract or agreement. Expenses of the new-born child are not covered under this or any other benefit in a surrogate mother situation. Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.	
Not Covered: *Routine sonograms to determine fetal age, size or sex; or procedures, services, drugs and 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.*	*All Charges*
Family Planning	
A range of voluntary family planning services, limited to: • Voluntary sterilization, male and female (limited to vasectomies and tubal ligations) • Surgically implanted contraceptives • Fitting, inserting or removing intrauterine devices (such as diaphragms and IUDs) • Sterilization procedures, and patient education and counseling for all women with reproductive capacity • Injection of contraceptive drugs (such as Depo Provera)	PPO: Nothing **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount **(No Deductible)** Nothing **(No Deductible)** for providers used outside of the 50 United States
• Contraceptive counseling on an annual basis • All Food and Drug Administration (FDA) approved contraceptive medications and devices • The morning after pill	PPO: Nothing **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount **(No Deductible)**

Family Planning - continued on next page

Benefit Description	You Pay
Family Planning (cont.)	
Note: FDA-approved prescription drugs and devices for birth control require a physician's prescription.	PPO: Nothing **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount **(No Deductible)** Nothing **(No Deductible)** for providers used outside the 50 United States
Not covered: *Reversal of voluntary surgical sterilization, genetic counseling (unless specifically noted as covered).*	*All charges*
Infertility services	
Diagnosis and treatment of infertility except as shown in *Not covered.* • Initial diagnostic tests and procedures done only to identify the cause of infertility • Fertility drugs, hormone therapy and related services • Medical or surgical procedures done to create or enhance fertility Note: We will pay up to $5,000 per person per live birth for covered infertility services, **including** prescription drugs. Note: The Plan will provide Infertility benefits as outlined in Section 5(a), Infertility services, if the couple has a relationship under which the FEHB Program recognizes each partner as a spouse of the other. Note: Refer to Section 10 for Definition of Infertility.	PPO, Non-PPO and providers used outside the 50 United States: 10% of billed charges and charges in excess of $5,000 per live birth.
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* *- Artificial insemination (AI)* *- In vitro fertilization (IVF)* *- Embryo transfer and gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* *- Intravaginal insemination (IVI)* *- Intracervical insemination (ICI)* *- Intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*

Infertility services - continued on next page

Benefit Description	You Pay
Infertility services (cont.)	
• *Cycles of therapeutic donor insemination (including donor sperm) performed during the evaluation period as a diagnosis of Infertility is not established until the cycles have been completed.*	*All charges*
Allergy care	
Allergy testing, injections and treatment (including allergy serum, RAST tests, and Food tests).	PPO services **in physician's office:** 10% of the Plan allowance **(No Deductible)** PPO services **outside physician's office:** 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance **(No Deductible) in physician's office** and 10% of the Plan allowance **outside physician's office** for providers used outside the 50 United States Note: Office visits and consultations by a physician are covered under professional services of physicians, see page 33.
Not covered: • *EndPoint titration techniques* • *Sublingual allergy desensitization* • *Hair Analysis*	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: Prior authorization is required for chemotherapy and radiation therapy. See Section 3 for details. Failure to prior authorize a service may result in a maximum non-prior authorization penalty of $500 per episode of care. Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed in Section 5(b) (*Organ/tissue transplants*). • Intravenous (IV) Infusion Therapy Home IV and antibiotic therapy Note: Prior authorization is required for infusion therapy, including chemotherapy. See Section 3 for details. Failure to prior authorize a service may result in a non-prior authorization penalty of a maximum $500 per episode of care. • Renal Dialysis	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance for providers used outside the 50 United States

Treatment therapies - continued on next page

Benefit Description	You Pay
Treatment therapies (cont.)	
Note: Prior authorization is required for renal dialysis. See Section 3 for details. Failure to prior authorize a service may result in a maximum non-prior authorization penalty of $500 per episode of care. • Respiratory and inhalation therapies • B12 injections • Pain management injections Note: Prior authorization is required for pain management injections. See Section 3 for details. Failure to prior authorize a service may result in a maximum non-prior authorization penalty of $500 per episode of care. • Growth hormone therapy (GHT) Note: We only cover GHT when you obtain prior approval. 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 that we determine are medically necessary. See Other services under You need prior Plan approval for certain services on page 19. • Applied Behavior Analysis (ABA) - Children up to age 18 years with autism spectrum disorder ABA services must be performed by a licensed health care professional practicing within the scope of his or her license or certification (preferably a Board Certified Behavior Analyst). Note: Prior authorization is required for ABA. See Section 3 for details. Failure to prior authorize a service may result in a non-prior authorization penalty of a maximum $500 per episode of care. Treatment plans specific to ABA therapy with goals-progress and updates are required at least every 6 months for review of ongoing therapy to evaluate continued medical necessity. Note: Treatment with ABA is subject to all other Plan provisions as applicable, such as experimental, investigational, unproven treatment, custodial care, nutritional or dietary supplements, or educational services that should be provided through the school district. Note: We cover drugs administered for therapies listed above in Section 5(f). Note: Specialty drugs that are received under the medical benefit and available under Section 5(f) must be obtained through Accredo after 2 courtesy fills (see Section 5(f)) Note: We cover cardiac rehabilitation following qualifying event/ condition in Section 5(c), pages 59-61.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance for providers used outside the 50 United States

Benefit Description	You Pay
Physical, occupational, and speech therapies	
• 90 total combined outpatient physical, speech and occupational therapy visits per calendar year for the following: - Physicians - Qualified physical therapists - Speech therapists - Occupational therapists - Chiropractors Note: Prior authorization for physical, occupational and speech therapy visits is required after your 12th visit. See Section 3 for details. Failure to prior authorize a service may result in a non-prior authorization penalty of a maximum $500 per episode of care. Note: 90 total combined visits does not include inpatient physical, speech and occupational therapy, which is covered under Section 5(c) hospital or facility coverage.	PPO: 10% of the Plan allowance Non-PPO:30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance for providers used outside the 50 United States
Note: We only cover therapy when a provider: *- 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.* Note: Inpatient rehabilitative services are covered under Section 5 (c) Note: Physical, speech and occupational therapy visits must be medically necessary to achieve significant improvement in function.	
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Massage therapy* • *Services deemed not medically necessary*	*All charges*
Hearing services (testing, treatment, and supplies)	
Hearing Exam 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.*	PPO: Nothing **(No Deductible)** Non-PPO: Any difference between our allowance and the billed amount **(No Deductible)** Nothing **(No Deductible)** for providers used outside of the 50 United States
Hearing aids for adults and children - one hearing aid and related services per ear every five calendar years when prescribed by an M.D., D.O., or Audiologist.	PPO, non-PPO and providers used outside the 50 United States: All charges over $1,200 for one hearing aid per ear, every five calendar years.

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

Benefit Description	You Pay
Hearing services (testing, treatment, and supplies) (cont.)	
• External hearing aids **Medicare B Primary** Hearing aids for adults when Medicare Part B is primary - one hearing aid and related services per ear every three calendar years when prescribed by an M.D., D.O., or Audiologist. • External hearing aids	PPO, non-PPO and providers used outside the 50 United States: All charges over $1,200 for one hearing aid per ear, every five calendar years. **Medicare B Primary** PPO, non-PPO and providers used outside the 50 United States: All charges over $1,200 for one hearing aid per ear, every three calendar years.
Not covered: *Hearing services that are not shown as covered*	*All charges*
Vision services (testing, treatment, and supplies)	
One (1) pair of eyeglasses with standard frames or one (1) pair of contact lenses per incident to correct an impairment directly caused by: • Accidental ocular injury or • Surgery in connection with the following diagnosis specifically ordered by the physician: • Cataract • Keratoconus or • Glaucoma Note: Services must be received within one year of the date of accident or surgery.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance for providers used outside the 50 United States
Not covered: • *Eyeglasses or contact lenses and examinations for them, except for accidental injury and intraocular surgery* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Eye refractions* • *Routine vision benefits*	*All charges*
Foot care	
Not Covered: *We do not provide benefits for **routine** foot care, such as:* • *Treatment or removal of corns and calluses, or trimming of toenails unless at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease* • *Orthopedic shoes, non-prescription orthotics, foot orthotics unless attached to a brace and other supportive devices including orthotic shoe inserts* Note: **Non-routine** foot conditions with a medical diagnosis are considered for coverage as outlined in Sections 5(a) and 5(b).	*All charges*

Benefit Description	You Pay
Orthopedic and prosthetic devices	
•Artificial limbs and eyes •Prosthetic sleeve or sock •Externally worn breast prostheses and surgical bras (four per year), including necessary replacements following a mastectomy. •Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implants following mastectomy. •Braces, including necessary adjustments to shoes to accommodate braces, which are used for the purpose of supporting a weak or injured part of the body. •Cranial helmets and similar devices when ordered as part of treatment for a medical illness or injury. •Lumbosacral supports Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services. Note: A $500 maximum penalty is applied if items over $2,000 are not prior authorized. See Section 3 for more information.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance for providers used outside the 50 United States
Diabetic shoes •One pair of diabetic shoes per person. Replacements allowed annually.	PPO, Non-PPO and providers used outside the 50 United States: All charges in excess of $150 **(No Deductible)**
Wigs, toupees, hairpieces up to $400 while covered under this Plan, when required due to hair loss in connection with cancer treatment or alopecia related to a medical condition.	PPO, Non-PPO and providers used outside the 50 United States: All charges in excess of $300 for 1 item per calendar year.
Not covered: *•Orthopedic and corrective shoes, arch supports, foot orthotics unless attached to a brace, heel pads and heel cups* *•Over-the-counter lumbosacral supports* *•Corsets, trusses, elastic stockings, support hose (except for the diagnosis of Lymphedema), and other supportive devices* *•Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.*	*All charges*

Benefit Description	You Pay
Durable medical equipment (DME)	
Durable medical equipment (DME) is equipment and supplies that: 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Are medically necessary; 3. Are primarily and customarily used only for a medical purpose; 4. Are generally useful only to a person with an illness or injury; 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury. We cover purchase or rental up to the purchase price, at our option, including repair and adjustment, of durable medical equipment. We will pay only for the cost of the standard item. Coverage for specialty equipment such as all-terrain wheelchairs is limited to the cost of the standard equipment. Under this benefit, we also cover: • Oxygen; • Hospital beds; • Dialysis equipment; • Glucose monitors; • Approved insulin pumps; • Respirators; • Ostomy supplies; • Wheelchairs, crutches, canes, walkers, casts; • Compression stockings (for the diagnosis of lymphedema) - four per year; • Cervical collars and traction kits; • Batteries and maintenance supplies for cochlear implants; • Splints; and • CPAP and BiPAP machines Note: Individual DME items costing $500 or more to rent or $1500 or more to purchase require prior authorization. If these items are not prior authorized, you will be subject to a no prior authorization penalty of a maximum $500 per item. Note: For assistance locating a PPO provider, please call 888-438-9135.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance for providers used outside the 50 United States
We cover the rental or purchase of augmentative and alternative communication devices such as: • Computer story boards • Light talkers • Enhanced vision systems • Speech aid prosthesis for pediatrics • Speech aid prosthesis for adults	PPO, Non-PPO and providers used outside the 50 United States: All charges in excess of $1200 for 1 device. Replacements allowed every 3 years

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay
Durable medical equipment (DME) (cont.)	
Not covered: *• Sun or heat lamps, whirlpool baths, heating pads, air purifiers, humidifiers, air conditioners, and exercise devices* *• Safety, hygiene, and convenience equipment and supplies* *• Lifts, such as seat, chair or van lifts* *• Computer items other than those specifically listed as covered* *• All equipment/supplies from an online retailer* *• Other items not meeting the definition of durable medical equipment*	*All charges*
Home health services	
For services provided on a **part-time basis** (less than an 8-hour shift): If **precertified**, 90 visit maximum per calendar year when: • A registered nurse (R.N.) or licensed practical nurse (L.P.N.) provides the services; • The attending physician orders the care; • The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services; and • The physician indicates the length of time the services are needed. Note: A maximum $500 penalty is applied if services are not prior authorized. See Section 3 for more information. Note: Home health physical, occupational and speech therapy are covered under Section 5(a) physical, occupational and speech therapies.	PPO: 10% of the Plan allowance **(No Deductible)** with a 90-visit maximum. All charges over the visit maximum. Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount **(No Deductible)** with a 90-visit maximum. All charges over the visit maximum. 10% of the Plan allowance **(No Deductible)** with a 90-visit maximum. All charges over the visit limit for providers used outside the 50 United States.
For private duty nursing provided on a **full-time basis** (more than an 8-hour shift) by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) when: • the care is ordered by the attending physician, and • your physician identifies the specific professional nursing skills that you require, as well as the length of time needed. Note: Prior authorization is required for private duty nursing. See Section 3 for details. Failure to prior authorize a service may result in a maximum non-prior authorization penalty of $500 per episode of care.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance for providers used outside the 50 United States
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;*	*All charges*

