

# Colorado Health Benefit Plan Description Form



UnitedHealthCare Insurance Company

Choice Plus Balanced 100 - 25/1500/100%  
Plan 7AF

## 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? <sup>1</sup>	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, Chafee, 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. DEDUCTIBLE TYPE <sup>2</sup>	Calendar Year	Calendar Year
4A. ANNUAL DEDUCTIBLE <sup>2a</sup> a) Individual Deductible <sup>2b</sup> b) Family Deductible <sup>2c</sup>	a) \$1,500 per year b) \$4,500 per year  > Member Copayments do not accumulate towards the Deductible.	a) \$3,000 per year b) \$9,000 per year  > Member Copayments do not accumulate towards the Deductible.

	IN-NETWORK	OUT-OF-NETWORK
<p>5. OUT-OF-POCKET ANNUAL MAXIMUM<sup>3</sup></p> <p>a) Individual Out-of-Pocket Maximum  b) Family Out-of-Pocket Maximum  c) Is deductible included in the out-of-pocket maximum?</p>	<p>a) \$1,500 per year  b) \$4,500 per year  c) Yes</p> <p>&gt; Member Copayments do not accumulate towards the Out-of-Pocket Maximum.</p>	<p>a) \$6,000 per year  b) \$12,000 per year  c) Yes</p> <p>&gt; Member Copayments do not accumulate towards the Out-of-Pocket Maximum.</p>
<p>6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE</p>	<p>Combined In-Network and Out-of-Network Maximum of \$5,000,000 per Covered Person.</p>	<p>Combined In-Network and Out-of-Network Maximum of \$5,000,000 per Covered Person.</p>
<p>7A. COVERED PROVIDERS</p>	<p>Over 400,000 physicians and 3,500 hospitals. See Physician and Provider Directory for a complete list.</p>	<p>All providers licensed or certified to provide covered benefits.</p>
<p>7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?</p>	<p>Yes</p>	<p>Not applicable</p>
<p>8. MEDICAL OFFICE VISITS<sup>4</sup></p> <p>a) Primary Care Providers</p> <p>b) Specialists</p>	<p>a) 100% after you pay a \$25 Copayment per visit.</p> <p>b) 100% after you pay a \$50 Copayment per visit.</p> <p>&gt; In addition to the visit Copayment, the applicable Copayment or Deductible/Coinsurance applies when these services are done: CT, PET, MRI, Nuclear Medicine; Pharmaceutical Products; Scopic Procedures; Surgery; Therapeutic Treatments.</p>	<p>a) 80% after Deductible has been met.</p> <p>b) 80% after Deductible has been met.</p> <p>&gt; In addition to the visit Copayment, the applicable Copayment or Deductible/Coinsurance applies when these services are done: CT, PET, MRI, Nuclear Medicine; Pharmaceutical Products; Scopic Procedures; Surgery; Therapeutic Treatments.</p>
<p>9. PREVENTIVE CARE</p> <p>a) Children's services</p> <p>b) Adults' services</p> <p>c) Lab, X-ray or other preventive tests</p>	<p>a) 100% after you pay a \$25 Copayment per visit for Primary Care Providers or a \$50 Copayment per visit for Specialist.</p> <p>b) 100% after you pay a \$25 Copayment per visit for Primary Care Providers or a \$50 Copayment per visit for Specialist.</p> <p>c) 100% Deductible does not apply.</p>	<p>No Benefits for Preventive Care, except for state mandated benefits. Annual Deductible does not apply to Child Health Supervision Services, mammography screening and prostate cancer screening.</p>

	IN-NETWORK	OUT-OF-NETWORK
<p>10. MATERNITY</p> <p>a) Prenatal care</p> <p>b) Delivery &amp; inpatient well baby care<sup>5</sup></p>	<p>a) Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.</p> <p>b) Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.</p> <p>For services provided in the Physician's Office, a Copayment will only apply to the initial office visit.</p>	<p>a) Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.</p> <p>b) Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.</p> <p>Pre-service Notification is required if the Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.</p>
<p>11. PRESCRIPTION DRUGS<sup>6</sup></p> <p>Level of coverage and restrictions on prescriptions</p>	<p>Prescription drug benefits are shown under separate cover.</p>	<p>Prescription drug benefits are shown under separate cover.</p>
<p>11A. PHARMACEUTICAL PRODUCTS - OUTPATIENT</p> <p>This includes medications administered in an Outpatient setting, in the Physician's Office and by a Home Health Agency.</p>	<p>100% after Deductible has been met.</p>	<p>80% after Deductible has been met.</p>
<p>12. INPATIENT HOSPITAL</p>	<p>100% after Deductible has been met.</p>	<p>80% after Deductible has been met.</p> <p>Pre-service Notification is required.</p>
<p>12A. PHYSICIAN FEES FOR SURGICAL AND MEDICAL SERVICES</p>	<p>100% after Deductible has been met.</p>	<p>80% after Deductible has been met.</p>
<p>12B. CONGENITAL HEART DISEASE (CHD) SURGERIES</p>	<p>100% after Deductible has been met.</p>	<p>80% after Deductible has been met.</p> <p>Benefits are limited to \$30,000 per surgery.</p> <p>Pre-service Notification is required.</p>
<p>13. OUTPATIENT/AMBULATORY SURGERY</p>	<p>100% after Deductible has been met.</p>	<p>80% after Deductible has been met.</p>

