

Colorado Health Plan Description Form

UnitedHealthcare®



A UnitedHealth Group Company

UnitedHealthcare Insurance Company

UnitedHealthcare Choice Plus Plan EAE

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Point of Services (i.e., a Network plan with some out-of-network benefits).
2. OUT-OF-NETWORK CARE COVERED? ¹	Only for specified services; patient pays more for such out-of-network care.
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available only in the following counties: Adams, Alamosa, Arapahoe, Archuleta, Baca, Bent, Boulder, Broomfield, Chaffee, Cheyenne, Clear Creek, Conejos, Costilla, Crowley, Custer, Delta, Denver, Dolores, Douglas, Eagle, El Paso, Elbert, Fremont, Garfield, Gilpin, Grand, Gunnison, Hinsdale, Huerfano, Jackson, Jefferson, Kiowa, Kit Carson, La Plata, Lake, Larimer, Las Animas, Lincoln, Logan, Mesa, Mineral, Moffat, Montezuma, Montrose, Morgan, Otero, Ouray, Park, Phillips, Pitkin, Prowers, Pueblo, Rio Blanco, Rio Grande, Routt, Saguache, San Juan, San Miguel, Sedgwick, Summit, Teller, Washington, Weld & Yuma.

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior notification, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

	IN-NETWORK	OUT-OF-NETWORK
4. ANNUAL DEDUCTIBLE ² a) Individual b) Family	a) \$2,000 per Covered Person per calendar year. b) \$6,000 for all Covered Persons in a family per calendar year.	a) \$4,000 per Covered Person per calendar year. b) \$12,000 for all Covered Persons in a family per calendar year.
5. OUT-OF-POCKET ANNUAL MAXIMUM ³ a) Individual b) Family c) Is deductible included in the out-of-pocket maximum?	a) \$2,000 per Covered Person per calendar year. b) \$6,000 for all Covered Persons in a family per calendar year. c) Yes The Out-of-Pocket Maximum does include the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the COC.	a) \$8,000 per Covered Person, per calendar year. b) \$16,000 for all Covered Persons in a family per calendar year. c) Yes The Out-of-Pocket Maximum does include the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the COC.
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	\$5,000,000 Maximum Policy Benefit per Covered Person for combined Network and Non-Network Benefits.	\$5,000,000 Maximum Policy Benefit per Covered Person for combined Network and Non-Network Benefits.
7A. COVERED PROVIDERS	Over 400,000 physicians and 3,500 hospitals. See Physician and Provider Directory for a complete list.	All providers licensed or certified to provide covered benefits.

	IN-NETWORK	OUT-OF-NETWORK
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes	Not applicable
8. ROUTINE MEDICAL OFFICE VISITS ⁴ a) Primary Care Providers b) Specialists	Preventive medical care: a) \$25 per visit b) \$50 per visit Sickness & Injury: a) \$25 per visit b) \$50 per visit	Preventive medical care: a) No Benefits for Preventive Care except for state mandated benefits. b) No Benefits for Preventive Care except for state mandated benefits. Sickness & Injury: a) 20% of Eligible Expenses after deductible (Plan Pays 80% after deductible) b) 20% of Eligible Expenses after deductible (Plan Pays 80% after deductible)
8A. INJECTIONS RECEIVED IN A PHYSICIAN'S OFFICE	\$25 per visit	20% of Eligible Expenses after deductible (Plan Pays 80% after deductible)
9. PREVENTIVE CARE a) Children's services b) Adults' services	a) \$25 per visit, except that the Copayment for a Specialist Physician Office visit is \$50 per visit. b) \$25 per visit, except that the Copayment for a Specialist Physician Office visit is \$50 per visit.	Annual Deductible does not apply to Preventive Prostate Cancer Screenings, Mammography Testing and Child Health Supervision Health Services. a) No Benefits for Preventive Care, except for Child Health Supervision Health Services. b) No Benefits for Preventive Care, except for state mandated benefits. 20% of Eligible Expenses after deductible (Plan Pays 80% after deductible)
10. MATERNITY a) Prenatal care b) Delivery & inpatient well baby care ⁵	a) Same as 8, 12, 12A, 13, 13A, 13B and 14 b) Same as 8, 12, 12A, 13, 13A, 13B and 14 No Copayment applies to Physician office visits for prenatal care after the first visit.	a) Same as 8, 12, 12A, 13, 13A, 13B and 14 b) Same as 8, 12, 12A, 13, 13A, 13B and 14 *Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
11. PRESCRIPTION DRUGS ⁶ Level of coverage and restrictions on prescriptions	See Attached pharmacy description form	See Attached pharmacy description form
12. INPATIENT HOSPITAL	0% of Eligible Expenses after deductible (Plan Pays 100% after deductible)	*20% of Eligible Expenses after deductible (Plan Pays 80% after deductible)
12A. PROFESSIONAL FEES FOR SURGICAL AND MEDICAL SERVICES	0% of Eligible Expenses after deductible (Plan Pays 100% after deductible)	20% of Eligible Expenses after deductible (Plan Pays 80% after deductible)
13. OUTPATIENT/AMBULATORY SURGERY	0% of Eligible Expenses after deductible (Plan Pays 100% after deductible)	20% of Eligible Expenses after deductible (Plan Pays 80% after deductible)