Home health services - continued on next page

Benefit Description	You Pay
Home health services (cont.)	
• *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative:* • *Custodial care as defined in Section 10.*	*All charges*
Chiropractic	
Covered services are limited to: • Manipulation of the spine and extremities Note: Chiropractic is a system of therapy that attributes disease to abnormal function of the nervous system and attempts to restore normal function by manipulation of the spinal column and other body structures. Note: Physical, occupational and speech therapy provided by a chiropractor are covered under Section 5(a) physical, occupational and speech therapies.	PPO: $20 copayment **(No Deductible)** up to the Plan maximum of 20 visits per person per calendar year Non-PPO: 30% of the Plan Allowance and any difference between our allowance and the billed amount up to the Plan maximum of 20 visits per person per calendar year $20 copayment **(No Deductible)** up to the Plan maximum of 20 visits per person per calendar year for providers used outside the 50 United States
Alternative treatments	
Acupuncture: • Anesthesia • Pain Relief Note: Acupuncture must be performed and billed by a health care provider who is licensed or certified to perform acupuncture by the state where the services are provided, and who is acting within the scope of that license or certification.	PPO: 10% of the Plan allowance up to the Plan maximum of 24 visits per person per calendar year Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount up to the Plan maximum of 24 visits per person per calendar year 10% of the Plan allowance up to the Plan maximum of 24 visits per person per calendar year for providers used outside the 50 United States
Not covered: • *Chelation therapy except for acute arsenic, gold, mercury, lead, or use of Deferoxamine in iron poisoning* • *Naturopathic services* • *Homeopathic services and medicines* • *Treatment, services or supplies for holistic or homeopathic medicine, hypnosis, or other alternative treatment that is not accepted as medical practice as determined by the Plan.*	*All charges*
Educational classes and programs	
Nutritional therapy Coverage Limited to: • Nutritional counseling Note: Refer to preventive services for additional coverage information. Note: We cover dieticians, nutritionists and diabetic educators who bill independently for nutritional counseling.	PPO, Non-PPO and providers used outside the 50 United States: $15 copayment. All charges in excess of 4 nutritional counseling sessions per year **(No Deductible)**

Educational classes and programs - continued on next page

Benefit Description	You Pay
Educational classes and programs (cont.)	
Diabetes training Note: Prescription drugs are covered under section 5(f).	PPO: $15 copayment **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount **(No Deductible)** $15 copayment **(No Deductible)** for providers used outside the 50 United States
Tobacco Cessation Tobacco Cessation Programs including individual phone counseling with a certified tobacco cessation specialist, physician written and prescribed over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. Coverage is provided for: • Up to five telephonic smoking cessation counseling sessions per quit attempt and two quit attempts per year. • FDA-approved prescription and over-the-counter drugs for the treatment of tobacco dependence. You can enroll in UMR's Tobacco Cessation Program by calling 800-207-7680.	PPO, Non-PPO and providers used outside the 50 United States: Nothing **(No Deductible)** Nothing for physician prescribed OTC and prescription drugs approved by the FDA to treat tobacco dependence.

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

Important things you should keep in mind about these benefits:

• Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.

• The calendar year deductible is: $350 for PPO per Self enrollment and $400 for non-PPO services per Self enrollment ($700 for PPO per Self Plus One enrollment or per Self and Family enrollment and $800 for non-PPO services per Self Plus One enrollment or Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No Deductible)" to show when the calendar year deductible **does not** apply.

• PPO benefits apply only when you reside in the PPO network area and use a PPO provider. When no PPO provider is available, non-PPO benefits apply. If outside the 50 United States the PPO benefits apply.

• The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply. Please refer to Page 12 when utilizing non-PPO providers to review how coverage will apply.

• Be sure to read Section 4, *Your costs for covered service*s for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.

• The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).

• YOU MUST GET PRIOR APPROVAL FOR SURGICAL SERVICES OUTSIDE A PHYSICIAN'S OFFICE. FAILURE TO DO SO WILL RESULT IN A MAXIMUM $500 PENALTY. Please refer to the prior approval information shown in Section 3 for additional details on prior approval.

Benefit Description	You Pay
Note: We say "(No Deductible)" when the deductible does not apply.	
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Medically necessary non-routine colonoscopy services. • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Replacement batteries for covered implantable devices Note: PPO surgical services related to maternity care are covered at 100%, see Section 5(a) maternity care.	PPO: 10% of the Plan allowance **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance **(No Deductible)** for providers used outside the 50 United States

Surgical procedures - continued on next page

Benefit Description	You Pay
Surgical procedures (cont.)	
Note: The first colonoscopy of the calendar year is covered under preventive care, see Section 5(a) preventive care	PPO: 10% of the Plan allowance **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance **(No Deductible)** for providers used outside the 50 United States
• Surgical treatment of morbid obesity (bariatric surgery) – a condition in which an individual is: (1) a BMI of >40 kg/m² with no other health conditions or a BMI >35 kg/m² with at least one comorbidity; (2) have documentation of a motivated attempt of weight loss through a structured diet program prior to surgery, which includes physician or other health care provider notes and/or diet or weight loss logs from a structured weight loss program for a minimum of 6 months and within the previous 12 months; (3) a psychological evaluation within 12 months of surgery to rule out major mental health disorders which would contraindicate surgery and determine patient compliance with post-operative follow-up care and dietary guidelines and (4) is age 18 or older. Covered procedures include: gastric banding, adjustable gastric banding, gastric sleeve procedure, vertical banded gastroplasty, biliopancreatic bypass and biliopancreatic diversion with duodenal switch and gastric bypass. Note: The procedure must be performed at an Optum Bariatric Resource Services Center of Excellence provider to receive PPO level of benefit. Note: You must enroll in the Optum Bariatric Resource Services (BRS) program. Note: Limited to one surgery per lifetime. Surgical adjustment or alteration of a prior procedure for complications of the original surgery, such as stricture, obstruction, pouch dilatation, erosion, or band slippage when the complication causes abdominal pain, inability to eat or drink, or causes vomited of prescribed meals is covered at standard surgery level of benefits.	PPO: 10% of the Plan allowance **(No Deductible)** when an Optum Bariatric Resource Services program provider is used Non-PPO: 100% 10% of the Plan allowance **(No Deductible)** for providers used outside the 50 United States
• Treatment of burns • Surgical treatment of bunions or spurs • Assistant surgeons - we cover up to 20% of our allowance for the surgeon's charge • Varicose vein surgery	PPO: 10% of the Plan allowance **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance **(No Deductible)** for providers used outside the 50 United States

Surgical procedures - continued on next page

Benefit Description	You Pay
Surgical procedures (cont.)	
Prior authorization is required for varicose vein surgery. See Section 3 for details. Failure to prior authorize a service may result in a maximum non-prior authorization penalty of $500 per episode of care. Note: For related services, see applicable benefits section (i.e., for inpatient hospital benefits, see Section 5(c)).	PPO: 10% of the Plan allowance **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance **(No Deductible)** for providers used outside the 50 United States
Transgender surgical services (gender reassignment surgery) to treat gender dysphoria. In order for the Plan to consider benefits, all of the following Plan requirements must have been met: 1. Twelve months of living in a gender role that is congruent with their gender identity (real life experience), and 2. Two referral letters from qualified mental health professionals, one in a purely evaluative role, and 3. Persistent, well-documented gender dysphoria, and 4. Capacity to make a fully informed decision and to consent for treatment, and 5. Age of majority (18 years or older), and 6. If significant medical or mental health concerns are present, they must be reasonably well controlled, and 7. **You have obtained preauthorization for the surgery even if the proposed treatment is outside of the 50 United States and services are deemed medically necessary.** Medical necessity: See Section 10, page 103. **Covered surgical procedures, limited to:** • For female to male surgery: mastectomy, hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, scrotoplasty, and placement of testicular and erectile prosthesis. • For male to female surgery: penectomy, orchidectomy, vagnoplasty, clitoroplasty, and labiaplasty *Not covered:* • *Rhinoplasty, face-lifting, lip enhancement, facial bone reduction, blepharoplasty, breast augmentation, liposuction of the waist (body contouring), reduction thyroid chondroplasty, hair removal, voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which have been used in feminization, are considered cosmetic.* • *Similarly, chin implants, nose implants, and lip reduction, which have been used to assist masculinization, are considered cosmetic.* Note: We define cosmetic surgery as any operative procedure or any portion of a procedure performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form.	PPO: 10% of the Plan allowance **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance for providers used outside the 50 United States **(No Deductible)**

Surgical procedures - continued on next page

Benefit Description	You Pay
Surgical procedures (cont.)	
When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, our benefits are: For the primary procedure: - PPO: 90% of the Plan allowance (No Deductible) - Non-PPO: 70% of the Plan allowance (calendar year deductible applies) For the secondary procedure(s): - PPO: 90% of one-half of the Plan allowance (No Deductible) - Non-PPO: 70% of one-half of the Plan allowance (calendar year deductible applies) Note: Multiple or bilateral surgical procedures performed through the same incision are "incidental" to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.	PPO: 10% of the Plan allowance for the primary procedure and 10% of one-half of the Plan allowance for the secondary procedure(s) **(No Deductible)** Non-PPO: 30% of the Plan allowance for the primary procedure and 30% of one-half of the Plan allowance for the secondary procedure(s); and any difference between our payment and the billed amount 10% of the Plan allowance for the primary procedure and 10% of one-half of the Plan allowance for the secondary procedure(s) **(No Deductible)** for providers used outside the 50 United States Note: For certain surgical procedures, we may apply a value of less than 50% of subsequent procedures.
Not covered: *Services of a standby surgeon, except during angioplasty or other high risk procedures when we determine standbys are medically necessary.*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and; - the condition can reasonably be expected to be corrected by such surgery. • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of the congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birthmarks; and webbed fingers and toes.	PPO: 10% of the Plan allowance **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance **(No Deductible)** for providers used outside the 50 United States
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 for coverage) Note: Internal breast prostheses are covered under Section 5(a).	PPO: 10% of the Plan allowance **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed 10% of the Plan allowance **(No Deductible)** for providers used outside the 50 United States

Reconstructive surgery - continued on next page

Benefit Description	You Pay
Reconstructive surgery (cont.)	
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.	PPO: 10% of the Plan allowance **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed 10% of the Plan allowance **(No Deductible)** for providers used outside the 50 United States
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*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Surgical correction of temporomandibular joint (TMJ) dysfunction • Surgical removal of impacted teeth, including anesthesia charges • Other surgical procedures that do not involve the teeth or their supporting structures Note: Prior authorization is required for oral and maxillofacial surgery. See Section 3 for details. Failure to prior authorize a service may result in a maximum non-prior authorization penalty of $500 per episode of care.	PPO: 10% of the Plan allowance **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance **(No Deductible)** for providers used outside the 50 United States
Not covered: • *Oral implants, transplants and related services* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone), including Apicoectomy (the excision of the tooth root without the extraction of the entire tooth)* • *Pre- and post-operative examinations in preparation for surgical removal of impacted teeth*	*All charges*

Benefit Description	You Pay
Organ/tissue transplants	
These **solid organ transplants** are covered. These solid organ transplants are subject to medical necessity and experimental/ investigational review by the Plan. See *Other services* under *You need prior Plan approval for certain services* on page 19. 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 intestines - Small intestines with the liver - Small intestines with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung single/bilateral/lobar • Pancreas	PPO: 10% of the Plan allowance **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance **(No Deductible)** for providers used outside the 50 United States
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) - Neuroblastoma - Pediatric brain tumors - Recurrent germ cell tumors (including testicular cancer)	PPO: 10% of the Plan allowance **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance **(No Deductible)** for providers used outside the 50 United States
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. • Allogenic transplants for: - Acute lymphocytic or non-lymphocytic (i.e. myelogenous) leukemia	PPO: 10% of the Plan allowance **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You Pay
Organ/tissue transplants (cont.)	
- Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Hemoglobinopathy - Infantile malignant osteoporosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Myeloproliferative disorders - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemiah - 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) - Aggressive non-Hodgkin's lymphoma - Amyloidosis	PPO: 10% of the Plan allowance **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance **(No Deductible)** for providers used outside the 50 United States

Organ/tissue transplants - continued on next page

Benefit Description	You Pay
Organ/tissue transplants (cont.)	
- Ependymoblastoma - Ewing's sarcoma - Medulloblastoma - Multiple myeloma - Neuroblastoma - Oligodendroglioma - Pineoblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors - Waldenstrom's macroglobulinemia	PPO: 10% of the Plan allowance **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance **(No Deductible)** for providers used outside the 50 United States
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 nonlymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia	PPO: 10% of the Plan allowance **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance **(No Deductible)** for providers used outside the 50 United States

