

Appendix A

Colorado Health Benefit Plan Description Form



UnitedHealthcare Insurance Company

UnitedHealthcare Standard Preferred Provider Health Benefit Plan for Colorado (JDN)

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Preferred provider plan
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 areas: 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 counties.

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 authorization, 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 Type²	Calendar Year	Calendar Year
4A. ANNUAL DEDUCTIBLE^{2a} a) Individual ^{2b} b) Family ^{2c}	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.
5. OUT-OF-POCKET ANNUAL MAXIMUM³ a) Individual b) Family c) Is deductible included in the out-of-pocket maximum?	a) \$4,500 b) \$9,000 c) Yes > Member Copayments do not accumulate towards the Out-of-Pocket Maximum.	a) \$9,000 b) \$18,000 c) Yes > Member Copayments do not accumulate towards the Out-of-Pocket Maximum.
5A. COINSURANCE OR COPAY	20% Coinsurance	50% Coinsurance
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	Combined In-Network and Out-of-Network Maximum of \$5,000,000 per Covered Person.	Combined In-Network and Out-of-Network Maximum of \$5,000,000 per Covered Person.
7A. COVERED PROVIDERS	UnitedHealthcare Insurance Company network. See provider directory for a complete list of current providers	All providers licensed or certified to provide covered benefits.
7B. With respect to network plans, are all the	Yes	Not Applicable

	IN-NETWORK	OUT-OF-NETWORK
providers listed in 7A accessible to me through my primary care physician?		
8. MEDICAL OFFICE VISITS ⁴ a) Primary Care Providers b) Specialists	a) \$30 Copayment per visit. b) \$50 Copayment per visit.	a) 50% after Deductible has been met. b) 50% after Deductible has been met.
9. PREVENTIVE CARE a) Children's services b) Adults' services	a) \$30 Copayment per visit. Additional preventive care services are covered at \$30 copayment per visit for office visits and \$250 copayment for outpatient/ambulatory surgery procedures. b) \$30 Copayment per visit. Additional preventive care services are covered at \$30 copayment per visit for office visits and \$250 copayment for outpatient/ambulatory surgery procedures.	a) 50% Additional preventive care services are covered at \$30 copayment per visit for office visits and \$250 copayment for outpatient/ambulatory surgery procedures. Deductible does not apply to preventive care services. b) 50% after Deductible has been met. Additional preventive care services are covered at \$30 copayment per visit for office visits and \$250 copayment for outpatient/ambulatory surgery procedures. Deductible does not apply to additional preventive care services. Annual Deductible does not apply to Child Health Supervision Services, mammography screening, prostate cancer screening and colorectal cancer screening services.
10. MATERNITY a) Prenatal care b) Delivery & inpatient well baby care ⁵	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 except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. b) 20% after Deductible has been met.	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 except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. b) 50% after Deductible has been met. 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.
11. PRESCRIPTION DRUGS ⁶ Level of coverage and restrictions on prescriptions.	See benefit schedule attached.	See benefit schedule attached.
12. INPATIENT HOSPITAL	20% after Deductible has been met.	50% after Deductible has been met. Pre-service Notification is required.
13. OUTPATIENT/AMBULATORY SURGERY	20% after Deductible has been met.	50% after Deductible has been met.
13A. SCOPIC PROCEDURES – OUTPATIENT DIAGNOSTIC AND THERAPEUTIC	Depending upon where the Covered Health Service is provided, Benefits will be the	Depending upon where the Covered Health Service is provided, Benefits will be the same as those