* = Prior Notification Required

	IN-NETWORK	OUT-OF-NETWORK
13A. OUTPATIENT DIAGNOSTIC SERVICES for mammography testing:	No Copayment (Plan Pays 100%)	Annual Deductible does not apply to Preventive Mammography Testing Services. No Benefits for Preventive Care, except for preventive mammography Testing. Please see the Addendum on the last page for further information. 20% of Eligible Expenses after deductible (Plan Pays 80% after deductible)
13B. OUTPATIENT THERAPEUTIC TREATMENTS	0% of Eligible Expenses after deductible (Plan Pays 100% after deductible)	20% of Eligible Expenses after deductible (Plan Pays 80% after deductible)
14. DIAGNOSTICS a) Laboratory & x-ray b) MRI, nuclear medicine, and other high-tech services	a) No Copayment (Plan Pays 100%) b) 0% of Eligible Expenses after deductible (Plan Pays 100% after deductible)	Annual Deductible does not apply to Preventive Prostate Cancer Screenings, Mammography Testing and Child Health Supervision Health Services. a) No Benefits for Preventive Care, except for state mandated benefits. Please see the Addendum on the last page for further information. b) 20% of Eligible Expenses after deductible (Plan Pays 80% after deductible)
15. EMERGENCY CARE ^{7, 8}	\$125 per visit	Same as Network Benefit *Notification is required if results in an Inpatient Stay.
16. AMBULANCE	Ground Transportation: 0% of Eligible Expenses after deductible (Plan Pays 100% after deductible) Air Transportation: 0% of Eligible Expenses after deductible (Plan Pays 100% after deductible)	Same as Network Benefit
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	\$75 per visit	20% of Eligible Expenses after deductible (Plan Pays 80% after deductible)
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE ⁹	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.
19. OTHER MENTAL HEALTH CARE a) Inpatient and Intermediate care Must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non-Network Benefits for Mental Health or Substance Abuse Services is limited to 45 days (or 90 partial days) per calendar year. The treatment of Biologically Based Mental Illness is not subject to this limit. b) Outpatient care Must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non-Network Benefits are limited to 20 visits per calendar year. The treatment of Biologically Based Mental Illness is not subject to this limit.	a) 0% of Eligible Expenses after deductible (Plan Pays 100% after deductible) When Mental Health Services are for the treatment of a Biologically Based Mental Illness, the Copayment is the same as the Copayment for any other Inpatient Stay in a Hospital. b) \$50 per visit When Mental Health Services are for the treatment of a Biologically Based Mental Illness, the Copayment is the same as the Copayment for Physician Office Services.	a) 20% of Eligible Expenses after deductible (Plan Pays 80% after deductible) When Mental Health Services are for the treatment of a Biologically Based Mental Illness, the Copayment is the same as the Copayment for any other Inpatient Stay in a Hospital. b) 20% of Eligible Expenses after deductible (Plan Pays 80% after deductible) When Mental Health Services are for the treatment of a Biologically Based Mental Illness, the Copayment is the same as the Copayment for Physician Office Services.