Organ/tissue transplants - continued on next page

Benefit Description	You Pay
Organ/tissue transplants (cont.)	
- Advanced childhood kidney cancers - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Childhood rhabdomyosarcoma - Ewing's sarcoma - Mantle Cell (Non-Hodgkin's lymphoma) - Neuroblastoma	PPO: 10% of the Plan allowance **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance **(No Deductible)** for providers used outside the 50 United States
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Beta Thalassemia Major - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - 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 - Chronic lymphocytic leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia	PPO: 10% of the Plan allowance **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance **(No Deductible)** for providers used outside the 50 United States

Organ/tissue transplants - continued on next page

Benefit Description	You Pay
Organ/tissue transplants (cont.)	
- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myelodysplasia/Myelodysplastic Syndromes - Myeloproliferative disorders (MDDs) • Autologous Transplants for - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin's lymphomas - Breast cancer - Childhood rhabdomyosarcoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin's lymphoma) - Scleroderma-SSc (severe, progressive) - Systemic sclerosis	PPO: 10% of the Plan allowance **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance **(No Deductible)** for providers used outside the 50 United States
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. Note: All allowable charges incurred for a surgical transplant, whether incurred by the recipient or donor will be considered expenses of the recipient and will be covered the same as for any other illness or injury subject to the limits stated below. This benefit applies only if we cover the recipient and if the donor's expenses are not otherwise covered. Note: We cover donor screening testing for up to four potential bone marrow transplant donors per year from individuals unrelated to the patient, in addition to testing of family members.	PPO: 10% of the Plan allowance **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance **(No Deductible)** for providers is used outside the 50 United States **(No Deductible)**
Not covered: • *Services or supplies for or related to surgical transplant procedures (including administration of high-dose chemotherapy) for artificial or human organ/tissue transplants not listed as specifically covered.*	*All charges*

Organ/tissue transplants - continued on next page

Benefit Description	You Pay
Organ/tissue transplants (cont.)	
• *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Donor search expense for bone marrow transplants*	*All charges*
Limited Benefits: • The process for preauthorizing organ transplants is more extensive than the normal precertification process. Before your initial evaluation as a potential candidate for a transplant procedure, you or your doctor must contact the Plan's Medical Management Program so we can arrange to review the clinical results of the evaluation and determine if the proposed procedure meets our definition of "medically necessary" and is on the list of covered transplants. Coverage for the transplant must be authorized in advance, in writing by the Plan's Medical Management Program. • We will pay for a second transplant evaluation recommended by a physician qualified to perform the transplant, if the transplant diagnosis is covered and the physician is not associated or in practice with the physician who recommended and will perform the organ transplant. A third transplant evaluation is covered only if the second evaluation does not confirm the initial evaluation. • The transplant must be performed at an Optum Health Transplant Center of Excellence to receive maximum benefits. • If benefits are limited to $100,000 per transplant, included in the maximum are all charges for hospital, medical and surgical care incurred while the patient was hospitalized for a covered transplant surgery and subsequent complications related to the transplant. Outpatient expenses for chemotherapy and any process of obtaining stem cells or bone marrow associated with bone marrow transplant (stem cell support) are included in benefits limit of $100,000 per transplant. Tandem bone marrow transplants approved as one (1) treatment protocol are limited to $100,000 when not performed at an Optum Health Transplant Center of Excellence. Expenses for aftercare such as outpatient prescription drugs are not a part of the $100,000 limit. • Chemotherapy and procedures related to bone marrow transplantation must be performed only at an Optum Health Transplant Center of Excellence to receive maximum benefits. • Simultaneous transplants such as kidney/pancreas, heart/lung, heart/liver are considered as one transplant procedure and are limited to $100,000 when not performed at an Optum Health Transplant Center of Excellence.	PPO: 10% of the Plan allowance **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance **(No Deductible)** for providers used outside the 50 United States Note: If prior approval is not obtained or an Optum Health Transplant Center of Excellence is not used, our allowance will be limited for hospital and surgery expenses up to a maximum of $100,000 per transplant. If we cannot refer a member in need of a transplant to a designated facility, the $100,000 maximum will not apply.

Organ/tissue transplants - continued on next page

Benefit Description	You Pay
Organ/tissue transplants (cont.)	
Transportation Benefit • We will also provide up to $15,000 per covered transplant for transportation (mileage or airfare) to a designated Optum transplant facility and reasonable temporary living expenses (i. e., lodging and meals) for the recipient and one other individual (or in the case of a minor, two other individuals), if the recipient lives more than 50 miles from the designated transplant facility. • Transportation benefits are payable for follow-up care up to one year following the transplant. You must contact Customer Service for what are considered reasonable temporary living expenses.	
Anesthesia	
Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	PPO: 10% of the Plan allowance **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance **(No Deductible)** for providers used outside the 50 United States Covered services provided in a PPO facility by a Non-PPO anesthesiologist or certified registered nurse anesthetist will be paid at 90% of the Plan allowance **(No Deductible)**.

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: $350 per Self enrollment ($700 per Self Plus One enrollment or Self and Family enrollment) for PPO services and $400 per Self enrollment ($800 per Self Plus One enrollment or Self and Family enrollment) for non-PPO services. We added "(No Deductible)" to show when the calendar year deductible **does not** apply.

• PPO benefits apply only when you reside in the PPO network area and use a PPO provider. When no PPO provider is available, non-PPO benefits apply. PPO benefits apply when you reside outside the 50 United States.

• The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply. Please refer to Page 12 when utilizing non-PPO providers to review how coverage will apply.

• 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, or if you are age 65 or over.

• The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Section 5(a) or (b).

• YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS, SKILLED NURSING FACILITIES (SNF), HOSPICE, HOME HEALTH CARE AND NON-EMERGENCY AIR AMBULANCE; FAILURE TO DO SO WILL RESULT IN A MAXIMUM $500 PENALTY. Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefit Description	You Pay
Note: We say "(No Deductible)" when the deductible does not apply.	
Inpatient hospital	
Room and board, such as • Ward, semiprivate or intensive care accommodations • General nursing care • Meals and special diets • Operating, recovery, and other treatment rooms • Rehabilitative services • Phase 1 of cardiac rehabilitation • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen	PPO: $200 copayment per hospital stay **(No Deductible)** Non-PPO: $400 copayment per hospital stay and 30% of the Plan allowance and any difference between the Plan allowance and the billed amount **(No Deductible)** $200 copayment per hospital stay for providers used outside the 50 United States **(No Deductible)**

Inpatient hospital - continued on next page

Benefit Description	You Pay
Inpatient hospital (cont.)	
• Anesthetics Note: Take-home drugs are covered under Section 5(f). Note: Medical supplies, medical equipment, prosthetic and orthopedic devices and any covered items billed by a hospital for use at home are covered under Section 5(a) and the calendar year deductible and coinsurance apply. Note: PPO inpatient hospital services related to maternity care are covered at 100%, see Section 5(a) maternity care.	PPO: $200 copayment per hospital stay **(No Deductible)** Non-PPO: $400 copayment per hospital stay and 30% of the Plan allowance and any difference between the Plan allowance and the billed amount **(No Deductible)** $200 copayment per hospital stay for providers used outside the 50 United States **(No Deductible)**
Not covered: • *Any part of a hospital admission that is not medically necessary (see definition in Section 10) such as when you do not need the acute hospital inpatient (overnight) setting but could receive care in some other setting without adversely affecting your condition or the quality of the medical care. Note: In this event, we pay benefits for services and supplies, excluding room and board and inpatient physician care, at the level of benefits that would have been covered if provided in another approved setting.* • *Inpatient hospital services and supplies for surgery that we do not cover* • *Custodial care (see definition, Section 10) even when provided by a hospital* • *Non-covered facilities, such as nursing homes, rest homes, places for the aged, convalescent homes or any place that is not a hospital, skilled nursing facility, or hospice* • *Personal comfort items, such as radio, television, phone, beauty and barber services* • *Private nursing care* • *Long term rehabilitative therapy*	*All charges*
Outpatient hospital	
• Operating, recovery, and other treatment room charges • Prescribed drugs and medications for use in the facility • X-ray, laboratory and pathology services, and machine diagnostic tests • Administration of blood, blood plasma, chemotherapy and other biologicals • Blood and blood plasma, if not donated or replaced • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between the Plan allowance and the billed amount 10% of the Plan allowance for providers used outside the 50 United States

Outpatient hospital - continued on next page

Benefit Description	You Pay
Outpatient hospital (cont.)	
• Phase II of cardiac rehabilitation - 12-week program provided by a hospital or medical center program on an outpatient basis beginning anywhere between 7 to 30 days after discharge from hospital	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between the Plan allowance and the billed amount 10% of the Plan allowance for providers used outside the 50 United States
Note: Take-home drugs are covered under Section 5(f). Note: Medical supplies, medical equipment, prosthetic and orthopedic devices and any covered items billed by a hospital for use at home are covered under Section 5(a) and the calendar year deductible and coinsurance apply. Note: We cover hospital services related to dental procedures (even though the dental procedure itself may not be covered) only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard your health. Note: Hospital observation care that exceeds 24 hours will be paid under the inpatient hospital benefit. Note: Specialty drugs that are received under the medical benefit and available under Section 5(f) must be obtained through Accredo after 2 courtesy fills (see Section 5(f))	
Not Covered: *• Phase III of cardiac rehabilitation - a maintenance program that is not considered treatment of an illness*	
Ambulatory surgical center	
• Operating, recovery, and other treatment room charges	PPO: 10% of the Plan allowance **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between the Plan allowance and the billed amount **(No Deductible)** 10% of the Plan allowance for providers used outside the 50 United States **(No Deductible)**
• Prescribed drugs and medications for use in the facility • X-ray, laboratory and pathology services, and machine diagnostic tests • Administration of blood, blood plasma, chemotherapy and other biologicals • Blood and blood plasma, if not donated or replaced • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between the Plan allowance and the billed amount 10% of the Plan allowance for providers used outside the 50 United States

Ambulatory surgical center - continued on next page

Benefit Description	You Pay
Ambulatory surgical center (cont.)	
Note: Specialty drugs that are received under the medical benefit and available under Section 5(f) must be obtained through Accredo after 2 courtesy fills (see Section 5(f))	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between the Plan allowance and the billed amount 10% of the Plan allowance for providers used outside the 50 United States
Skilled nursing care facility benefits	
We cover semiprivate room, board, services and supplies in a Skilled Nursing Facility (SNF) for up to 90 days when: 1. Skilled Nursing Facility stay is medically necessary and; 2. When the Skilled Nursing Facility is under the supervision of a physician. Note: A maximum $500 penalty is applied if services are not pre-certified. See Section 3 for more information	PPO: Charges in excess of 90-day maximum after deductible Non-PPO: 30% of the Plan allowance and any difference between our allowance and billed charges. Charges in excess of the 90-day maximum. Charges in excess of 90-day maximum after deductible for providers used outside the 50 United States
Not Covered: • *Custodial care*	*All charges*
Hospice care	
Hospice is a coordinated inpatient and outpatient program of maintenance and supportive care for the terminally ill provided by a medically supervised team under the direction of a Plan-approved independent hospice administration. All Hospice benefits must be precertified. A penalty maximum of $500 per confinement or episode of care will be applied for services not precertified. Respite care – if you are under hospice care, inpatient respite care is covered up to 2 times a year for up to 5 days at a time. Note: Bereavement counseling is covered under Section 5 (e). Mental Health and Substance Use Disorder Benefits	**Inpatient:** PPO: $200 copayment per confinement **(No Deductible)** Non-PPO: $400 copayment per confinement and 30% of the Plan Allowance and any difference between the Plan allowance and the billed amount **(No Deductible)** $200 copayment per confinement for providers used outside the 50 United States **(No Deductible)** **Outpatient:** PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and billed charges 10% of the Plan allowance for providers used outside the 50 United States.
Ambulance	
• Professional ambulance service (including air ambulance when medically necessary) to or from the nearest hospital equipped to handle your condition. Note: All non-emergency air ambulance transportation must be prior authorized through Sentinel at (877) 542-8828 or is subject to a maximum $500 penalty for non prior authorization. See Section 3 for more details.	10% of the Plan allowance and any difference between our allowance and the billed amount.

Ambulance - continued on next page

Benefit Description	You Pay
Ambulance (cont.)	
Not covered: • *Ambulance/professional transportation from facility to home* • *Ambulance/professional transport for you or your family's convenience*	*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: $350 per person ($700 per Self Plus One or Self and Family) for PPO and $400 per person ($800 per Self Plus One or Self and Family) for non-PPO services. We added "(No Deductible)" to show when the calendar year deductible does not apply.
- PPO benefits apply only when you reside in the PPO network area and use a PPO provider or if you use a provider outside the 50 United States. When no PPO provider is available, non-PPO benefits apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply. Please refer to Page 12 when utilizing non-PPO providers to review how coverage will apply.
- 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, or if you are age 65 or over.

