

UnitedHealthcare

UnitedHealth BasicsSM Options PPO Plan 152

This plan pays a portion of your costs when you receive certain medical services. The purpose of this document is to summarize:

- Services UnitedHealth BasicsSM will pay for,
- Services UnitedHealth BasicsSM will not pay for,
- The percentage or dollar amount you are responsible for.

As you read through this Benefits Summary, please note:

- Annual benefit maximums are for Network and Non-Network services combined.
- Certain Physicians, Hospitals, and other providers have agreed to be part of the Network. Network providers generally cost you less than providers who are not part of the Network, also known as Non-Network providers.
- If you choose to seek care outside the Network, the plan only pays a portion of those charges and it is your responsibility to pay the remainder.
- You may obtain treatment with any provider without the need to obtain a referral.
- In addition, there are no claim forms when you use Network providers.

UnitedHealth BasicsSM Benefits Summary

| Types of Coverage | Network Benefits / Copayment Amounts | Non-Network Benefits / Copayment Amounts |
|---|--|--|
| <p>This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. More complete descriptions of Benefits and the terms under which they are provided are contained in the Certificate of Coverage that you will receive upon enrolling in the Plan. If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail. Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage.</p> <p>All Benefit limits apply to any combination of Network and Non-Network Benefits.</p> <p>*Prior Notification is required for certain services.</p> | <p>Annual Deductible: No Annual Deductible.</p> <p>Out-of-Pocket Maximum: No Out of Pocket Maximum.</p> <p>Maximum Policy Benefit: No Maximum Policy Benefit.</p> | <p>Annual Deductible: No Annual Deductible.</p> <p>Out-of-Pocket Maximum: No Out of Pocket Maximum.</p> <p>Maximum Policy Benefit: No Maximum Policy Benefit.</p> |
| <p>(1) Hospital - Inpatient Stay Benefits for services, supplies and room and board in a Semi-private Room during an Inpatient Stay. Annual Benefit Maximum: Any combination of Network and Non-Network Benefits is limited to a maximum of 30 days per Covered Person per Policy year.</p> | <p>*We pay \$1,000 in Eligible Expenses per day.</p> | <p>*We pay \$700 in Eligible Expenses per day.</p> |
| <p>(2) Outpatient Diagnostic Services Benefits for services received on an outpatient basis at a Hospital or Alternate Facility include lab and radiology/X-ray (such as CT scans, PET scans and MRI), mammography testing, electrocardiograms (ECG) and electroencephalograms (EEG). Annual Benefit Maximum: Any combination of Network and Non-Network Benefits is limited to \$300 in Eligible Expenses per Covered Person per Policy year.</p> | <p>We pay 100% of Eligible Expenses.</p> | <p>We pay 50% of Eligible Expenses.</p> |
| <p>(3) Outpatient Surgery Benefits for outpatient surgery received at a Hospital or Alternate Facility include the facility charge, the charge for required services, supplies and equipment and the Facility-Based Physician fees. Annual Benefit Maximum: Any combination of Network and Non-Network Benefits is limited to \$2,000 in Eligible Expenses per Covered Person per Policy year.</p> | <p>We pay 80% of Eligible Expenses.</p> | <p>We pay 50% of Eligible Expenses.</p> |