* = Prior Notification Required

	IN-NETWORK	OUT-OF-NETWORK
<p>20. ALCOHOL & SUBSTANCE ABUSE</p> <p>a) Inpatient care Must receive prior authorization through the Mental Health/ Substance Abuse Designee. Network and Non-Network Benefits for Mental Health or Substance Abuse Services is limited to 45 days (or 90 partial days) per calendar year. The treatment of Biologically Based Mental Illness is not subject to this limit.</p> <p>b) Outpatient care Must receive prior authorization through the Mental Health/ Substance Abuse Designee. Network and Non-Network Benefits are limited to 20 visits per calendar year.</p>	<p>a) 0% of Eligible Expenses after deductible (Plan Pays 100% after deductible) When Mental Health Services are for the treatment of a Biologically Based Mental Illness, the Copayment is the same as the Copayment for any other Inpatient Stay in a Hospital.</p> <p>b) \$50 per visit</p>	<p>a) 20% of Eligible Expenses after deductible (Plan Pays 80% after deductible) When Mental Health Services are for the treatment of a Biologically Based Mental Illness, the Copayment is the same as the Copayment for any other Inpatient Stay in a Hospital.</p> <p>b) 20% of Eligible Expenses after deductible (Plan Pays 80% after deductible)</p>
<p>21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY</p> <p>Network and Non-Network Benefits are subject to combined limits as follows: Physical therapy - 20 visits per calendar year Occupational therapy - 20 visits per calendar year Speech therapy - 20 visits per calendar year</p>	<p>0% of Eligible Expenses after deductible (Plan Pays 100% after deductible)</p>	<p>20% of Eligible Expenses after deductible (Plan Pays 80% after deductible)</p>
<p>21A. CARDIAC AND PULMONARY REHABILITATION</p> <p>Network and Non-Network Benefits are subject to combined limits as follows: Pulmonary Rehab - 20 visits per calendar year Cardiac Rehab - 36 visits per calendar year.</p>	<p>0% of Eligible Expenses after deductible (Plan Pays 100% after deductible)</p>	<p>20% of Eligible Expenses after deductible (Plan Pays 80% after deductible)</p>
<p>22. DURABLE MEDICAL EQUIPMENT</p> <p>Network and Non-Network Benefits for Durable Medical Equipment are limited to \$2,500 per calendar year.</p>	<p>0% of Eligible Expenses after deductible (Plan Pays 100% after deductible)</p>	<p>*20% of Eligible Expenses after deductible (Plan Pays 80% after deductible) *Prior notification is required when the cost is more than \$1,000.</p>
<p>22A. PROSTHETIC DEVICES</p> <p>Network and Non-Network Benefits for prosthetic are limited to \$2,500 per calendar year. This limit does not apply to prosthetic arms and legs.</p>	<p>0% of Eligible Expenses after deductible (Plan Pays 100% after deductible)</p>	<p>20% of Eligible Expenses after deductible (Plan Pays 80% after deductible)</p>
<p>23. OXYGEN</p>	<p>Included under Durable Medical Equipment.</p>	<p>Included under Durable Medical Equipment.</p>
<p>24. ORGAN TRANSPLANTS</p>	<p>*0% of Eligible Expenses after deductible (Plan Pays 100% after deductible)</p>	<p>*20% of Eligible Expenses after deductible (Plan Pays 80% after deductible) Benefits are limited to \$30,000 per transplant.</p>
<p>25. HOME HEALTH CARE</p> <p>Network and Non-Network Benefits are limited to 60 visits for skilled care services per calendar year.</p>	<p>0% of Eligible Expenses after deductible (Plan Pays 100% after deductible)</p>	<p>*20% of Eligible Expenses after deductible (Plan Pays 80% after deductible)</p>

* = Prior Notification Required

	IN-NETWORK	OUT-OF-NETWORK
26. HOSPICE CARE Network and Non-Network Benefits are limited to three benefit periods of three months per benefit period during the entire period of time you are covered under the Policy.	0% of Eligible Expenses after deductible (Plan Pays 100% after deductible)	*20% of Eligible Expenses after deductible (Plan Pays 80% after deductible)
27. SKILLED NURSING FACILITY CARE Network and Non-Network Benefits are limited to 60 days per calendar year.	0% of Eligible Expenses after deductible (Plan Pays 100% after deductible)	*20% of Eligible Expenses after deductible (Plan Pays 80% after deductible)
28. DENTAL CARE - ACCIDENT ONLY	*0% of Eligible Expenses after deductible (Plan Pays 100% after deductible) *Prior notification is required before follow-up treatment begins.	*Same as Network Benefit *Prior notification is required before follow-up treatment begins.
29. VISION CARE Refractive eye examinations are limited to one every other calendar year from a Network Provider.	\$25 per visit	20% of Eligible Expenses after deductible (Plan Pays 80% after deductible) Eye Examinations for refractive errors are not covered.
30. CHIROPRACTIC CARE Benefits include diagnosis and related services and are limited to one visit and treatment per day. Network and Non-Network Benefits are limited to 24 visits per calendar year.	0% of Eligible Expenses after deductible (Plan Pays 100% after deductible)	20% of Eligible Expenses after deductible (Plan Pays 80% after deductible)
31. SIGNIFICANT ADDITIONAL COVERAGE SERVICES (list up to 5) 1) CHILDREN'S DENTAL ANESTHESIA 2) CLEFT LIP AND CLEFT PALATE 3) DIABETES TREATMENT 4) RECONSTRUCTIVE PROCEDURES 5) TELEMEDICINE	1) *Same as 8, 11, 12, 13, 13A and 13B 2) *Same as 8, 11, 12, 13, 13A, 13B and 14 3) Same as 8, 11 and 12 4) Same as 8, 12, 12A, 13, 13A, 13B, 14 and 22A 5) Same as 8, 11 and 12	1) *Same as 8, 11, 12, 13, 13A and 13B 2) *Same as 8, 11, 12, 13, 13A, 13B and 14 3) Same as 8, 11 and 12 4) Same as 8, 12, 12A, 13, 13A, 13B, 14 and 22A 5) Same as 8, 11 and 12