	IN-NETWORK	OUT-OF-NETWORK
<p>13A. SCOPIC PROCEDURES - OUTPATIENT DIAGNOSTIC AND THERAPEUTIC</p> <p>Diagnostic scopic procedures include, but are not limited to:  Colonoscopy  Sigmoidoscopy  Endoscopy  For Preventive Scopic Procedures, refer to the Preventive Care Category.</p>	100% after Deductible has been met.	80% after Deductible has been met.
13B. RECONSTRUCTIVE PROCEDURES	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.  Pre-service Notification is required.
<p>14. DIAGNOSTICS</p> <p>a) Laboratory &amp; x-ray</p> <p>Lab, X-ray and diagnostic services for preventive care are described under Preventive Care.</p> <p>b) MRI, nuclear medicine, and other high-tech services</p>	<p>a) 100% Deductible does not apply.</p> <p>b) 100% after Deductible has been met.</p>	<p>a) 80% after Deductible has been met.</p> <p>b) 80% after Deductible has been met.</p>
15. EMERGENCY CARE <sup>7, 8</sup>	100% after you pay a \$200 Copayment per visit.	100% after you pay a \$200 Copayment per visit.  Pre-service Notification is required if results in an Inpatient Stay.
16. AMBULANCE	<p>Ground Transportation: 100% after Deductible has been met.</p> <p>Air Transportation: 100% after Deductible has been met.</p>	<p>Ground Transportation: 100% after In-Network Deductible has been met.</p> <p>Air Transportation: 100% after In-Network Deductible has been met.</p> <p>Pre-service Notification is required for Non-Emergency Ambulance.</p>
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	<p>100% after you pay a \$75 Copayment per visit.</p> <p>&gt; In addition to the visit Copayment, the applicable Copayment or Deductible/Coinsurance applies when these services are done: CT, PET, MRI, Nuclear Medicine; Pharmaceutical Products; Scopic Procedures; Surgery; Therapeutic Treatments.</p>	<p>80% after Deductible has been met.</p> <p>&gt; In addition to the visit Copayment, the applicable Copayment or Deductible/Coinsurance applies when these services are done: CT, PET, MRI, Nuclear Medicine; Pharmaceutical Products; Scopic Procedures; Surgery; Therapeutic Treatments.</p>

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
18. <b>BIOLOGICALLY-BASED MENTAL ILLNESS CARE<sup>9</sup></b>	For Biologically Based Mental Illness, depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	For Biologically Based Mental Illness, depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.
19. <b>OTHER MENTAL HEALTH CARE</b> a) Inpatient & Intermediate care In-Network and Out-of-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 In-Network and Out-of-Network Benefits for Mental Health or Substance Abuse Services are limited to 20 visits, but in no event less than \$1,000 per calendar year. The treatment of Biologically Based Mental Illness is not subject to this limit.	a) 100% after Deductible has been met. 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) 100% after you pay a \$50 Copayment 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) 80% after Deductible has been met. 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) 80% after Deductible has been met. 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 Authorization is required from the MH/SA Designee.
20. <b>ALCOHOL &amp; SUBSTANCE ABUSE</b> a) Inpatient & Intermediate care In-Network and Out-of-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 In-Network and Out-of-Network Benefits for Mental Health or Substance Abuse Services are limited to 20 visits, but in no event less than \$500 for the treatment of alcoholism, per calendar year. The treatment of Biologically Based Mental Illness is not subject to this limit.	a) 100% after Deductible has been met. 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) 100% after you pay a \$50 Copayment per visit.	a) 80% after Deductible has been met. 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) 80% after Deductible has been met.  Prior Authorization is required from the MH/SA Designee.