YOUR BENEFITS

| Types of Coverage | Network Benefits / Copayment Amounts | Non-Network Benefits / Copayment Amounts |
|---|---|---|
| <p>(4) Physician's Office Services Benefits are provided for the diagnosis and treatment of a Sickness or Injury and for preventive care. Services include lab and radiology/X-ray performed in a Physician's office. Annual Benefit Maximum: Any combination of Network and Non-Network Benefits is limited to \$450 in Eligible Expenses per Covered Person per Policy year.</p> | <p>You pay \$10 per visit.</p> | <p>We pay 50% of Eligible Expenses.</p> |
| <p>(5) Medical Emergency Health Services Benefits for the treatment of a Medical Emergency are limited to a maximum of \$500 in Eligible Expenses per Covered Person per Policy year.</p> <p>(6) Professional Fees for Surgical and Medical Services - Inpatient Benefits are provided for Professional Fees for Surgical and Medical Services provided during an Inpatient Stay in a Hospital. Annual Benefit Maximum: Any combination of Network and Non-Network Benefits is limited to \$500 in Eligible Expenses per Covered Person per Policy year.</p> | <p>We pay 100% of Eligible Expenses.</p> <p>We pay 100% of Eligible Expenses.</p> | <p>We pay 100% of Eligible Expenses.</p> <p>We pay 50% of Eligible Expenses.</p> |
| <p>(7) Reconstruction - Post Mastectomy Benefits are subject to the limits stated under Hospital - Inpatient Stay, Outpatient Surgery and Diagnostic Services, Physician's Office Services and Professional Fees for Surgical and Medical Services - Inpatient. Annual Benefit Maximum: Any combination of Network and Non-Network Benefits for breast prosthesis, mastectomy bras, and lymphedema stockings for the arms are limited to \$450 in Eligible Expense per Covered Person per Policy year.</p> | <p>Same as 1, 2, 3, 4 & 5</p> <p>*Notification is required if results in an Inpatient Stay.</p> <p>We pay 80% of Eligible Expenses for breast prosthesis, mastectomy bras and lymphedema stockings.</p> | <p>Same as 1, 2, 3, 4 & 5</p> <p>*Notification is required if results in an Inpatient Stay.</p> <p>We pay 50% of Eligible Expenses for breast prosthesis, mastectomy bras and lymphedema stockings.</p> |

| Types of Coverage | Network Benefits / Copayment Amounts | Non-Network Benefits / Copayment Amounts |
|--|---|---|
| <p>Benefits Required Under DC state law:</p> <p>Mammography</p> <p>Annual Cytology screening</p> <p>Diabetes Treatment</p> <p>Colorectal and Prostate Cancer Screening</p> <p>Child health screenings and immunizations</p> <p>Mental Health and Substance Abuse Services - Inpatient and Intermediate Must receive prior authorization through the Mental Health/Substance Abuse Designee. Any combination of Network and Non-Network Benefits for Mental Health Services are limited to 45 days per Policy year. Any combination of Network and Non-Network Benefits for Substance Abuse Services other than intermediate care for the purpose of detoxification are limited to 28 days per Policy year. Intermediate care services for the purpose of detoxification are limited to 12 days per Policy year.</p> | <p>Depending on where the service is provided, the payments will be the same as those stated above.</p> <p>No Copayment applies to Network services for mammography testing and cytology screenings except for services received in connection with a Physician office visit. In this case, the Copayment shown under Physician's Office Services will apply.</p> <p>We pay 50% of Eligible Expenses.</p> | <p>Depending on where the service is provided, the payments will be the same as those stated above.</p> <p>We pay 50% of Eligible Expenses.</p> |

| Prescription Drug Coverage Annual Benefit Maximum: Benefits for Prescription Drug Products are limited to \$350 per Covered Person not to exceed \$1,750 for all Covered Persons in a family per Policy year. | Retail Network Pharmacy For up to a 31 day supply | Home Delivery Network Pharmacy For up to a 90 day supply | Retail Non-Network Pharmacy For up to a 31 day supply |
|---|---|--|---|
| Tier 1 | \$10 | \$25 | \$10 |
| Tier 2 | \$25 | \$62.50 | \$25 |
| Tier 3 | \$60 | \$150 | \$60 |

Medical Exclusions

The information below describes medical services that are *not* covered by UnitedHealth BasicsSM plan.

Preexisting Conditions are not covered by your plan. A preexisting condition is a sickness or injury that was (a) diagnosed or treated within 6 months of when your new coverage starts or (b) a condition or Injury for which medications were prescribed or taken within 6 months of when your new coverage starts.

Benefits for the treatment of a Preexisting Condition are excluded until the earlier of the following:

- The date you have had Continuous Creditable Coverage for 12 months.
- The date you have had Continuous Creditable Coverage for 18 months if you are a Late Enrollee.

This exclusion does not apply to newborn children or newly adopted children. This exception for newborn and adopted children no longer applies after the end of the first 63-day period during which the child has not had Continuous Creditable Coverage.

Alternative treatments such as acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, or other forms of alternative treatment.

Comfort or convenience items, such as TV, phone, beauty/barber service, guest service, air conditioners, air purifiers or filters, batteries or battery chargers, dehumidifiers or humidifiers, or devices and computers to assist in communication or speech.

Dental care of any kind is not covered.

Drugs: Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications, non-injectable medications given in a Physician's office except as required in an emergency, **over-the-counter drugs** and treatments, and **allergy injections**.