What is an accidental injury?

An accidental injury is a bodily injury that requires immediate medical attention and is sustained solely through violent, external, and accidental means, such as broken bones, animal bites, insect bites and stings, and poisonings. Accidental dental injury is covered under Section 5(g).

Benefit Description	You pay
Note: We say "(No Deductible)" when the deductible does not apply.	
Accidental injury	
We pay 100% of the Plan allowance after the listed copayments for the following care you receive as a result of an accidental injury: • Emergency room (ER) facility charge and ER physician's charge or • Initial office visit for accidental injury Note: We pay for services performed outside the ER facility under the appropriate Plan benefit. Note: We pay for services in the ER, but billed separately from the hospital bill such as X-ray, laboratory, pathology and machine diagnostic tests under the appropriate Plan benefit (see Section 5 (a)). Note: We pay Hospital benefits as specified in Section 5(c) if you are admitted to the hospital. Note: We pay for services performed at the time of the initial office visit such as X-ray, laboratory tests, drugs or any supplies or other services under the appropriate Plan benefit (see Section 5 (a)).	PPO services **in physician's office**: $15 copayment **(No Deductible)** $25 copayment for specialist **(No Deductible)** PPO services **outside physician's office**: $200 copayment per occurrence **(No Deductible)** (copayment is waived if admitted to the hospital) Non-PPO service **in physician's office**: 30% of the Plan allowance and any difference between our allowance and the billed amount **(No Deductible)** Non-PPO Services **outside physician's office**: $200 copayment per occurrence **(No Deductible)** (copayment is waived if admitted to the hospital) Services **in physician's office:** $15 copayment **(No Deductible)** $25 copayment for Specialist **(No Deductible)** for providers used outside the 50 United States Services **outside physician's office:** $200 copayment per occurrence **(No Deductible)** (copayment is waived if admitted to the hospital) for services used outside the 50 United States
If you receive outpatient care for your accidental injury in an urgent care center, we cover: • Non-surgical physician services and supplies	PPO: $50 copayment per occurrence **(No Deductible)** (copayment is waived if admitted to the hospital)

Accidental injury - continued on next page

Benefit Description	You pay
Accidental injury (cont.)	
• Surgery and related services	PPO: $50 copayment per occurrence **(No Deductible)** (copayment is waived if admitted to the hospital) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount **(No Deductible)** $50 copayment per occurrence for providers used outside of the 50 United States **(No Deductible)** (copayment is waived if admitted to the hospital)
Medical emergency	
We pay 100% of the Plan allowance after the listed copayments for the following care you receive as a result of an accidental injury: • Emergency room (ER) facility charge and ER physician's charge or • Initial office visit for accidental injury Note: We pay for services performed outside the ER facility under the appropriate Plan benefit. Note: We pay for services in the ER, but billed separately from the hospital bill such as X-ray, laboratory, pathology and machine diagnostic tests under the appropriate Plan benefit (see Section 5 (a)). Note: We pay Hospital benefits as specified in Section 5(c) if you are admitted to the hospital. Note: We pay for services performed at the time of the initial office visit such as X-ray, laboratory tests, drugs or any supplies or other services under the appropriate Plan benefit (see Section 5 (a)).	PPO services **in physician's office**: $15 copayment **(No Deductible)** $25 copayment for Specialist **(No Deductible)** PPO services **outside physician's office:** $200 copayment per occurrence (copayment is waived if admitted to the hospital) **(No Deductible)** Non-PPO **in physician's office**: 30% of the Plan allowance and any difference between our allowance and the billed amount **(No Deductible)** Non-PPO **outside physician's office**: $200 copayment per occurrence (copayment is waived if admitted to the hospital) **(No Deductible)** Services **in physician's office**: $15 copayment **(No Deductible)** $25 copayment for Specialist **(No Deductible)** for providers used outside the 50 United States Services **outside physician's office:** $200 copayment per occurrence for providers used outside the 50 United States (copayment is waived if admitted to the hospital) **(No Deductible)**
If you receive outpatient care for your medical emergency in an urgent care center, we cover: • Non-Surgical physician services and supplies • Surgery and related services	PPO: $50 copayment per occurrence **(No Deductible)** (copayment is waived if admitted to the hospital) Non-PPO: 30% of Plan allowance and any difference between our allowance and the billed amount **(No Deductible)** $50 copayment per occurrence for providers used outside the 50 United States **(No Deductible)** (copayment is waived if admitted to the hospital)

Benefit Description	You pay
Ambulance	
• Professional ambulance service (including air ambulance when medically necessary) to or from the nearest hospital equipped to handle your condition. Note: All non-emergency transportation must be prior authorized or it is subject to the maximum $500 penalty for non prior authorization. All non-emergency air ambulance transportation must be prior authorized through Sentinel at 877-542-8828 or is subject to the maximum $500 penalty for non prior authorization. See Section 3 for more details.	10% of Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Ambulance/professional transportation from facility to home* • *Ambulance/professional transport for you or your family's convenience*	*All charges*

If you reside in the PPO network area, you may choose to get PPO or non-PPO care. To locate a PPO provider, visit www.compassrosebenefits.com/UHC and select "*View directory of behavioral health providers.*" Cost-sharing and limitations for PPO mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions. If you use a provider outside the 50 United States the PPO benefit applies.

Important things you should keep in mind about these benefits:

• Please remember 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: $350 for PPO per Self enrollment and $400 for non-PPO services per Self enrollment ($700 for PPO per Self Plus One enrollment or per Self and Family enrollment and $800 for non-PPO services per Self Plus One enrollment or Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No Deductible)" to show when the calendar year deductible **does not** apply.

• The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply. Please refer to Page 12 when utilizing non-PPO providers to review how coverage will apply.

• 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, or if you are age 65 or over.

• 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 (1) clinically appropriate treatment plan in favor of another.

• YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MAXIMUM $500 PENALTY. Please refer to the precertification and prior authorization information shown in Section 3 to be sure which services require precertification or prior authorization.

Benefit Description	You Pay
Note: We say "(No Deductible)" when the deductible does not apply.	
Professional Services	
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 family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Professional Services Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnosis evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment	PPO services **in physician's office**: $15 copayment **(No Deductible)** PPO services **outside physician's office:** 10% of the Plan allowance. Non-PPO: 30% 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.)	
• Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug misuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy • Bereavement counseling	PPO services **in physician's office**: $15 copayment **(No Deductible)** PPO services **outside physician's office:** 10% of the Plan allowance. Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Services **in physician's office**: $15 copayment **(No Deductible)** for providers used outside the 50 United States. Services **outside physician's office:** 10% of the Plan allowance for providers used outside the 50 United States.
Telehealth	
• Telehealth Note: Doctor On Demand physicians treat hundreds of conditions, including providing mental health counseling and medication management. For more information on telehealth benefits, please see Section 5(h) Wellness and other special features.	PPO and Doctor On Demand: Nothing **(No Deductible)** Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Nothing **(No Deductible)** for providers used outside the 50 United States
Diagnostics	
• Outpatient diagnostic tests are 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	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance for providers used outside the 50 United States
Inpatient hospital and other covered facility	
• 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 • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	PPO: $200 copayment per hospital stay **(No Deductible)** Non-PPO: $400 copayment per hospital stay and 30% of the Plan allowance and any difference between our allowance and the billed amount **(No Deductible)** $200 copayment per hospital stay for providers used outside the 50 United States **(No Deductible)**

Benefit Description	You Pay
Outpatient hospital or other covered facility	
• Outpatient services provided and billed by a hospital or other covered facility • Services such as half-way house, full-day hospitalization, or facility-based intensive outpatient treatment	**Outpatient services** provided and billed by a hospital or other covered facility: PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount. 10% of the Plan allowance for providers used outside the 50 United States **Other Outpatient services including half-way house, full day hospitalization or facility based intensive outpatient treatment:** PPO: 10% of the Plan allowance **(No Deductible)** with a 90-visit maximum. All charges over the visit maximum. Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount **(No Deductible)** with a 90-visit maximum. All charges over the visit maximum. 10% of the Plan allowance **(No Deductible)** with a 90-visit maximum. All charges over the visit limit for providers used outside the 50 United States.
Partial Hospitalization	
• Partial hospitalization Note: Subject to the maximum $500 penalty for partial hospitalization services if not precertified.	PPO: 10% of the Plan allowance **(No Deductible)** with a 90-visit maximum. All charges over the visit maximum. Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount **(No Deductible)** with a 90-visit maximum. All charges over the visit maximum. 10% of the Plan allowance **(No Deductible)** with a 90-visit maximum. All charges over the visit limit for providers used outside the 50 United States.
Residential treatment services	
Residential treatment services Note: Subject to the maximum $500 per admission penalty for Residential Treatment Services, if not precertified. Note: Covered residential treatment center facilities are approved by the Joint Commission or Commission on Accreditation of Rehabilitation Facilities (CARF)	PPO: Charges in excess of the 90-day maximum after deductible Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed charges. Charges in excess of the 90-day maximum Charges in excess of the 90-day maximum after deductible for providers used outside the 50 United States

Residential treatment services - continued on next page

Benefit Description	You Pay
Residential treatment services (cont.)	
Not covered under mental health and substance use disorder : • *All charges for chemical aversion therapy, conditioned reflex treatments, narcotherapy or any similar aversion treatments and all related charges (including room and board)* • *Any provider not specifically listed as covered* • *Marital counseling* • *Treatment for learning or mental disabilities* • *Travel time to the patient's home to conduct therapy* • *Services rendered or billed by schools or members of their staff* • *Personality Disorders* • *Behavior/Impulse Control Disorders*	*All charges*

See these sections of the brochure for more valuable information about these benefits:

- Section 4, *Your cost for covered services,* for information about catastrophic protection for these benefits
- Section 7, *Filing a claim for covered services*, for information about submitting non-PPO claims

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described below.
- 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.
- Members must make sure their prescribers obtain prior approval/authorization for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically. See *Other services* under *You need prior Plan approval for certain services* on Page 19.
- Federal law prevents the pharmacy from accepting unused medications.
- Certain drugs require prior authorization or may be subject to quantity limits. If your prescription is for a drug requiring prior authorization, additional information from your physician will be needed before the medication is dispensed. Your physician may call 800-753-2851 to begin the review process.
- The calendar year deductible does not apply to benefits in this Section.
- 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, or if you are age 65 or over.

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

Who can write your prescription. A licensed physician, optometrist, podiatrist 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 network pharmacy or by home delivery. To locate a network pharmacy in your area, call 877-438-4449 or visit our Express-Scripts website through our member portal at member.compassrosebenefits.com. For prospective members, please go to www.compassrosebenefits.com/pharmacy. We will send you information on the home delivery drug program. To use the program: 1) complete the initial home delivery form; 2) enclose your prescription and copayment; 3) mail your order to Express Scripts, PO Box 66577, St Louis, MO 63166-6577; 4) allow two to three weeks for delivery. You will receive forms for refills and future prescription orders each time you receive drugs or supplies under this program. If you have questions about the home delivery program, call 877-438-4449. Note: Prescriptions filled by non-network pharmacy providers are not covered by the Plan.

You are required to obtain all specialty drugs used for long term therapy (chronic specialty drugs) from Accredo (home delivery), your exclusive Specialty Pharmacy. Express Scripts can advise you if your prescription is required to be obtained from Accredo and cannot be obtained from a retail pharmacy. Your physician can fax your prescription directly to Accredo at 800-803-2523 or you can mail your prescription to: Express Scripts, P. O. Box 66577, St. Louis, MO 63166-6567. If you purchase your chronic specialty drugs from a retail pharmacy, you will be responsible for their full cost. Note: This does not apply to specialty medications you purchase from a retail pharmacy outside the 50 United States. You file a claim for them as you would for other medications purchased in this manner.

In addition, certain specialty drugs must be obtained from Accredo (home delivery) and not from your prescriber's office or outpatient facility when Medicare B is not your primary coverage for the drug. You or your prescriber can contact Express Scripts at 800-803-2523 to speak to an Accredo representative to inquire if your drug should be obtained through Accredo. If you currently are using a specialty drug supplied by the prescriber’s office or an outpatient facility, you are required to obtain the drug from Accredo after two courtesy fills through the medical benefit. Nursing services are provided by Accredo when necessary. If you continue to purchase your drugs from your prescriber, outpatient facility, or another pharmacy, you will be responsible for their full cost after two courtesy fills. Note: This does not apply to specialty drugs you obtain from a provider or Military Treatment Facility outside the 50 United States. You file a claim for them as you would for other drugs purchased in this manner.