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<p>21. <b>PHYSICAL, OCCUPATIONAL, &amp; SPEECH THERAPY</b>            In-Network and Out-of-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>100% after you pay a \$25 Copayment per visit.</p>	<p>80% after Deductible has been met.             Pre-service Notification is required for certain services.</p>
<p>21A. <b>CARDIAC &amp; PULMONARY REHABILITATION, &amp; POST-COCHLER IMPLANT AURAL THERAPY</b>            In-Network and Out-of-Network Benefits are subject to combined limits as follows:            Cardiac Rehabilitation - 36 visits per calendar year.            Pulmonary Rehabilitation - 20 visits per calendar year.            Post-Cochlear Implant Aural Therapy - 30 visits per calendar year.</p>	<p>100% after you pay a \$25 Copayment per visit.</p>	<p>80% after Deductible has been met.             Pre-service Notification is required for certain services.</p>
<p>21B. <b>REHABILITATION SERVICES – OUTPATIENT THERAPY (CONGENITAL DEFECTS AND BIRTH ABNORMALITIES)</b></p>	<p>100% after you pay a \$25 Copayment per visit.</p>	<p>80% after Deductible has been met.             Pre-service Notification is required for certain services.</p>
<p>21C. <b>THERAPEUTIC TREATMENTS - OUTPATIENT</b>            Therapeutic treatments include, but are not limited to:            Dialysis            Intravenous Chemotherapy or other            Intravenous infusion therapy            Radiation Oncology</p>	<p>100% after Deductible has been met.</p>	<p>80% after Deductible has been met.             Pre-service Notification is required for certain services.</p>
<p>21D. <b>CLINICAL TRIALS</b>            Participation in a qualifying clinical trial for the treatment of Cancer            Cardiovascular (cardiac/stroke)            Surgical musculoskeletal disorders of the spine, hip and knees.</p>	<p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary</p>	<p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary             Pre-service Notification is required.</p>
<p>22. <b>DURABLE MEDICAL EQUIPMENT</b>            In-Network and Out-of-Network Benefits for Durable Medical Equipment are limited to \$2,500 per calendar year.</p>	<p>100% after Deductible has been met.</p>	<p>80% after Deductible has been met.             Pre-service Notification is required for Durable Medical Equipment in excess of \$1,000.</p>

	IN-NETWORK	OUT-OF-NETWORK
<p>22A. DIABETES SERVICES Diabetes Self Management and Training. Diabetic Eye Examinations / Foot Care</p> <p>Diabetes Self Management Items</p>	<p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under Durable Medical Equipment and in the Outpatient Prescription Drug Rider.</p>	<p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under Durable Medical Equipment and in the Outpatient Prescription Drug Rider.</p> <p>Pre-service Notification is required for Durable Medical Equipment and Diabetes Equipment in excess of \$1,000.</p>
<p>22B. OSTOMY SUPPLIES In-Network and Out-of-Network Benefits are limited to \$2,500 per calendar year.</p>	100% after Deductible has been met.	80% after Deductible has been met.
<p>22C. PROSTHETIC DEVICES In-Network and Out-of-Network Benefits for Prosthetic Devices are limited to \$2,500 per calendar year. This limit does not apply to prosthetic arms, legs, feet and hands.</p>	100% after Deductible has been met.	80% after Deductible has been met.
23. OXYGEN	Included under Durable Medical Equipment.	Included under Durable Medical Equipment.
24. ORGAN TRANSPLANTS	<p>100% after Deductible has been met.</p> <p>For Network Benefits, services must be received at a Designated Facility.</p>	<p>80% after Deductible has been met.</p> <p>Benefits are limited to \$30,000 per transplant.</p> <p>Pre-service Notification is required.</p>
<p>25. HOME HEALTH In-Network and Out-of-Network Benefits are limited to 60 visits for skilled care services per calendar year.</p>	100% after Deductible has been met.	<p>80% after Deductible has been met.</p> <p>Pre-service Notification is required.</p>
<p>26. HOSPICE CARE Bereavement support services are limited to a maximum of \$1,150 during the 12-month period following the Covered Person's death.</p>	100% after Deductible has been met.	<p>80% after Deductible has been met.</p> <p>Pre-service Notification is required for Inpatient stays.</p>
<p>27. SKILLED NURSING FACILITY CARE In-Network and Out-of-Network Benefits are limited to 60 days per calendar year.</p>	100% after Deductible has been met.	<p>80% after Deductible has been met.</p> <p>Pre-service Notification is required.</p>
<p>28. DENTAL CARE - ACCIDENTAL ONLY In-Network and Out-of-Network are limited as follows: \$3,000 maximum per calendar year. \$900 maximum per tooth.</p>	100% after Deductible has been met.	<p>100% after In-Network Deductible has been met.</p> <p>Pre-service Notification is required.</p>