Experimental, investigational or unproven services and medications are not covered, even if the treatment, service, device or drug regimen is the only available treatment for a condition.

Foot care if it's not related to an Injury or illness, such as removal of corns/calluses, soaking/cleaning of feet, nail trimming, application of skin creams in order to maintain skin tone, treatment of flat feet, treatment of subluxation of the foot, or shoe orthotics.

Home health care or other care provided by a home health agency.

Hospice care including bereavement counseling.

Inpatient services including, but not limited to, care at a **nursing home, a skilled nursing facility, or inpatient rehabilitation facility**. This exclusion does not apply to Hospital - Inpatient Stay.

Medical equipment, supplies and appliances of any kind (except for medical equipment for diabetes treatment as described under Diabetes Treatment in Section 1 of the COC), including all prosthetic devices. All prescribed or non-prescribed outpatient medical supplies and disposable supplies except for medical supplies for diabetes treatment as described under Diabetes Treatment in Section 1 of the COC. Devices used as safety items, sports-performance enhancing items, orthotic appliances that straighten or reshape a part of the body (including cranial banding and braces), and oral appliances for snoring.

Mental Health/Substance Abuse services for the inpatient and outpatient treatment of mental illness or mental health conditions and substance abuse services and chemical dependency services. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements.

Nutrition: Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups; enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

Outpatient rehabilitation services including, but not limited to, physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy, pulmonary rehabilitation therapy and cognitive therapy. **Outpatient therapeutic services** including, but not limited to, dialysis, nuclear medicine, intravenous chemotherapy and other intravenous infusion therapy; this exclusion does not apply to outpatient therapeutic services provided in the Physician's office for Benefits available as described under Physician's Office Services. Physician Services provided on an outpatient basis for non-facility-based Physicians; this exclusion does not apply to services provided in a Physician's office for Benefits available as described under Physician's Office Services.

Physical Appearance: Cosmetic procedures including, but not limited to, pharmacological regimens, nutritional procedures or treatments, salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Breast implant replacement if the earlier breast implant was for cosmetic rather than medical reasons. **Physical conditioning programs and medications** for athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. **Weight loss programs. Wigs**, regardless of the reason for the hair loss.

Providers: Services from a provider who is a family member by birth or marriage or services performed by a provider with the same legal address as you. This includes services that a provider may perform on himself or herself. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a physician. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility when that Physician or other provider has not been actively involved in your medical care prior to ordering the service or who is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography testing.

Reproduction including **infertility treatments, surrogate parenting,** and the **reversal of voluntary sterilization,** health services and associated expenses for elective abortion, contraceptive supplies and services, fetal reduction surgery and health services associated with the use of non-surgical or drug-induced Pregnancy termination.

Services provided under another plan: Health services required by Federal, state or local law to be purchased or provided through other arrangements including, but not limited to, worker's compensation or no-fault automobile insurance. If worker's compensation or other similar compensation was available to you but you did not choose it or have it chosen for you, this plan will not pay toward charges for any Injury, mental illness or Sickness that would have been covered by worker's compensation or similar legislation. Health services for treatment of **military** service-related disabilities if you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

Transplants: This plan does not cover health services for solid organ, bone marrow and stem cell transplants and transplant evaluations. This plan does not cover health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. The only exceptions to this exclusion are corneal transplants, bone/cartilage grafts and skin grafts.

Travel/Transportation: This plan does not cover health services provided in a foreign country. This plan does not cover travel or transportation expenses (including emergency and non-emergency ambulance) even when prescribed by a physician.

Vision and Hearing: Routine refractive eye examinations, eye exercise therapy and surgery to help you see better without glasses, including radial keratotomy, laser, and other refractive eye surgery is not covered. Purchase cost and fitting of eye glasses, contact lenses, or hearing aids are not covered.