	IN-NETWORK	OUT-OF-NETWORK
	same as those stated under each Covered Health Service category in this Benefit Summary.	stated under each Covered Health Service category in this Benefit Summary. Pre-service Notification is required.
13B. RECONSTRUCTIVE PROCEDURES	Depending upon where the Covered Health Service is provided, Benefits, including breast prosthesis, mastectomy bras and lymphedema stockings for the arms, 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, including breast prosthesis, mastectomy bras and lymphedema stockings for the arms, will be the same as those stated under each Covered Health Service category in this Benefit Summary. Pre-service Notification is required.
14. DIAGNOSTICS a) Laboratory & x-ray b) MRI, nuclear medicine, and other high tech services	a) 20% after Deductible has been met. b) 20% after Deductible has been met.	a) 50% after Deductible has been met. b) 50% after Deductible has been met.
15. EMERGENCY CARE ^{7,8}	\$150 Copayment per visit then 20%. If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copayment. The Benefits for an inpatient stay in a Hospital will apply instead.	\$150 Copayment per visit then 20%. If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copayment. The Benefits for an inpatient stay in a Hospital will apply instead.
16. AMBULANCE	Ground Ambulance: 20% after Deductible has been met. Air Ambulance: 20% after Deductible has been met.	Ground Ambulance: 20% after In-Network Deductible has been met. Air Ambulance: 20% after In-Network Deductible has been met
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	\$75 Copayment per visit.	50% after Deductible has been met.
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE ⁹	Coverage is no less extensive than the coverage provided for any other physical illness under that plan.	Coverage is no less extensive than the coverage provided for any other physical illness under that plan.
19. OTHER MENTAL HEALTH CARE a) Inpatient care	a) 50% 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. Must receive prior authorization through the Mental Health/Substance Abuse Designee. In-Network and Out-of-Network Benefits for Mental Health or Substance Abuse Services is	a) 50% 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. Must receive prior authorization through the Mental Health/Substance Abuse Designee. 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.

	IN-NETWORK	OUT-OF-NETWORK
b) Outpatient care	<p>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) 50% 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. Must receive prior authorization through the Mental Health/Substance Abuse Designee. In-Network and Out-of-Network Benefits are limited to \$1,500 per calendar year. The treatment of Biologically Based Mental Illness is not subject to this limit.</p>	<p>The treatment of Biologically Based Mental Illness is not subject to this limit.</p> <p>b) 50% 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 Mental Health Designee. Must receive prior authorization through the Mental Health/Substance Abuse Designee. In-Network and Out-of-Network Benefits are limited to \$1,500 per calendar year. The treatment of Biologically Based Mental Illness is not subject to this limit.</p>
20. ALCOHOL & SUBSTANCE ABUSE	<p>Inpatient care: 50% after Deductible has been met. Must receive prior authorization through the Mental Health/ Substance Abuse Designee. In-Network and Out-of-Network Benefits for Substance Abuse Services are limited to acute detoxification. Maximum of 5 days per episode and 2 episodes per lifetime combined inpatient and outpatient and In-Network and Out-of-Network. The treatment of Biologically Based Mental Illness is not subject to this limit.</p> <p>Outpatient care: 50% after Deductible has been met. Must receive prior authorization through the Mental Health/ Substance Abuse Designee. In-Network and Out-of-Network Benefits for Substance Abuse Services are limited to acute detoxification. Maximum of 5 days per episode and 2 episodes per lifetime combined inpatient and outpatient and In-Network and Out-of-Network. The treatment of Biologically Based Mental Illness is not subject to this limit.</p>	<p>Inpatient care: 50% after Deductible has been met. Must receive prior authorization through the Mental Health/ Substance Abuse Designee. In-Network and Out-of-Network Benefits for Substance Abuse Services are limited to acute detoxification. Maximum of 5 days per episode and 2 episodes per lifetime combined inpatient and outpatient and In-Network and Out-of-Network. The treatment of Biologically Based Mental Illness is not subject to this limit.</p> <p>Outpatient care: 50% after Deductible has been met. Must receive prior authorization through the Mental Health/ Substance Abuse Designee. In-Network and Out-of-Network Benefits for Substance Abuse Services are limited to acute detoxification. Maximum of 5 days per episode and 2 episodes per lifetime combined inpatient and outpatient and In-Network and Out-of-Network. The treatment of Biologically Based Mental Illness is not subject to this limit.</p>