PART C: LIMITATIONS AND EXCLUSIONS

	IN-NETWORK	OUT-OF-NETWORK
32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED. ¹⁰	Six months for all pre-existing conditions.	Six months for all pre-existing conditions.
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No	No

* = Prior Notification Required

	IN-NETWORK	OUT-OF-NETWORK
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	A pre-existing condition is a condition for which medical advice, diagnosis, care or treatment was recommended or received within the last 6 months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn or other special enrollees or for pregnancy.	A pre-existing condition is a condition for which medical advice, diagnosis, care or treatment was recommended or received within the last 6 months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn or other special enrollees or for pregnancy.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent or plan sponsor. Review the list to see if a service or treatment you may need is excluded from the policy.	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent or plan sponsor. Review the list to see if a service or treatment you may need is excluded from the policy.

PART D: USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
36. Does the enrollee have to obtain a referral and/or prior notification for specialty care in most or all cases?	No	No
37. Is prior notification required for surgical procedures and hospital care (except in an emergency)?	Prior notification is required for selected procedures.	Prior notification is required for selected procedures.
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes
39. What is the main customer service number?	Prior to receiving ID card, contact your Employer Benefits Administrator. After receiving ID card, contact the Customer Service Department at the toll free number listed on your ID card. Sales and Marketing office - 800-516-3344.	Prior to receiving ID card, contact your Employer Benefits Administrator. After receiving ID card, contact the Customer Service Department at the toll free number listed on your ID card. Sales and Marketing office - 800-516-3344.
40. Whom do I write/call if I have a complaint or want to file a grievance? ¹¹	Contact the Customer Service Department at toll free number listed on your ID card. UnitedHealthcare National Appeals and Service Center: P.O. Box 659773 San Antonio, TX 78265-9773	Contact the Customer Service Department at toll free number listed on your ID card. UnitedHealthcare National Appeals and Service Center: P.O. Box 659773 San Antonio, TX 78265-9773
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202

	IN-NETWORK	OUT-OF-NETWORK
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy Form #CHOICE.cert.01.CO Group-all sizes	Policy Form #PLUScert.01.CO Group-all sizes
43. Does the plan have a binding arbitration clause?	No	No

Endnotes

- ¹ "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).
- ² "Deductible" means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible may be noted in boxes 8 through 31.
- ³ "Out-of-pocket maximum" means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy. Expenses that are applied toward the out-of-pocket maximum may be noted in boxes 8 through 31.
- ⁴ Routine medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically-based mental illness.
- ⁵ Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together; there are not separate copayments.
- ⁶ Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.
- ⁷ "Emergency care" means services delivered by an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.
- ⁸ Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours care, then urgent care copayments apply.
- ⁹ "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.
- ¹⁰ Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.
- ¹¹ Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

EXCLUSIONS AND LIMITATIONS

Except as may be specifically provided in Section 1 of your Certificate of Coverage (COC) or through a Rider to the Policy, the following are not covered:

A. Alternative Treatments

Acupressure; hypnosis; rolfing; massage therapy; aroma therapy; acupuncture; and other forms of Alternative Treatment.

B. Comfort or Convenience

Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery charges, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.

C. Dental

Dental care except as described in (Section 1: What's Covered--Benefits) under the headings Children's Dental Anesthesia, Cleft Lip and Cleft Palate Treatment, and Dental Services - Accident only. There is no coverage for services provided for preventive care, diagnosis, treatment of the teeth, jawbones or gums (including extraction, restoration, and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses including hospitalizations and anesthesia are excluded, except as might otherwise be required for transplant preparation, initiation of immunosuppressives, or the direct treatment of acute traumatic injury, cancer, or cleft palate, or as described in (Section 1: What's Covered--Benefits) under the heading Children's Dental Anesthesia. Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of a Congenital Anomaly.

D. 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.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational or Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to a prescribed drug if the drug has been approved by the Food and Drug Administration (FDA) as an "investigational new drug for treatment use" or if it is a drug classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life-threatening disease" as that term is defined in FDA regulations.