These are the dispensing limitations. You may purchase your covered prescription drugs and supplies by presenting your prescription drug card and your prescription to a participating provider. If obtaining prescription drugs from a VA hospital or military treatment facility, you may obtain a 3-month supply of covered drugs. Refills are allowed by your plan at a retail pharmacy after 80% of the medication is consumed. Refills are allowed by your plan through mail order after 77% of the medication is consumed. The calculation is based on the total amount of medication dispensed in the last 180 days.

If your physician or dentist prescribes a medication that will be taken over an extended period of time, you should request two (2) prescriptions, one for immediate use with a participating retail pharmacy and the other for up to a 90-day supply from the Home Delivery Program. Medications received from the Home Delivery Program must be for a minimum 84-day supply. The Plan also covers a 90-day supply of covered medications at CVS and Walgreens in addition to Express Scripts home delivery pharmacy. Most drugs and supplies covered by the Plan are available under this program with the exception of specialty medications and fertility drugs. If you have questions about a particular drug or a prescription, and to request your first order forms, call Express Scripts at 877-438-4449. If a generic equivalent to the prescribed drug is available, Express Scripts will dispense the generic equivalent instead of the brand name unless you or your physician specifies that the brand name is required. If a generic equivalent is not available, you will be charged the applicable copayment or coinsurance for the medication prescribed. When purchasing drugs at a pharmacy, you must use your health plan member identification (ID) card.

You may be able to obtain certain therapy directly through the pharmacy benefit including but not limited to specialty medications (i.e. gene therapy, antineoplastic agents, immunoglobulin preparations).

We use a formulary. We use the Express Scripts National Preferred Formulary. Preferred Drugs are selected according to safety, efficacy (whether the drug works for the indicated purpose), therapeutic merit (how appropriate the drug is for the treatment of a particular condition), current standard of practice, and cost. Non-Preferred drugs are also on the Formulary, but at a higher copay. Drugs that are excluded from the Formulary are not covered by the prescription drug program unless approved through a Formulary exception process managed by Express Scripts. If approved through the process, the non-preferred copay applies.

The Formulary is the same for both the Mail-Order Pharmacy and the retail network pharmacies and is comprehensive for all major categories of acute and maintenance medications. To find out the Formulary status of a drug, you can either call Express Scripts at 877-438-4449 or look on the web at www.compassrosebenefits.com/Formulary.

We have a six-tier prescription drug benefit.

Level 1: includes generic drugs

Level 2: includes preferred/formulary brand name drugs

Level 3: includes non-preferred/non-formulary brand name drugs

Specialty Generic: includes generic specialty drugs

Specialty Formulary: includes specialty preferred brand name drugs

Specialty Non-Formulary: includes specialty non-preferred brand name drugs

Why use generic drugs? Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand name product. Generics cost less than the equivalent brand name product. The U.S. Food and Drug Administration (FDA) sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand name drugs.

How to reach an Express Scripts Specialist Pharmacist. If you have questions on your medications, call 877-438-4449. The pharmacists specialize in caring for patients with complex and costly conditions. This includes but is not limited to cardiovascular, diabetes, cancer, HIV, asthma, depression, and specialty conditions.

Some drugs require prior authorization. A Prior Authorization (PA) is a clinical program that ensures appropriate use of prescription medications. You, your pharmacist or your physician can initiate a PA for medication by contacting Express Scripts Prior Authorization department directly at 800-753-2851 and requesting a PA for the medication. You, your pharmacist or your physician can initiate a PA for medication. Your doctor can also visit www.ESRX.com/PA and complete the information online. Medications subject to a PA require a clinical review and pre-approval from the Express Scripts Prior Authorization Team before they can qualify for coverage under this Program. Medications requiring Prior Authorization are subject to change. Therefore, if you have questions about a particular drug, please contact Express Scripts customer service at 877-438-4449.

Quantity allowances. Specific allowances are in place for certain medications based on FDA-approved prescribing and safety information and clinical guidelines. These include but are not limited to quantity limits, days supply and refill limitations.

Step therapy (non-specialty and specialty). Within specific therapy classes, there are multiple drugs available to treat the same condition. Step Therapy manages drug costs by ensuring that patients try first line, clinically effective, lower-cost medications before they utilize a higher-cost medication. The step therapy program applies edits to drugs in specific classes at the point of sale. Coverage for second-line therapies (second/third step) is determined at the patient level based on the presence or absence of first-line drugs or other automated factors in the patient's claim history.

Express Scripts SafeGuardRx^{SM} Program. The SafeGuardRx^{SM} Program is a suite of solutions that addresses specific chronic therapeutic conditions focused on reducing costs and improving care. The emphasis is on ensuring members are getting appropriate therapy for their condition, adherence and specialized care for better therapy outcomes. These programs may include prior authorization, step therapy, and refill and quantity limits. Some medications may be preferred over others based on FDA indications. These programs may require that you receive your medications from a specific preferred network pharmacy. You may pay a higher cost for your medications at a retail pharmacy after obtaining multiple fills. Medications used to treat high cholesterol and multiple sclerosis are a couple of the targeted therapies. We will incorporate additional therapies where appropriate to address member needs.

In order to manage an affordable prescription benefit, it is important that we are reactive to unnecessary cost increases. Safety and effectiveness of medication will remain a priority, however, one medication may be more cost effective than another. We may act upon an unexplainable cost increase during the year and make medications that are less costly preferred.

Express Scripts Patient Assurance Program (PAP). Compass Rose, through Express Scripts' Patient Assurance Program (PAP), may lower copays on select medications you may receive.

Compound Medications. A compound medication is a compounded prescription in a customized dosage form that contains at least one federal legend drug. You should contact Express Scripts at 877-438-4449 to determine if a compound medication is covered before you fill the prescription.

The U.S. Food and Drug Administration (FDA) defines a compound medication as one that requires a licensed pharmacist to combine, mix or alter the ingredients of a medication when filling a prescription. The FDA does not verify the quality, safety and/or effectiveness of compound medications.

Pharmacies must submit all ingredients in a compound prescription as part of the claim for both online and paper claim submissions. All ingredients submitted with the compound prescription claim must be covered and at least one of the ingredients must require a physician’s prescription for reimbursement.

Prescriptions containing certain ingredients (such as, over-the-counter (OTC) products, bulk powders, kits, solid dosage forms, and proprietary bases) when compounded for dispensing are not covered through the prescription benefit. Investigational drugs are not FDA-approved. If the compound includes an investigational drug, the compound will not be covered.

Benefits Description	You Pay
Note: The calendar year deductible does NOT apply to benefits in this Section	
Covered medications and supplies	
You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by home delivery: • Drugs, vitamins and minerals that by Federal law of the United States require a doctor's prescription for their purchase. • Insulin • Diabetic supplies limited to: - Disposable needles and syringes for the administration of covered medications - Supplies required for administration of injectable medication - Lancets and test strips Note: Members with diabetes who have Medicare B as their primary insurer, must obtain their testing supplies through a diabetic supplier that coordinates benefits with Medicare. Please contact Express Scripts at 877-438-4449. • FDA-approved drugs and devices requiring a physician's prescription for the purpose of birth control. See Section 5(a) Family planning • Needles and syringes for the administration of covered medications Here are some things to keep in mind about our prescription drug program: • A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. Your physician must specify "dispense as written" if a brand name drug is required. • Brand/Generic Cost Differential: If there is a generic substitution available and you request a brand-name drug, you will be responsible for the brand copay plus the difference in the cost of the brand-name and generic drug. If your provider's prescription is for the brand-name drug and indicates "Dispense as Written" you are responsible only for the brand copay. • We use the Express Scripts National Preferred Formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. To request a prescription drug formulary, call Customer Service at 877-438-4449.	**Network Retail 30-day supply:** Level 1: $5 **(No Deductible)** Level 2: $45 **(No Deductible)** Level 3: 40% of the Plan cost or $75, whichever is greater **(No Deductible)** **Network Retail 30-day supply when Medicare Part B is primary:** Level 1: $3 **(No Deductible)** Level 2: $25 **(No Deductible)** Level 3: 35% of the Plan cost or $50, whichever is greater **(No Deductible)** **Network Home Delivery:** Level 1: $10 **(No Deductible)** Level 2: $90 **(No Deductible)** Level 3: 40% of the Plan cost or $150, whichever is greater **(No Deductible)** **Network Home Delivery when Medicare Part B is primary:** Level 1: $6 **(No Deductible)** Level 2: $50 **(No Deductible)** Level 3: 35% of the Plan cost or $100, whichever is greater **(No Deductible)** **Note: If there is no generic equivalent available, you will still have to pay the Level 2 or Level 3 copayment.** When purchasing drugs at a pharmacy, you must use your Health Insurance Card.

Covered medications and supplies - continued on next page

Benefits Description	You Pay
Covered medications and supplies (cont.)	
Note: Refer to Section 6. General Exclusions - services, drugs and supplies we do not cover.	**Network Retail 30-day supply:** Level 1: $5 **(No Deductible)** Level 2: $45 **(No Deductible)** Level 3: 40% of the Plan cost or $75, whichever is greater **(No Deductible)** **Network Retail 30-day supply when Medicare Part B is primary:** Level 1: $3 **(No Deductible)** Level 2: $25 **(No Deductible)** Level 3: 35% of the Plan cost or $50, whichever is greater **(No Deductible)** **Network Home Delivery:** Level 1: $10 **(No Deductible)** Level 2: $90 **(No Deductible)** Level 3: 40% of the Plan cost or $150, whichever is greater **(No Deductible)** **Network Home Delivery when Medicare Part B is primary:** Level 1: $6 **(No Deductible)** Level 2: $50 **(No Deductible)** Level 3: 35% of the Plan cost or $100, whichever is greater **(No Deductible)** **Note: If there is no generic equivalent available, you will still have to pay the Level 2 or Level 3 copayment.** When purchasing drugs at a pharmacy, you must use your Health Insurance Card.
Narcan and Naloxone	**Network Retail:** • Nothing
Voluntary Smart90: You have the option to obtain a 90-day supply at Walgreens and CVS retail pharmacies or use the Express Scripts home delivery pharmacy. You can also fill 30-day supplies of any medication at an in-network retail pharmacy.	**Voluntary Smart90**: Level 1: $10 **(No Deductible)** Level 2: $90 **(No Deductible)** Level 3: 40% of the Plan cost or $150, whichever is greater **(No Deductible)** **Voluntary Smart90 when Medicare Part B is primary**: Level 1: $6 **(No Deductible)** Level 2: $50 **(No Deductible)**

Covered medications and supplies - continued on next page

Benefits Description	You Pay
Covered medications and supplies (cont.)	
	Level 3: 35% of the Plan cost or $100, whichever is greater **(No Deductible)**
Specialty medications are those injectable and oral drugs typically used to treat chronic or complex conditions. They have one or more of several key characteristics, including frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and increase the probability for beneficial treatment outcomes; patient training and compliance assistance to facilitate therapeutic goals; specialized product handling and/or administration requirements. • Antihemophilic factor • Blood growth factors • Calcimimetic agent • Growth hormone medications • Immunoglobulin preparations • Immunosuppressive drugs • Interferons • Interleukin-receptor antagonist • Monoclonal antibody • Mucolytic enzyme • Platelet aggregation inhibitor • Prostaglandin drugs • Synthetic nucleoside analog • Tumor necrosis factor modulators Drugs in these categories are subject to the Specialty Pharmacy Benefits. The medication examples provided are not all inclusive. Call our Customer Service department at 877-438-4449 to determine if other medications not listed apply to this benefit.	**Specialty Generic**: 10% of the plan cost up to a maximum of $100 for up to 30-day supply **(No Deductible)** **Specialty Formulary:** 25% of the Plan cost up to a maximum of $250 for up to 30-day supply **(No Deductible)** **Specialty Non-Formulary:** 35% of the Plan cost up to a maximum of $400 for up to 30-day supply **(No Deductible)** Note: Specialty medications are **not** eligible for the home delivery benefit of three months' supply for two copayments.
Obtaining Specialty Medication under the Plan: Specialty medications are injectable and oral medications that are used to treat chronic health conditions including but not limited to such conditions as transplant recipients, immunological conditions, growth hormone, bleeding disorder, HIV/AIDS. Please refer to your drug plan formulary to determine if the drug you have been prescribed by your physician needs to be filled by our network specialty pharmacy, Accredo at 800-803-2523.	**Specialty Generic**: 10% of the plan cost up to a maximum of $100 for up to 30-day supply **(No Deductible)** **Specialty Formulary:** 25% of the Plan cost up to a maximum of $250 for up to 30-day supply **(No Deductible)** **Specialty Non-Formulary:** 35% of the Plan cost up to a maximum of $400 for up to 30-day supply **(No Deductible)** Note: Specialty medications are **not** eligible for the home delivery benefit of three months' supply for two copayments.