Other exclusions under this plan:

- Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered by the plan when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any type.
- Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
- Health services received after the Policy ends.
- Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
- In the event that a non-Network provider waives Copayments for a particular health service, no Benefits are provided for the health service for which the Copayments are waived.
- Charges in excess of Eligible Expenses or in excess of any specified limitation.
- **Spinal treatment** including services and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment of manipulation of skeletal structure, and muscle treatment by any means except treatment of fractures and dislocation of the extremities.
- Services for the evaluation and treatment of temporomandibular joint syndrome (**TMJ**), whether the services are considered to be medical or dental in nature.
- **Jaw bone surgery** (upper and lower), except as required for direct treatment of acute traumatic injury or cancer. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.
- Surgical and non-surgical treatment of **obesity** (including morbid obesity).
- Surgical removal of excess skin and tissue resulting from weight loss.
- **Growth hormone therapy.**
- Sex transformation operations.
- Treatment of benign breast enlargement in males.
- Medical and surgical treatment of excessive sweating (hyperhidrosis).
- Medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea.
- Custodial care, domiciliary care, respite care, rest cures or private duty nursing.
- Psychosurgery.
- Charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
- Charges for services, supplies or equipment advertised by the provider as free.
- Charges prohibited by federal anti-kickback or self-referral statutes.

Prescription Drug Exclusions

The information below describes prescription drug services that are not covered by your UnitedHealth BasicsSM plan. *Exclusions from coverage listed in the Certificate also apply to this Outpatient Prescription Drug Rider. In addition, the following exclusions apply:*

Coverage for Prescription Drug Products for the amount dispensed (days supply or quantity limit) which exceeds the supply limit.

Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.

Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.

Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven.

Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

Any product dispensed for the purpose of appetite suppression and other weight loss products.

A specialty medication Prescription Drug Product (such as immunizations and allergy serum) which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.

General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.

Unit dose packaging of Prescription Drug Products.

Medications used for cosmetic purposes.

Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that are determined to not be a Covered Health Service.

Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

Prescription Drug Products when prescribed to treat infertility.

Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed. Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug. Prescription Drug Products that are comprised of components that are available in over-the-counter form or equivalent.

Prescription Drug Products for smoking cessation.

Compounded drugs that do not contain at least one ingredient that requires a Prescription Order or Refill. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.

New Prescription Drug Products and/or new dosage forms until the date they are reviewed by our Prescription Drug List Management Committee.

Growth hormone therapy for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

Glossary

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|--------------------------------|---|
| Alternate Facility | A health care facility that is not a Hospital, but provides surgical services and laboratory or diagnostic services on an outpatient basis. |
| notification | We require notification before you receive certain Covered Health Services. If you do not notify us in advance, your Benefits may be reduced or may not be covered at all. Services for which you must provide prior notification are listed in the Certificate of Coverage under the "Must you notify us?" column. To notify us, call the telephone number on your medical ID card for customer service. |
| Continuous Creditable Coverage | Health care coverage during which there was a break in coverage of no more than 63 days. A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage. |
| Covered Health Services | Services that the plan pays either completely or partially for are called "Covered Health Services." A Covered Health Service is a health care service or supply described in "Section 1: What's Covered - Benefits" in the Certificate of Coverage. It includes those health services provided for the purpose of preventing, diagnosing or treating a Sickness, Injury or their symptoms. |
| Eligible Expenses | The amount of each Covered Health Service the plan will pay is known as the "Eligible Expense." Eligible expenses are determined by the claims administrator. When you use in-Network providers, you are not responsible for any difference between the eligible expense and the amount the provider charges. For Out-of-Network Benefits, you are responsible for paying the provider the difference between the amount the provider bills and the amount the claims administrator will pay. |
| exclusions | Medical Services that are not covered are called "exclusions." |
| Network | The claims administrator has arranged for certain Physicians, Hospitals and other providers to participate in a Network. These are said to be Network providers. In general, you pay much less out of your pocket for covered services when you use Network providers. |
| Non-Network | If a provider has not agreed to be part of the Network, they are said to be Non-Network providers. In general, you will pay more when you use Non-Network providers for covered services. |
| inpatient | When you are admitted to a Hospital, you are known as an "inpatient". |
| Physician | Any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is properly licensed and qualified by law. Also, any podiatrist, dentist, psychologist, chiropractor, or other provider who acts within the scope of their license. |
| tier | All covered prescriptions are categorized into three tiers, each with its own Copayment (which is an amount you pay when you visit the pharmacy or order your medications through the mail order service). To find out what tier a prescription belongs in, you can go to www.myuhc.com . |

This benefit plan may not cover all of your health care expenses. More complete descriptions of Benefits and terms under which they are provided are contained in the Certificate of Coverage that you receive upon enrolling in the plan. If this benefit summary conflicts in any way with the Certificate of Coverage (COC), the COC shall prevail.

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