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
29. VISION CARE In-Network Benefits are limited to 1 exam every 2 calendar years.	100% after you pay a \$25 Copayment per visit.	Out-of-Network Benefits are not available.
30. CHIROPRACTIC CARE In-Network and Out-of-Network Benefits are limited to 20 visits per calendar year.	100% after you pay a \$25 Copayment per visit.	80% after Deductible has been met.  Pre-service Notification is required for certain services.
31. SIGNIFICANT ADDITIONAL COVERAGE SERVICES (list up to 5) 1) CHILDREN'S DENTAL ANESTHESIA  2) CLEFT LIP AND CLEFT PALATE  3) TELEMEDICINE  4) PHENYLKETONURIA (PKU) TESTING AND TREATMENT	1) Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary  2) Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary  3) Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary  4) Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary	1) Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary Pre-service Notification is required.  2) Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary Pre-service Notification is required.  3) Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary  4) Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary

## **PART C: LIMITATIONS AND EXCLUSIONS**

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED. <sup>10</sup>	Six months for all pre-existing conditions for groups with less than 50 employees. For groups with 51 or more employees, the exclusion for pre-existing conditions does not apply.	Six months for all pre-existing conditions for groups with less than 50 employees. For groups with 51 or more employees, the exclusion for pre-existing conditions does not apply.
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No	No

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
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**

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
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 your ID card, contact your Employer Benefits Administrator. After receiving your 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 your ID card, contact your Employer Benefits Administrator. After receiving your 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? <sup>11</sup>	Contact the Customer Service Department at toll free number listed on your ID card. United Healthcare - 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. United Healthcare - 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

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
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 COC.CER.1.07.CO Group-all sizes	Policy Form COC.CER.1.07.CO Group-all sizes
43. Does the plan have a binding arbitration clause?	No	No

## MEDICAL EXCLUSIONS

It is recommended that you review your COC for an exact description of the service and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

### Endnotes

<sup>1</sup> "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).

<sup>2</sup> "Deductible Type" indicates whether the deductible period is "Calendar Year" (January 1 through December 31) or "Benefit Year" (i.e., based on a benefit year beginning on the policy's anniversary date) or if the deductible is based on other requirements such as "Per Accident or Injury" or "Per Confinement".

<sup>2a</sup> "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 or benefit 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 should be noted in boxes 8 through 31.

<sup>2b</sup> "Individual" means the deductible amount you and each individual covered by a non-HSA qualified policy will have to pay for allowable covered expenses before the carrier will cover those expenses. "Single" means the deductible amount you will have to pay for allowable covered expenses under an HSA-qualified health plan when you are the only individual covered by the plan.

<sup>2c</sup> "Family" is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified policy and it may be an aggregated amount (e.g., "\$3000 per family") or specified as the number of individual deductibles that must be met (e.g., 3 deductibles per family). "Non-Single" is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any covered expenses are paid.

<sup>3</sup> "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 deductibles 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 should be noted in boxes 8 through 31.

<sup>4</sup> Medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically based mental illness.

<sup>5</sup> 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.

<sup>6</sup> Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

<sup>7</sup> "Emergency care" means all 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.

<sup>8</sup> 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.

<sup>9</sup> "Biologically based mental illness" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

<sup>10</sup> 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.

<sup>11</sup> Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

## MEDICAL EXCLUSIONS

It is recommended that you review your COC for an exact description of the service and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

### Alternative Treatments

Acupressure; acupuncture; aromatherapy; hypnosis; massage therapy; rolfing; art, music, dance, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Chiropractic Treatment and osteopathic care for which Benefits are provided as described in Section 1 of the COC.

### Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia) except as described under Childrens Dental Anesthesia and Cleft Lip and Cleft Palate Treatment in Section 1 of the COC. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of cancer or cleft palate; as described under Childrens Dental Anesthesia and Cleft Lip and Cleft Palate Treatment in Section 1 of the COC. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: extraction, restoration, and replacement of teeth; medical or surgical treatment of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services - Accidental Only in Section 1 of the COC. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. Dental braces (orthodontics). Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

### Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics, cranial banding and some types of braces, including over-the-counter orthotic braces. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; home coagulation testing equipment; non-wearable external defibrillator; trusses; ultrasonic nebulizers; and ventricular assist devices. Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo-esophageal voice prosthetics. Oral appliances for snoring. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

### Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This

exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy.

### Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or 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 or 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. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC.

### Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet or subluxation of the foot. Shoes; shoe orthotics; shoe inserts and arch supports.

### Medical Supplies

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: elastic stockings, ace bandages, gauze and dressings, urinary catheters. This exclusion does not apply to: Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC. Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1 of the COC. Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment as described in Section 1 of the COC.

### 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. Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis. Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol, Cyclazocine), or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions, court ordered treatment and other similar arrangements, unless

## MEDICAL EXCLUSIONS

It is recommended that you review your COC for an exact description of the service and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

authorized by the Mental Health/Substance Abuse Designee. Residential treatment services. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following: Not consistent with prevailing national standards of clinical practice for the treatment of such conditions. Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome. Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective. Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time. The Mental Health/Substance Abuse Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

### **Nutrition**

Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

Nutritional education is required for a disease in which patient self-management is an important component of treatment.

There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Enteral feedings, even if the sole source of nutrition except for the first 31 days of life. Benefits for medical foods are described under the Outpatient Prescription Drug Rider. Infant formula and donor breast milk. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

### **Personal Care, Comfort or Convenience**

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; electric scooters; exercise equipment; home modifications such as elevators, handrails and ramps; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; speech generating devices; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

### **Physical Appearance**

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Breast reduction except as coverage is

required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. Wigs regardless of the reason for the hair loss.

### **Procedures and Treatments**

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Speech therapy except as described under Rehabilitation Services – Outpatient Therapy in Section 1 of the COC; or speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or autism spectrum disorders; or therapy for the care and treatment of congenital defect and birth abnormalities for children from age 3 to 6 are covered, without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity; or as described under Cleft Lip and Cleft Palate Treatment in Section 1 of the COC. Outpatient rehabilitation services, except for services as described under Rehabilitation Services – Outpatient Therapy in Section 1 of the COC. Examples include cardiac rehabilitation therapy, cardiac rehabilitation therapy, pulmonary rehabilitation therapy, chiropractic treatment, post-cochlear implant aural therapy. Psychosurgery. Sex transformation operations. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. 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 jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors 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. Stand-alone multi-disciplinary smoking cessation programs.

### **Providers**

Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal residence. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which 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 is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography. Foreign language and sign language interpreters.

### **Reproduction**

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive

## MEDICAL EXCLUSIONS

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materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization.

### 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. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness, or Mental Illness 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.

### Transplants

Health services for organ and tissue transplants, except those described under Transplantation Services in Section 1 of the COC. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.) Health services for transplants involving permanent mechanical or animal organs.

### 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 Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion.

### Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis. Custodial care; domiciliary care. Private duty nursing. This means nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true: no skilled services are identified; skilled nursing resources are available in the facility; the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose. Respite care, except as described under Hospice Care in Section 1 of the COC; rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

### Vision and Hearing

Purchase cost and fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.

### All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when: required solely for purposes of career, school, sports or camp, travel, employment, insurance, marriage or adoption. This exclusion does not apply to treatments for Injuries resulting from a Covered Person's casual or nonprofessional participation in motorcycling, snowmobiling, off-highway vehicle riding, skiing or snowboarding. Related to judicial or administrative proceedings or orders except as described under Mental Health and Substance Abuse Services-Inpatient and Intermediate and Mental Health and Substance Abuse Services-Outpatient. Conducted for purposes of medical research; required 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. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended. 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. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. Autopsy. Services and supplies solely for the treatment of intractable pain, including but not limited to services provided by a pain management specialist. For purposes of this exclusion, "pain management" means a pain state in which the cause of the pain cannot be removed and which, in 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 perceived as the source of pain. Consultation provided by a provider by telephone or facsimile.

### Preexisting Conditions (Applies only to groups of 50 or less employees)

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; or 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 under the age of 18, including a child placed for adoption. This exclusion 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. Pregnancy is not considered a Preexisting Condition, as indicated in the definition of Preexisting Condition in Section 9 of the COC.

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This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Certificate of Coverage (COC), the COC shall prevail. It is recommended that you review your COC for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

**Colorado Health Plan Description Form Addendum**  
**UnitedHealthcare Insurance Company**



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

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Routine Cancer Screening Coverage -Breast Cancer Screening -Cervical Cancer Screening -Colorectal Cancer Screening -Prostate Cancer Screening	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each covered Health Service category in this Benefit Summary.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each covered Health Service category in this Benefit Summary.

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.