Covered medications and supplies - continued on next page

Benefits Description	You Pay
Covered medications and supplies (cont.)	
If your medication has been identified as being a specialty medication, you will be required to call the number on your insurance card for instructions on how to arrange the filling and delivery of your specialty medication. • Medications will be mailed to you at no additional cost • For safety, all mailing will be shipped based on temperature requirements and considerations • Specialty Medications cannot be obtained through the traditional 90-day home delivery program • **Unless on an emergency basis, the Plan will not pay for Specialty Medications through the retail pharmacy.**	**Specialty Generic**: 10% of the plan cost up to a maximum of $100 for up to 30-day supply **(No Deductible)** **Specialty Formulary:** 25% of the Plan cost up to a maximum of $250 for up to 30-day supply **(No Deductible)** **Specialty Non-Formulary:** 35% of the Plan cost up to a maximum of $400 for up to 30-day supply **(No Deductible)** Note: Specialty medications are **not** eligible for the home delivery benefit of three months' supply for two copayments.
If you reside outside of the United States and do not order prescription drugs through the Home Delivery Prescription Drug Program. If you are provided drugs, including specialty pharmacy drugs, directly by a physician or covered facility (not a pharmacy), including FDA-approved drugs and devices requiring a physician's prescription for the purpose of birth control. If you do not use your prescription drug card to purchase needles and syringes for the administration of covered medications or diabetic supplies. If you purchase colostomy or ostomy supplies.	10% of the total cost of the drug

Covered medications and supplies - continued on next page

Benefits Description	You Pay
Covered medications and supplies (cont.)	
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Vitamins, nutrients, medical foods, and food supplements not listed as a covered benefit even if a physician prescribes or administers them.* • *Nutritional supplements and vitamins that do not require a prescription* • *Medication that does not require a prescription under Federal law even if your physician prescribes it or a prescription is required under your State law* • *Medical supplies such as dressings and antiseptics* • *Medication for which there is a non-prescription equivalent available.* • *Prescriptions received from non-participating pharmacies unless overseas or through a covered physician or facility. (Call 877-438-4449 to locate a participating pharmacy.)* • *Drug copayments* • *Fertility drugs are covered only under "Infertility services" in Section 5(a)* • *Drugs obtained at a non-Plan pharmacy; except for out-of-network area emergencies* Note: Only FDA-approved medications are covered by the Plan.	*All charges*
Preventive care medications Medications to promote better health as recommended by ACA and USPSTF A and B recommendations. The following drugs and supplements are covered without cost-share, even if over-the-counter, when prescribed by a health care professional and filled at a network pharmacy. These benefits are subject to change as ACA and USPSTF A and B recommendations change. • Low-dose aspirin for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50-59 with a 10% or greater 10-year cardiovascular risk. • Low-dose aspirin (81mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.	**Network Retail:** • Nothing **Network Home Delivery:** • Nothing

Covered medications and supplies - continued on next page

Benefits Description	You Pay
Covered medications and supplies (cont.)	
• Low-to-moderate dose generic statin medication for adults ages 40-75 with no history of cardiovascular disease (CVD) when the following criteria are met: (1) have one or more CVD risk factors (2) have a calculated 10-year risk of a cardiovascular event of 10% or greater. • FDA-approved contraceptives prescribed for persons capable of childbearing • Generic prenatal vitamins with Folic Acid (0.4 mg to 0.8 mg). • Breast cancer preventive medications when ordered by your physician and obtained from a network pharmacy at no cost sharing to the member. • Fluoride tablets, solution (not toothpaste, rinses) for children age 6 months through 16 years • Generic bowel prep products – one prescription per calendar year • Smoking cessation products • Antiretroviral pre-exposure prophylaxis (PrEP) therapy for persons who are at high risk of HIV acquisition Note: To receive this benefit a prescription from a doctor must be presented to a pharmacy.	**Network Retail:** • Nothing **Network Home Delivery:** • Nothing

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

• If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) dental plan, your FEHB plan will be First/Primary payor of any Benefit payments and your FEDVIP plan is secondary to your FEHB Plan. See Section 9 *Coordinating benefits with other coverage, including with Medicare.*

• 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 does not apply to the benefits in this Section. We added "(No Deductible)" to show that 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 for information about how we pay if you have other coverage, or if you are age 65 or over.

Note: Even when the dental procedure itself may not be covered, we cover hospitalization for dental procedures 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.

Accidental injury benefit	You Pay
Accidental injury benefit	
We cover outpatient restorative services performed within 12 months of an accident to repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury from an external force such as a blow or fall that requires immediate attention (not from biting or chewing).	20% of the Plan allowance and any difference between our allowance and the billed amount **(No Deductible)**

Dental Benefits		
Service	**We pay (scheduled allowance)**	**You Pay**
Routine oral examinations including X-rays, cleaning, diagnosis, and preparation of a treatment plan	$39 twice per year	All charges in excess of the scheduled amounts listed to the left **(No Deductible)**
Dental fillings:		
• One Surface	$12	
• Two Surface	$19	
• Three or more surfaces	$24	

Not Covered

- *Dental appliances, study models, splints, and other devices or dental services associated with the treatment of temporomandibular joint (TMJ) dysfunction*
- *Root canals and crowns (except for accidental dental injury benefit)*
- *Other dental services not listed as covered*

Note: Surgical removal of impacted teeth is covered in Section 5(b).

Section 5(h). Wellness and Other Special Features

Special feature	Description
Flexible Benefits Option	
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 benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms 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).
Centers of Excellence	
Centers of Excellence	The Plan has special arrangements with facilities to provide services for tissue, organ transplants and bariatric surgery. The network was designed to give you an opportunity to access providers that demonstrate high quality medical care for transplant and bariatric patients. For additional information regarding our transplant network and bariatric network, please call UMR at 888-438-9135.
Medical Management	
Medical Management	This Plan offers a medical management program for members and covered dependents with diabetes, heart failure, asthma, coronary artery disease, or chronic obstructive pulmonary disease. Your health is important to us! If you or your covered dependent has any of the above, you will be contacted to voluntarily participate. If you would like more information about this program, please call UMR at 888-438-9135.
Lifestyle Prescription Medications	
Lifestyle Prescription Medications	Many lifestyle prescription drugs are available at a discounted rate through participating pharmacies and the Plan's mail order program. You are responsible for the entire cost of the drugs; however, they are available to you at a discounted rate at certain participating pharmacies. The following lifestyle prescription drugs are covered under this program: **Cosmetic**: Renova, Vaniqua, Propecia **Infertility**: A.P.L., Chorex-5, Chorex-10, Chronon 10, Clomid, Clomiphene, Crinone gel, Fertinex, Follistem, Gonal-F, Gonic, HCG, Humegon, Pergonal, Pregnyl, Profasi, Repronex, Serophone **Sexual Dysfunction:** Caverject, Edex, Muse, Viagra, Cialis, Addyi, and Testim

Lifestyle Prescription Medications - continued on next page

Special feature	Description
Lifestyle Prescription Medications (cont.)	
	This list is subject to change and may be subject to medical necessity review if they are covered under another benefit provision (i.e., infertility). If you have a question on drug coverage, call 877-438-4449.
Services Overseas	
Services Overseas	Our overseas customers receive the same PPO benefits and prompt customer service as their stateside counterparts. There may be additional claims processing time for foreign claims. The same medical necessity requirements for stateside claims apply to overseas claims.
The Lab Program	
The Lab Program	This program gives you and your dependents the option of receiving 100% benefit for covered outpatient laboratory testing if your doctor sends your lab work to **LabCorp** or **Quest** for processing. This is an optional program. If you choose not to use the Lab Program, you will not be penalized. You will simply pay the deductible, coinsurance or copayment portion of your lab work. The Lab Program does not replace your current health care benefits; it simply gives you and your covered family members the option of receiving 100% benefits for covered outpatient laboratory testing. The Lab Program covers most outpatient laboratory testing included in your health insurance plan provided the tests are covered by the Plan, have been ordered by a physician and processed at the designated labs. Outpatient lab work includes: Blood testing (e.g., cholesterol, CBC), Urine testing (e.g., urinalysis), Cytology and pathology (e.g., pap smears, biopsies), Cultures (e.g., throat culture). **The Lab Program does not cover:** lab work ordered during hospitalization, lab work needed on an emergency (STAT) basis and time sensitive, esoteric outpatient laboratory testing such as fertility testing, bone marrow studies and spinal fluid tests, non- laboratory work such as mammography, X-ray, imaging and dental work. When Medicare is primary, the Program does not apply.
Smoking Cessation	
Tobacco Cessation Programs	The Plan is pleased to support its members wishing to quit smoking with a free program provided through UMR. Quitting smoking is one of the BEST things you can do to improve your health and the health of those around you. With determination, a positive attitude and a little help, you can do it! UMR's Tobacco Cessation Program is effective in helping participants break the habit and remain tobacco-free. UMR's certified tobacco cessation specialists use proven behavior-change techniques to support participants in meeting their goals. They serve as partners in the change process and work with each participant to develop a personalized quit plan. They provide you and your covered dependents: • Encouragement and accountability • Education on the harmful effects of tobacco use • Insight into your relationship with tobacco and personal triggers • Follow-up support to prevent relapse • Counseling sessions in the form of coaching phone calls (up to five per quit attempt)

Smoking Cessation - continued on next page

Special feature	Description
Smoking Cessation (cont.)	
	• Printed educational material mailed to your home For more information on UMR's Tobacco Cessation Program, or to enroll, call 800-207-7680.
Telehealth	
Telehealth	We provide coverage for telehealth services through Doctor On Demand. Doctor On Demand allows you to see a doctor face-to-face by using your mobile device or computer equipped with a camera. The board-certified physician who performs your visit is able to diagnose, treat and even prescribe medications if necessary. Members are able to utilize Doctor On Demand, 24 hours a day, 7 days a week. Doctor On Demand physicians treat hundreds of conditions, in addition to providing mental health counseling and medication management. These physicians are board-certified doctors**,** psychiatrists and psychologists trained and based in the United States. Plan members, including those with Medicare, are able to take advantage of this program. You pay nothing (no deductible) at the time of your visit. To ensure that you receive coverage under the Plan, use these instructions: Download the Doctor On Demand app from your smartphone or tablet's app store. You may also text **Compass** to **68398**. Once downloaded, open the app and follow the prompts. If you are using a computer, visit www.compassrosebenefits.com/DrNow. When setting up your account, be sure to select **UMR** as your insurance. Plan members with Medicare B, select **Medicare** as your insurance. You may choose to receive telehealth services from your regular UnitedHealthcare Choice Plus network provider, or non-PPO provider. See section 5(a) for the amounts you must pay. If you have any questions regarding the Doctor On Demand benefit, you can contact Doctor On Demand's Customer Support by emailing support@doctorondemand.com or calling 800-997-6196.
Maternity Management	
Maternity Management	The Plan is pleased to support its members who are considering having a baby or who are already expecting with a free program provided through UMR. UMR Maternity Management can teach you how to reduce your risk of complications and prepare you to have a successful, full-term pregnancy and a healthy baby. To enroll, please call UMR at 888-438-8105. Once enrolled, you will receive one-on-one calls with a nurse and no-cost educational materials including your choice of one out of six top-selling pregnancy books.
Wellness Rewards Program	
Wellness Rewards Program	The Plan has a Wellness Rewards Program for members and covered spouses. Each member and their covered spouse can earn a maximum of $250 per calendar year by completing specific activities and screenings. Rewards earned by November 30th of the plan year will be available for use the following calendar year. The reward will be applied to the deductible for members who do not have Medicare B as their primary insurance. Members who have Medicare B as their primary insurance will receive their reward in a health reimbursement account that can be used for qualified medical expenses. For more information, visit www.compassrosebenefits.com/rewards or call UMR at 888-438-9135.

Non-FEHB Benefits Available to Plan Members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or 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 866-368-7227, or visit our website at www.compassrosebenefits.com.

NON-FEHB Benefits are not part of the FEHB contract.

We offer access to various programs in order to support your overall well-being. To learn more about these programs visit www.compassrosebenefits.com/Programs.

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 we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition (see specifics regarding transplants).** The fact that one of our covered providers has prescribed, recommended, or approved a service or supply does not make it medically necessary or eligible for coverage under this Plan.

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.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Any portion of a provider's fee or charge that has been waived. If a provider routinely waives (does not require you to pay) a deductible, copayment or coinsurance, we will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived).
- Charges you or the Plan has no legal obligation to pay, such as excess charges for an annuitant 65 years or older who is not covered by Medicare Part A and/or Part B, physician charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge), or State premium taxes however applied.
- Services, drugs, or supplies for which you would not be charged if you had no health insurance coverage.
- Services or supplies we are prohibited from covering under the Federal Law.
- Services, drugs, or supplies you receive as the result of injury or illness resulting from taking part in the commission of an assault or felony.
- Drugs and supplies related to weight control or any treatment of obesity except surgery for morbid obesity or nutritional counseling as described in Section 5 (a & b).
- Services, drugs, or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption.
- The Plan does not cover expenses related to medical records submission if the medical records are needed to process a claim. If medical records are inappropriately requested, the charges can be covered.