	IN-NETWORK	OUT-OF-NETWORK
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	20% after Deductible has been met. In-Network and Out-of-Network Benefits are subject to combined limits as follows: Physical therapy – 25 visits per calendar year Occupational therapy – 25 visits per calendar year Speech therapy – 25 visits per calendar year	50% after Deductible has been met. In-Network and Out-of-Network Benefits are subject to combined limits as follows: Physical therapy – 25 visits per calendar year Occupational therapy – 25 visits per calendar year Speech therapy – 25 visits per calendar year
21A. REHABILITATION SERVICES – OUTPATIENT THERAPY (CONGENITAL DEFECT AND BIRTH ABNORMALITIES)	20% after Deductible has been met. Care and treatment of congenital defect and birth abnormalities for children from age 3 to age 6 are covered 20 visits each for physical, occupational and speech therapy, 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.	50% after Deductible has been met. Care and treatment of congenital defect and birth abnormalities for children from age 3 to age 6 are covered 20 visits each for physical, occupational and speech therapy, 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.
21B. THERAPEUTIC TREATMENTS - OUTPATIENT	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.
21C. CLINICAL TRIALS	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.
22. DURABLE MEDICAL EQUIPMENT	20% after Deductible has been met. In-Network and Out-of-Network Benefits for Durable Medical Equipment are limited to \$2,500 per calendar year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) as necessary. Items required by the Women’s Health and Cancer Rights Act of 1998 and for prosthetic arms, legs, feet and hands are not subject to the DME limit, 20%.	50% after Deductible has been met. In-Network and Out-of-Network Benefits for Durable Medical Equipment are limited to \$2,500 per calendar year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) as necessary. Items required by the Women’s Health and Cancer Rights Act of 1998 and for prosthetic arms, legs, feet and hands are not subject to the DME limit; 20%. Pre-service Notification is required for Durable Medical Equipment in excess of \$1,000.
22A. DIABETES SERVICES	Diabetes Self-Management and Training Diabetic Eye Examinations	Diabetes Self-Management and Training Diabetic Eye Examinations

	IN-NETWORK	OUT-OF-NETWORK
	<p>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations will be the same as those stated under each Covered Health Service category in this benefit summary.</p> <p>Diabetes Self-Management Items</p> <p>Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under Durable Medical Equipment. Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items 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 for diabetes self-management and training/diabetic eye examinations will be the same as those stated under each Covered Health Service category in this benefit summary.</p> <p>Diabetes Self-Management Items</p> <p>Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under Durable Medical Equipment. Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items 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>
22B. PROSTHETIC DEVICES	<p>20% after Deductible has been met.</p> <p>Benefits are limited to a single purchase of each type of prosthetic device. Prosthetic devices are not subject to the DME limit.</p> <p>Items required by the Women's Health and Cancer Rights Act of 1998 are not subject to the DME limit.</p> <p>Prosthetic arms, legs, feet and 20% coinsurance Network and Non-Network and are not subject to the DME limit.</p>	<p>50% after Deductible has been met.</p> <p>Benefits are limited to a single purchase of each type of prosthetic device. Prosthetic devices are not subject to the DME limit.</p> <p>Items required by the Women's Health and Cancer Rights Act of 1998 are not subject to the DME limit. Prosthetic arms, legs, feet and 20% coinsurance Network and Non-Network and are not subject to the DME limit.</p>
22C. HEARING AIDS FOR ADULTS	<p>20% after Deductible has been met.</p> <p>In-Network and Out-of-Network Benefits are limited to \$2,500 per year.</p>	<p>50% after Deductible has been met.</p> <p>In-Network and Out-of-Network Benefits are limited to \$2,500 per year.</p>
23. OXYGEN	Included under Durable Medical Equipment.	Included under Durable Medical Equipment.
24. ORGAN TRANSPLANTS	20% after Deductible has been met.	50% after Deductible has been met.
25. HOME HEALTH CARE	20% after Deductible has been met.	50% after Deductible has been met.
26. HOSPICE CARE	20% after Deductible has been met.	50% after Deductible has been met.
	Included in Hospice Care is bereavement support services which will be covered for a	Included in Hospice Care is bereavement support services which will be covered for a