F. Foot Care

Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of flat feet or subluxation of the foot; shoe orthotics.

G. Medical Supplies and Appliances

Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to elastic stockings, ace bandages, gauze and dressings and ostomy supplies. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces). Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of your COC.

H. Mental Health/Substance Abuse

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention. Treatment of insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis.

Treatment of Mental Illnesses which will not substantially improve beyond the current level of functioning, or for conditions not subject to favorable modification or management according to generally accepted standards of psychiatric care, as determined by the Mental Health/Substance Abuse Designee, including, but not limited to, conduct and impulse control disorders; personality disorder; and paraphilias.

Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclozocine, or their equivalents; Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. Residential treatment services.

I. Nutrition

Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups, except as described as a Covered Health Service in (Section 1: What's Covered - Benefits) under Diabetes Treatment. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

J. 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. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.)

Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, regardless of the reason for the hair loss.

K. Providers

Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

L. Reproduction

Health services and associated expenses for infertility treatments.

Surrogate parenting. The reversal of voluntary sterilization.

M. Services Provided under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers' compensation, or similar legislation, but does not include no-fault automobile coverage. If coverage under workers' compensation coverage or similar legislation is optional because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Mental Illness or Sickness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

N. Transplants

Health services for organ or tissue transplants are excluded, except those specified as covered in Section 1 of your COC. Any solid organ transplant that is performed as a treatment for cancer. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs. Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the COC.

O. Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

P. Vision and Hearing

Purchase cost of eye glasses, contact lenses, or hearing aids. Fitting charge for hearing aids, eye glasses or contact lenses. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

Q. Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see definition in Section 10 of your COC.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Policy, 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 date your coverage under the Policy ends, including health services for medical conditions arising prior to the date your coverage under 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 and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which Copayments and/or Annual Deductible are waived.

Charges in excess of Eligible Expenses or in excess of any specified limitation. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.

Upper and lower jaw bone surgery 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 treatment and non-surgical treatment of obesity (including morbid obesity). Growth hormone therapy; sex transformation operations; treatment of benign gynecosmastia (abnormal 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. Oral appliances for snoring.

Custodial care; domiciliary care; private duty nursing. Respite care except as described as a Covered Health Service in (Section 1: What's Covered - Benefits) under Hospice Care. Rest cures and Psychotherapy. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke or Congenital Anomaly or as described as a Covered Health Service in (Section 1: What's Covered - Benefits) under Cleft Lip and Cleft Palate Treatment.

Services and supplies solely for the treatment of intractable pain, including but not limited to services provided by a pain management specialist. (Pain management means a pain state in which the cause of the pain cannot be removed and which, the generally accepted course of medical practice, no relief or cure of the cause of the pain is possible, or none has been found after reasonable efforts including, but not limited to, evaluation by the attending Physician and one or more Physicians specializing in the treatment of the area, system, or organ of the body perceive as the source of the pain).

R. Preexisting Conditions

Benefits for the treatment of a Preexisting Condition are excluded until the date you have had Continuous Creditable Coverage for 6 months. This exclusion does not apply to newborn children or newly adopted children under the age of 18. This exception for newborn and adopted children no longer applies after the end of the first 90-day period during which the child has not had Continuous Creditable Coverage.

This summary of Benefits is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This plan may not cover all your health care expenses. Please refer to the Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Certificate of Coverage, the Certificate of Coverage prevails. Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage.

Colorado Health Plan Description Form Addendum

UnitedHealthcare Insurance Company



UnitedHealthcare Insurance Company
In-Network and Out-of-Network

	IN-NETWORK	OUT-OF-NETWORK
Routine Cancer Screening Coverage		
1) Breast Cancer Screening	1) Same as 8, 9, 13A and 14	1) Same as 8, 9, 13A and 14
2) Cervical Cancer Screening	2) Same as 8, 9 and 14	2) Same as 8, 9 and 14
3) Colorectal Cancer Screening	3) Same as 8, 9 and 14	3) Same as 8, 9 and 14
4) Prostate Cancer Screening	4) Same as 8, 9 and 14	4) Same as 8, 9 and 14

Benefits for Routine Cancer Screenings are paid the same as Routine Medical Office Visits, Outpatient Diagnostic Services (for Mammography testing only) and Laboratory and X-Ray services.

A Deductible does not apply to Routine Cancer Screenings for Breast (Mammography) and Prostate Cancer.

There is no age limitation and no limit as to the number of screenings per year, when services are provided by a network provider. Certain limitations apply when services are provided by an out-of-network provider.

Please refer to the Certificate of Coverage for complete information on Routine Cancer Screening services and limitations.