Listed below are examples of some of our exclusions:

- Biofeedback, conjoint therapy, hypnotherapy, milieu therapy, and interpretation/preparation of reports;
- Charges for completion of reports or forms;
- Charges for interest on unpaid balances;
- Charges for missed or canceled appointments;
- Charges for mailings, faxes, emails or any other communication to or from a hospital or covered provider;
- Custodial care;

- Formula unless administered through a tube as the sole source of nutrition;
- Medical Marijuana;
- Massage Therapy;
- Mutually exclusive procedures. These are procedures that are not typically provided to you on the same date of service;
- "Never Events" are errors in patient care that can and should be prevented. We will follow the policy of the Centers for Medicare and Medicaid Service (CMS). The Plan will not cover care that falls under these policies. For additional information, visit www.cms.gov, enter Never Events into Search;
- Non-medical services such as social services, recreational, educational and visual;
- Therapies and devices for non-surgical treatment of temporomandibular joint (TMJ) dysfunction including dental appliances, study models, splints and other devices;
- Over-the-counter supplemental feedings, and nutritional and electrolyte supplements;
- Physical, Occupational or Speech therapy and other medical charges for services related to developmental delay. If a temporary developmental delay related to a short-term illness or injury occurs, coverage will be subject to normal Plan provisions;
- Prescriptions for compound powders that have no clinical value;
- Sales tax for durable medical equipment;
- Sales tax, shipping and handling for other than durable medical equipment;
- Select allergy testing, see Section 5(a);
- Services, drugs or supplies not specifically listed as covered; and
- Treatment for learning disabilities, developmental delay and mental retardation;
- The Plan does not cover research 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.

Note: Exclusions that are primarily identified with a specific benefit category may also apply to other categories.

Note: Only FDA-approved medications are covered by the Plan.

Note: Refer to Section 5(e) for additional services listed as not covered under mental health and substance abuse benefits.

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.

How to claim benefits

To obtain claim forms, claims filing advice or answers about our benefits, contact (888) 438-9135, or at our website at www.compassrosebenefits.com/Forms

In most cases, providers and facilities file claims for you. Your provider must file on the form CMS-1500 or a claim form. Your facility will file on the UB-04 form. For claims questions and assistance, call 888-438-9135.

When you must file a claim—such as for services you received overseas or when another group health plan is primary—submit it on the CMS-1500 or a claim form that includes the information shown below. Itemized bills and receipts should be sent to UMR, P.O. Box 8095, Wausau, WI 54402-8095. For prescriptions, itemized bills and receipts should be sent to Express Scripts, ATTN: Commercial Claims, PO Box 14711, Lexington, KY 40512-4711.

- Patient's name, date of birth, address, phone number and relationship to enrollee
- Patient's Plan identification number
- Name and address of person or company providing the service or supply
- Dates that services or supplies were furnished
- Diagnosis
- Type of each service or supply
- Charge for each service or supply

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

In addition:

- If another health plan is your primary payor, you must send a copy of the explanation of benefits (EOB) form you received from your primary payor (such as the Medicare Summary Notice (MSN)) with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse.
- If your claim is for the rental or purchase of durable medical equipment; private duty nursing; and physical therapy, occupational therapy, or speech therapy, you must provide a written statement from the provider specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and supplies must include receipts that show the prescription number, name of drug or supply, prescribing provider name, date, and charge.
- We will provide translation and currency conversion services for claims for overseas (foreign) services.

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.

You will be reimbursed the amount approved, not necessarily the amount submitted. 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.

Records

Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

Deadline for filing your claim

Send us all 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. If you could not file on time because of Government administrative operations or legal incapacity, you must submit your claim as soon as reasonably possible. If we return a claim or part of a claim for additional information, you must resubmit it within 90 days, or before the timely filing period expires, whichever is later. Once we pay benefits, there is a three-year limitation on the re-issuance of uncashed checks.

Overseas claims

For covered services you receive by providers and hospitals outside the United States and Puerto Rico, send a completed Claim Form and the itemized bills to: UMR, P.O. Box 8095, Wausau, WI 54402-8095, or fax to 855-405-2189. Obtain Claim Forms from: www.compassrosebenefits.com/ClaimForm. If you have questions about the processing of overseas claims, contact 888-438-9135.

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. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

Authorized Representative

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

Notice Requirements

The Secretary of Health and Human Services has identified counties where at least 10 percent of the population is literate only in certain non-English languages. The non-English languages meeting this threshold in certain counties are Spanish, Chinese, Navajo and Tagalog. If you live in one of these counties, we will provide language assistance in the applicable non-English language. You can request a copy of your explanation of benefits (EOB) statement, related correspondence, oral language services (such as phone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

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

Section 8. The Disputed Claims Process

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

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing: UMR, P.O. Box 8095, Wausau, WI 54402-8095 or calling 888-438-9135.

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

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

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

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

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: UMR-CRBG Appeals, P.O. Box 8080, Wausau, WI 54402-8080. c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or

c) Ask you or your provider for more information.

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

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

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

You must write to OPM within:

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

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, FEHB 2, 1900 E Street, NW, Washington, DC 20415-3620.

Send OPM the following information:

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

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

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

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

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

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

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

You may not 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 888-438-9135. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's FEHB 2 at 202-606-3818 between 8 a.m. and 5 p.m. Eastern Time.

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

Section 9. Coordinating Benefits with 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 health care expenses without regard to fault. This is called "double coverage".

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payer. 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.compassrosebenefits.com/NAIC.

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

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

Please see Section 4, *Your costs for covered services*, for more information about how we pay claims.

- **TRICARE and CHAMPVA**

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

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

- **Workers' Compensation**

We do not cover services that:

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

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

- **Medicaid**

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

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

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

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

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

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 (FDA); 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 test, 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.

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-4028) or at www.medicare.gov.

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

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

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

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

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

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

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claims 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 claims, call 888-438-9135, or email us at askcrbg@compassrosebenefits.com.

We waive some costs when the Original Medicare Plan is your primary payor. We will waive some out-of-pocket costs, as follows:

- If you are enrolled in Medicare Part B, we may waive calendar year deductible, copayments and coinsurance for medical services and supplies provided by physicians and other health care professionals. We will also waive deductibles and coinsurance for extended dental treatment for accidental dental injuries.
- If you are enrolled in Medicare Part A, we will waive hospital copayments, deductible and coinsurance.

Please review the following table, it illustrates your cost share if you are enrolled in Medicare Part B. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

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

Benefit Description	**High Option** **You pay without Medicare**		**High Option** **You pay with Medicare Part B**	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	$350	$400	$0	$0
Catastrophic Protection Out-of-Pocket Maximum	$5,000 Self Only/$7,000 Self Plus One or Self and Family	$7,000 Self Only/$9,000 for Self Plus One or Self and Family	$0	$0
Part B Premium Reimbursement Offered	N/A	N/A	N/A	N/A
Primary Care Physician	$15 copayment	30% Plan allowance and difference between Plan allowance and billed amount	$0	$0
Specialist	$25 copayment	30% Plan allowance and difference between Plan allowance and billed amount	$0	$0
Inpatient Hospital	$200 copayment per stay	$400 copayment per stay and 30% Plan allowance and difference between Plan allowance and billed amount	$0	$0
Outpatient Hospital	10% of Plan allowance	30% Plan allowance and difference between Plan allowance and billed amount	$0	$0
Incentives offered	N/A	N/A	Up to $2,400 coverage for hearing aids every 3 years, receive discount on non-specialty prescriptions	Up to $2,400 coverage for hearing aids every 3 years, receive discount on non-specialty prescriptions

You can find more information about how our Plan coordinates benefits with Medicare at www.compassrosebenefits.com/MedicareCoverage.

- **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.

- **Private contract with your physician**

  If you are enrolled in Medicare Part B, a physician may ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Original Medicare's payment. You may be responsible for paying the difference between the billed amount and the amount we paid.

- **Medicare Advantage (Part C)**

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

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

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

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

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

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

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

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

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

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

When you are 65 and you do NOT have Medicare

Under the FEHB law, we must limit our payments for inpatient hospital care and physician care to those payments you would be entitled to if you had Medicare. Your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. You and the FEHB benefit from these payment limits. Outpatient hospital care and non-physician based care are not covered by this law; regular Plan benefits apply. The following chart has more information about the limits.

If you:

- are age 65 or over; and
- do not have Medicare Part A, Part B, or both; and
- have this Plan as an annuitant or as a former spouse, or as a family member of an annuitant or former spouse; and
- are not employed in a position that gives FEHB coverage. (Your employing office can tell you if this applies.)

Then, for your inpatient hospital care:

- The law requires us to base our payment on an amount—the "equivalent Medicare amount"—set by Medicare's rules for what Medicare would pay, not on the actual charge.
- You are responsible for your applicable deductibles, coinsurance, or copayments under this Plan.
- You are not responsible for any charges greater than the equivalent Medicare amount; we will show that amount on the explanation of benefits (EOB) form that we send you.
- The law prohibits a hospital from collecting more than the "equivalent Medicare amount."

And, for your physician care, the law requires us to base our payment and your coinsurance or copayment on:

- an amount set by Medicare and called the "Medicare approved amount," or
- the actual charge if it is lower than the Medicare approved amount.

If your physician:	Then you are responsible for:
Participates with Medicare or accepts Medicare assignment for the claim and is a member of our PPO network,	your deductibles, coinsurance, copayments.
Participates with Medicare and is **not** in our PPO network,	your deductibles, coinsurance, copayments, and any balance up to the Medicare approved amount.
Does not participate with Medicare,	your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount.
Does not participate with Medicare and is not a member of our PPO network	your out-of-network deductibles, coinsurance, and any balance up to 115% of the Medicare approved amount
Opts-out of Medicare via private contract	your deductibles, coinsurance, copayments, and any balance your physician charges

It is generally to your financial advantage to use a physician who participates with Medicare. Such physicians are permitted to collect only up to the Medicare approved amount.

Physicians Who Opt-Out of Medicare

A physician may have opted-out of Medicare and may or may not ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. This is different than a non-participating doctor, and we recommend you ask your physician if he or she has opted-out of Medicare. Should you visit an opt-out physician, the physician will not be limited to 115% of the Medicare approved amount. You may be responsible for paying the difference between the billed amount and our regular in-network/out-of-network benefits.

Our explanation of benefits (EOB) form will tell you how much the physician or hospital can collect from you. If your physician or hospital tries to collect more than allowed by law, ask the physician or hospital to reduce the charges. If you have paid more than allowed, ask for a refund. If you need further assistance, call 888-438-9135.

When you have the Original Medicare Plan (Part A, Part B, or both)

We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare A (Hospital insurance) and Medicare B (Medical insurance), regardless of whether Medicare pays. *Note: We pay our regular benefits for emergency services to an institutional provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.*

We use the Department of Veterans Affairs (VA) Medicare-equivalent Remittance Advice (MRA) when the statement is submitted to determine our payment for covered services provided to you if Medicare does not pay the VA facility.

If you are covered by Medicare Part B and it is primary, your out-of-pocket costs for services that both Medicare Part B and we cover depend on whether your physician accepts Medicare assignment for the claim.

If your physician accepts Medicare assignment, you pay nothing for covered charges.

If your physician does not accept Medicare assignment, you pay the difference between the "limiting charge" or the physician's charge (whichever is less) and our payment combined with Medicare's payment.

It is important to know that a physician who does not accept Medicare assignment may not bill you for more than 115% of the amount Medicare bases its payment on, called the "limiting charge." The Medicare Summary Notice (MSN) that Medicare will send you will have more information about the limiting charge. If your physician tries to collect more than allowed by law, ask the physician to reduce the charges. If the physician does not, report the physician to the Medicare carrier that sent you the MSN form. Call us if you need further assistance.

Section 10. Definitions of Terms We Use in This Brochure

Admission

The period from entry (admission) into a hospital or other covered facility until discharge. In counting days of inpatient care, the date of entry and the date of discharge are counted as the same day.

Assignment

Your authorization for the Plan to issue payment of benefits directly to the provider. We reserve the right to pay the member directly for all covered services.

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 (FDA); 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 are generally covered by the clinical trials. This Plan does not cover these costs.

Coinsurance

See Section 4 page 24

Congenital anomalies

A condition existing at or from birth that is a significant deviation from the common form or anomaly norm. For purposes of this Plan, congenital includes protruding ear deformities, cleft lips, cleft palates, webbed fingers or toes, and other conditions that we may determine to be congenital anomalies. In no event will the term congenital anomaly include conditions relating to teeth or intra-oral structures supporting the teeth.