	IN-NETWORK	OUT-OF-NETWORK
	minimum of \$1,150 during the 12-month period following the Covered Person's death.	minimum of \$1,150 during the 12-month period following the Covered Person's death. Pre-service Notification is required.
27. SKILLED NURSING FACILITY CARE	20% after Deductible has been met. Benefits are limited to 100 days per year.	50% after Deductible has been met. Benefits are limited to 100 days per year. Pre-service Notification is required.
28. DENTAL CARE	Depending upon where the Covered Health Services is provided, Benefits for Dental care related to accidental injury treatment will be the same as those stated under each Covered Health Service category in this Benefit Summary. Dental care related to accidental injury: Treatment, supplies and appliances that are needed to restore the mouth, sound natural teeth or jaws to the condition they were in immediately prior to the accident. The first dental services must be performed within 60 days of the accident unless the patient's medical condition prohibited the initial dental care from being provided within that timeframe. Only services provided within 12 months of the accident are covered.	Depending upon where the Covered Health Services is provided, Benefits for Dental care related to accidental injury treatment will be the same as those stated under each Covered Health Service category in this Benefit Summary. Dental care related to accidental injury: Treatment, supplies and appliances that are needed to restore the mouth, sound natural teeth or jaws to the condition they were in immediately prior to the accident. The first dental services must be performed within 60 days of the accident unless the patient's medical condition prohibited the initial dental care from being provided within that timeframe. Only services provided within 12 months of the accident are covered.
29. VISION CARE	Not covered.	Not covered.
30. CHIROPRACTIC CARE	Not covered.	Not covered.
31. SIGNIFICANT ADDITIONAL COVERAGE SERVICES (list up to 5)	<ul style="list-style-type: none"> a) CHILDREN'S DENTAL ANESTHESIA b) CLEFT LIP AND CLEFT PALATE c) PKU TESTING AND TREATMENT d) TELEMEDICINE e) HEARING AIDS (MINOR CHILDREN) <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>	<ul style="list-style-type: none"> a) CHILDREN'S DENTAL ANESTHESIA b) CLEFT LIP AND CLEFT PALATE c) PKU TESTING AND TREATMENT d) TELEMEDICINE e) HEARING AIDS (MINOR CHILDREN) <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>Pre-service Notification is required.</p>

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED. ¹⁰	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	
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, 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 (e.g., employer). 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 authorization for specialty care in most or all cases?	No	No
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes, prior notification is required for selected procedures.	Yes, 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	
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 Service Center P.O. Box 659773 San Antonio, TX 78265-9773	
41. Whom do I contact if I'm 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	
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group ; or if it is a short-term policy.	Policy form #: StdChcCOC.I.07.CO (01/2010), Small Group	
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 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”.
- ^{2a} “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.
- ^{2b} “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.
- ^{2c} “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., “\$3,000 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.
- 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 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.
- ⁴ 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 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.
- 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.

IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM THE INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

UNITEDHEALTHCARE HAS PREPARED AND MAINTAINS A NETWORK ACCESS PLAN THAT DESCRIBES HOW THE PLAN MONITORS THE NETWORK OF PROVIDERS TO ENSURE THAT YOU HAVE ACCESS TO NETWORK PROVIDERS. THE ACCESS PLAN ALSO HAS INFORMATION ON THE REFERRAL PROCESSES, COMPLAINT PROCEDURES, QUALITY PROGRAMS AND EMERGENCY SERVICES COVERAGE PROVISIONS. THE NETWORK ACCESS PLAN IS AVAILABLE AT THE PLAN’S OFFICE: 6465 GREENWOOD PLAZA BLVD, SUITE 300, CENTENNIAL, CO, 80111 OR CALL (800) 842-4509.

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; 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 osteopathic care for which Benefits are provided as described in Section 1 of the COC.

B. Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia) except as described under Children's 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 Children's Dental Anesthesia 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 Children's Dental Anesthesia, Cleft Lip and Cleft Palate Treatment and Dental Services – Accidental Only in Section 1 of the COC. Dental braces (orthodontics) except as described under Cleft Lip and Cleft Palate Treatment in Section 1 of the COC. Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly except as described under Children's Dental Anesthesia and Cleft Lip and Cleft Palate Treatment in Section 1 of the COC.

C. 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. 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.

D. 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.

E. Experimental, Investigational or Unproven Services

Experimental and 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 in Section 1 of the COC.

F. 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.

G. Medical Supplies

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: elastic stockings, ace bandages, gauze and dressings, urinary catheters, ostomy supplies. 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. Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment as described in Section 1 of the 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. 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 authorized by the Mental Health/Substance Abuse Designee. 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.

I. Neurobiological Disorders – Autism Spectrum Disorders

Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Autism Spectrum Disorder services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services. Mental retardation as the primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association and which are not a part of Autism Spectrum Disorder. Treatments for the primary diagnoses of learning disabilities, 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. Treatment provided in connection with or to comply with involuntary commitments, police detentions, court-ordered treatment and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following: not consistent with generally accepted standards of medical practice for the treatment of such conditions; not consistent with services backed by credible research soundly demonstrating that the services or supplies will have measurable and beneficial health outcome, and therefore considered experimental; 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; not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks. 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 or supply meets any of these criteria.

J. 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 associated with PKU 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).

K. 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.

L. 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 Rights 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.

M. Preexisting Conditions

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 6 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.

N. 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. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including but not limited to routine, long-term or maintenance/preventive treatment except as described under Rehabilitation Services – Outpatient Therapy and Rehabilitation Services – Outpatient Therapy (Congenital Defects and Birth Abnormalities) in Section 1 of the COC. 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. Therapy for the care and treatment of congenital defect and birth abnormalities for children from age 3 to age 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. 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. Manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiological treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function). 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. Breast reduction except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC.

O. Providers

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.

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

Q. 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. This includes, but is not limited to, coverage required by workers' compensation or similar legislation. This exclusion does not apply to Enrolling Groups that are not required by law to purchase or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners. 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.

R. 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.) Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure and shall include animal-to-human and artificial and mechanical devices as medically appropriate.

S. 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.

T. Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis. Custodial care or maintenance care; domiciliary care. Private duty nursing. Respite care. This exclusion does not apply to respite care that is part of and integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described 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).

U. Vision and Hearing

Purchase cost and fitting charge for eye glasses and contact lenses. Routine vision examinations, including refractive examinations to determine the need for vision correction. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Bone Anchored Hearing Aids except when either of the following applies: For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid. For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions. This exclusion does not apply to hearing aids for minor children as described under Hearing Aids for Minor Children. Eye exercise or vision 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.

V. 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 except as otherwise recommended by the Advisory Committee on Immunization Practices to the Centers for Disease Control and Prevention in the federal Department of Health and Human Services, 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. Related to judicial or administrative proceedings or orders. 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. Autopsy. Foreign language and sign language services. 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 except as required by Colorado law.

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 Benefit Plan Description Form Addendum



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

IN-NETWORK

OUT-OF-NETWORK

	IN-NETWORK	OUT-OF-NETWORK
Routine Cancer Screening Coverage		
1) Breast Cancer Screening	1) Additional preventive care services are covered at \$30 copayment per visit for office visits and \$250 copayment for outpatient/ambulatory surgery procedures.	1) Additional preventive care services are covered at \$30 copayment per visit for office visits and \$250 copayment for outpatient/ambulatory surgery procedures.
2) Cervical Cancer Screening	2) Additional preventive care services are covered at \$30 copayment per visit for office visits and \$250 copayment for outpatient/ambulatory surgery procedures.	2) Additional preventive care services are covered at \$30 copayment per visit for office visits and \$250 copayment for outpatient/ambulatory surgery procedures.
3) Colorectal Cancer Screening	3) Additional preventive care services are covered at \$30 copayment per visit for office visits and \$250 copayment for outpatient/ambulatory surgery procedures.	3) Additional preventive care services are covered at \$30 copayment per visit for office visits and \$250 copayment for outpatient/ambulatory surgery procedures.
4) Prostate Cancer Screening	4) Same as 8, 9 and 14	4) Same as 8, 9 and 14

A Deductible does not apply to Routine Cancer Screenings.