Copayment

See Section 4 page 24

Cosmetic surgery

Any operative procedure or any portion of a procedure performed primarily to improve physical appearance and/or treat a mental condition through a change in bodily form.

Cost-sharing

See Section 4 page 24

Covered services

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

Custodial care

Treatment or services, regardless of who recommends them or where they are provided, that could be provided safely and reasonably by a person who is not medically skilled, or are designed mainly to help the patient with daily living activities. These activities include but are not limited to:

1) personal care such as help in: walking; getting in or out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing;

2) homemaking, such as preparing meals or special diets;

3) moving the patient;

4) acting as a companion or sitter;

5) supervising medication that can usually be self administered; or

6) treatment services such as recording temperature, pulse, and respirations, or administration and monitoring of feeding systems.

Custodial care that lasts 90 days or more is sometimes known as Long Term Care.

Deductible See Section 4 page 24

Developmental delay Impairment in the performance of tasks or the meeting of milestones that a child should achieve by a specific chronological age.

Effective date The date the benefits described in this brochure are effective:

1. January 1 for continuing enrollments and for all annuitant enrollments;
2. the first day of the first full pay period of the new year for enrollees who change plans or options or elect FEHB coverage during Open Season for the first time; or
3. for new enrollees during the calendar year, but not during Open Season, the effective date of enrollment as determined by your employing office or retirement system.

Expense The cost incurred for a covered service or supply ordered or prescribed by a covered provider. You can incur an expense on the date the service or supply is received. Expense does not include any charge:

1. for a service or supply that is not medically necessary; or
2. that is in excess of the Plan's allowance for the service or supply.

Experimental or investigational services A drug, device, or biological product is experimental or investigational if it cannot lawfully be marketed without approval of the U.S. Food and Drug Administration (FDA), and approval for marketing has not been given at the time it is furnished. Approval means all forms of acceptance by the FDA.

A medical treatment or procedure, or a drug, device, or biological product is experimental or investigational if 1) reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or 2) reliable evidence shows that the consensus of opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

Gender identity disorder A disorder characterized by the following criteria:

1. A strong and persistent cross gender identification (not merely a desire for any perceived cultural advantages of being the other sex).
2. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.
3. The disturbance is not concurrent with a physical intersex condition.

4. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
5. The transsexual identity has been present persistently for at least two years.
6. The disorder is not a symptom of another mental disorder or chromosomal abnormality.

Group health coverage — Health care coverage that you are eligible for because of employment, membership in, or connection with, a particular organization or group that provides payment for hospital, medical or other health care service or supplies, or that pays a specific amount for each day or period hospitalization.

Habilitative services — Health care services that help you keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

Home health care agency — A public or private agency or organization appropriately licensed, qualified and operated under the law of the state in which it is located.

Home health care plan — A written plan, approved in writing by a physician, for continued care and treatment for a Plan member who is under the care of a physician and who would need a continued stay in a hospital or skilled nursing facility with the home health care.

Hospice care program — A coordinated program of home and inpatient pain control and supportive care for the terminally ill patient and the patient's family. Care is provided by a medically supervised team under the direction of an independent hospice administration that we approve.

Hospital stay — An inpatient admission as a registered bed patient using and being charged for room and board in a hospital for 24 hours or more. A person is not an inpatient on any day on which he or she is on leave or otherwise gone from the hospital, whether or not a room and board charge is made.

Infertility — A disease defined by the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or therapeutic donor insemination. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women over age 35 years. Disease is defined as "any deviation from or interruption of the normal structure or function of any part, organ or system of the body as manifested by characteristic symptoms and signs; the etiology, pathology and prognosis may be known or unknown" (American Society for Reproductive Medicine, 2013d)

Intensive outpatient program (IOP) — A program that offers time-limited services that are coordinated, structured, and intensively therapeutic. Such programs are designed to treat a variety of individuals with moderate to marked impairment in at least one area of daily life resulting from psychiatric or addictive disorders. At a minimum, IOPs offer three to four hours of active treatment per day at least two to three days per week.

Medically necessary/ Medical necessity — Health care services provided for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, mental illness, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by us or our designee, within our sole discretion:

- In accordance with *Generally Accepted Standards of Medical Practice;* and

- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for Your Illness, Injury, mental illness, substance use disorder, disease or its symptoms; and
- Not mainly for Your convenience or that of Your doctor or other health care provider; and
- Not more costly than an alternative 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 Illness, Injury, disease or symptoms.

Mental conditions/ substance abuse

Conditions and diseases listed in the most recent edition of the International Classification of Diseases (ICD) as psychoses, neurotic disorders, or personality disorders; other nonpsychotic mental disorders listed in the ICD to be determined by the Plan; or disorders listed in the ICD requiring treatment for abuse of or dependence upon substances such as alcohol, narcotics, or hallucinogens.

Mental health disorder

A disorder that is a clinically significant psychological syndrome associated with distress, dysfunction or Illness. The syndrome must represent a dysfunctional response to a situation or event that exposes the Covered Person to an increased risk of pain, suffering, conflict, Illness, or death.

Mentally disabled

An individual who has been diagnosed to have a psychiatric or behavior disorder that severely limits the individual's ability to function without daily supervision or assistance.

Not medically necessary

Services, supplies, treatment, facilities or equipment which the Plan determines are not Medically Necessary. Furthermore, this Plan excludes services, supplies, treatment, facilities or equipment which reliable scientific evidence has shown does not cure the condition, slow the degeneration/deterioration or harm attributable to the condition, alleviate the symptoms of the condition, or maintain the current health status of the Covered Person.

Observation stay

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as a hospital inpatient or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge.

Partial hospitalization

A time-limited, ambulatory, active treatment program that offers therapeutically intensive, coordinated, and structured clinical services with a stable therapeutic environment. It provides 20 hours of scheduled programming, extended over a minimum of five days per week, by a licensed or Joint Commission accredited facility

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowance in different ways. We determine our allowances as follows:

PPO Providers - Our Plan allowance is a negotiated amount between the Plan and the provider. We base our coinsurance on this negotiated amount, and the provider has agreed to accept the negotiated amount as full payment for any covered services rendered. This applies to all benefits in Section 5 of this brochure. **Please note that the PPO benefit also applies to providers used outside the 50 United States.**

	Non-PPO Providers - Our Plan allowance is the lesser of: (1) the providers' billed charge; or (2) the Plan's out-of-network (OON) fee schedule amount. The Plan's OON fee schedule amount is equal to the 80th percentile amount of prevailing health care charges from FAIR Health (or its successor) utilized by the Plan's underwriter. The OON fee schedule amounts vary by geographic area in which services are furnished. We base our coinsurance on this OON fee schedule amount. This applies to all benefits in Section 5 of this brochure. For certain services, exceptions may exist to the use of the OON fee schedule to determine the Plan's allowance for non-PPO providers, including, but not limited to, the use of Medicare fee schedule amounts. For claims governed by OBRA '90 and '93, the Plan allowance will be based on Medicare allowable amounts as is required by law. For claims where the Plan is the secondary payor to Medicare (Medicare COB situations), the Plan allowance is the Medicare allowable charge. For more information, see Section 4, *Differences between our allowance and the bill.*
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.
Prosthetic device	An artificial substitute for a missing functional body part (such as an arm or leg) because the body part is permanently damaged, is absent or is malfunctioning.
Rehabilitative services	Health care services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.
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.
Respite Care	Provides temporary relief to the family or other caregivers in the case of an emergency or to provide temporary relief from the daily demands of caring for a terminally ill person.
Routine physical examination	A complete evaluation, including a comprehensive history and physical examination, without symptoms or illness.
Routine testing/screening	Health care services you receive from a covered provider without any apparent signs or symptoms of an illness, injury or disease.
Sound natural tooth	A tooth that is whole or properly restored and is without impairment, periodontal, or other conditions and is not in need of the treatment provided for any other reason other than an accidental injury.
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.

Substance abuse	Disorders listed in the International Classification of Diseases (ICD) requiring treatment for abuse of or dependence upon substances such as alcohol, narcotics, or hallucinogens.
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 UMR, P.O. Box 8095 Wausau, WI 54402-8095, or call (888) 438-9135. 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 the Compass Rose Health Plan.
You	You refers to the enrollee and each covered family member.

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

Summary of Benefits for the Compass Rose Health Plan - 2021

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.compassrosebenefits.com/SBC. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (*) means the item is subject to the $350 PPO and $400 non-PPO calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a non-PPO physician or other health care professional.

High Option Benefits	You pay	Page
• Diagnostic and treatment services provided in the office	PPO: $15 copayment (No Deductible) $25 copayment for Specialist (No Deductible) *Non-PPO: 30% of our Plan allowance $15 copayment (No Deductible) for providers used outside of the 50 United States $25 copayment for Specialist (No Deductible) used outside the 50 United States	31
• Surgery	PPO: 10% of our allowance *Non-PPO: 30% of our Plan allowance 10% of our allowance for providers used outside the 50 United States	47-58
Services provided by a hospital:		
• **Inpatient**	PPO: $200 hospital stay (No Deductible) Non-PPO: $400 hospital stay and 30% of our Plan allowance (No Deductible) $200 hospital stay (No Deductible) for providers used outside the 50 United States	59-60
• **Outpatient**	*PPO: 10% of our allowance *Non-PPO: 30% of our Plan allowance *10% of our allowance for providers used outside the 50 United States	60-61
Emergency benefits:		
• **Accidental injury and medical emergency** • Regular Plan benefits apply except for the copayments listed on the right when you receive care because of an accidental injury and medical emergency. See Section 5(a).	PPO: Emergency Room $200 copayment per occurrence (No Deductible). Non-PPO: $200 Emergency Room copayment per occurrence (No Deductible). Emergency Room $200 copayment per occurrence (No Deductible) for providers outside the 50 United States. PPO: Urgent Care $50 copayment per occurrence (No Deductible). Non-PPO: Urgent Care 30% of the Plan Allowance and any difference between our allowance and the billed amount (No Deductible).	64-66

	Urgent Care $50 copayment per occurrence (No Deductible) for providers outside the 50 United States.	
Mental health and substance use disorder treatment:	PPO: Regular cost- sharing. Non-PPO: Regular cost- sharing Regular cost-sharing for providers used outside the 50 United States	67-70
Prescription drugs	**Network Retail 30-day supply:** Level 1: $5 (No Deductible), Level 2: $45 (No Deductible), Level 3: 40% or $75, whichever is greater (No Deductible) **Network Home Delivery:** Level 1: $10 (No Deductible), Level 2: $90 (No Deductible), Level 3: 40% or $150, whichever is greater (No Deductible) **Voluntary Smart90:** Level 1: $10 (No Deductible), Level 2: $90 (No Deductible), Level 3: 40% of the Plan cost or $150, whichever is greater (No Deductible) **Network Retail 30-day supply when Medicare Part B is primary:** Level 1: $3 (No Deductible), Level 2: $25 (No Deductible), Level 3: 35% or $50, whichever is greater (No Deductible) **Voluntary Smart90 when Medicare Part B is primary:** Level 1: $6 (No Deductible), Level 2: $50 (No Deductible), Level 3: 35% of the Plan cost or $100, whichever is greater (No Deductible) **Network Home Delivery when Medicare Part B is primary:** Level 1: $6 (No Deductible), Level 2: $50 (No Deductible), Level 3: 35% or $100, whichever is greater (No Deductible) **Specialty Generic:** 10% of the plan cost up to a maximum of $100 for up to 30-day supply (No Deductible) **Specialty Formulary:** 25% of the Plan cost up to a maximum of $250 for up to 30-day supply (No Deductible) **Specialty Non-Formulary:** 35% of the Plan cost up to a maximum of $400 for up to 30-day supply (No Deductible) **Specialty Medications must be received through our Specialty Pharmacy Provider, Accredo to receive the benefit. There is no benefit if other providers are used. Please contact 800-803-2523 for more information.** **Note: If there is no generic equivalent available, you will still have to pay the Level 2 copay or Level 3 copay.**	71-79
Protection against catastrophic costs (out-of-pocket maximum)	Medical PPO and Pharmacy Network Providers: Nothing after $5,000 for Self Only and $7,000 for Self Plus One or Self and Family enrollment per year Medical, Non-PPO: Nothing after $7,000 for Self Only and $9,000 for Self Plus One or Family enrollment per year Medical and Pharmacy, Nothing after $5,000 for Self Only and $7,000 for Self Plus One or Family enrollment per year for providers used outside the 50 United States	26

2021 Rate Information for Compass Rose Health Plan

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

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

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

Type of Enrollment	Enrollment Code	Non-Postal Premium			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
High Option Self Only	421	$241.58	$105.97	$523.42	$229.61
High Option Self Plus One	423	$517.46	$247.16	$1,121.16	$535.52
High Option Self and Family	422	$562.25	$271.88	$1,218.21	$589.07