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.

Attachment 1

Covered Preventive Services¹	
All Persons	Chicken pox vaccination for all persons who have not had chicken pox. Colorectal screening for all high risk individuals, regardless of age. ^{1a}
Females	Full cost of cervical cancer vaccine. ^{1b}
All Children	Immunizations, including the influenza and pneumococcal vaccinations pursuant to the schedule established by the ACIP. ^{1c, 4} Immunization deficient children are not bound by “recommended ages”.
Age 0–12 months	1 newborn home visit during first week of life if newborn released from hospital less than 48 hours after delivery.
	6 well-child visits. ²
	1 PKU.
Age 13–35 months	3 well-child visits.
Age 3–6	4 well-child visits.
Age 7–12	4 well-child visits.
Age 13–18	1 age appropriate health maintenance visit ³ every year.
	1 Td.
	Females: screening pap smears not to exceed 1 per year. ⁴
	1 hepatitis B vaccination if not given previously. ⁴
Age 18 and older	Tobacco use screening and tobacco cessation interventions by any provider furnishing primary care services to the patient in accordance with the “A” or “B” recommendations of the U.S. Preventive Services Task Force. ^{3a}
	Alcohol misuse screening and behavioral counseling interventions by any provider furnishing primary care services to the patient in accordance with the “A” or “B” recommendations of the U.S. Preventive Services Task Force. ⁴
Age 19–39	1 Td every ten years.
	1 age appropriate health maintenance visit every three years.
	Influenza and pneumococcal vaccinations pursuant to the schedule established by the ACIP. ^{1c, 4}
	Females: screening pap smears not to exceed 1 per year. ⁴
	Males ages 20-34: Screening for lipid disorders if at an increased risk for coronary heart disease in accordance with the “A” or “B” recommendations of the U.S. Preventive Services Task Force. ⁴
	Males ages 35-39: Screening for lipid disorders in accordance with the “A” or “B” recommendations of the U.S. Preventive Services Task Force. ⁴
Age 40–64	Females ages 20-39: Screening for lipid disorders if at an increased risk for coronary heart disease in accordance with the “A” or “B” recommendations of the U.S. Preventive Services Task Force. ⁴
	1 Td every ten years.
	Influenza and pneumococcal vaccinations pursuant to the schedule established by the ACIP. ^{1c, 4}
	Adults ages 50-64: Colorectal screening in accordance with the “A” or “B” recommendations of the U.S. Preventive Services Task Force. ⁴
	1 age appropriate health maintenance visit every 24 months.
	Females ages 40-64: 1 screening mammogram and clinical breast exam every 1 to 2 years (annually, if high risk). ⁴
	Females: screening pap smears not to exceed 1 per year. ⁴
Males: Screening for lipid disorders in accordance with the “A” or “B” recommendations of the U.S. Preventive Services Task Force. ⁴	

Covered Preventive Services¹	
	Females: Screening for lipid disorders if at an increased risk for coronary heart disease in accordance with the “A” or “B” recommendations of the U.S. Preventive Services Task Force. ⁴
	Males: Prostate screening as specified in state law. (Not covered under the Basic Limited Mandate Health Benefit Plans and the Basic HSA Limited Mandate Health Benefit Plans.)
Age 65 and older	Influenza and pneumococcal vaccinations pursuant to the schedule established by the ACIP. ^{1c, 4}
	Females: screening pap smears not to exceed 1 per year. ⁴
	1 Td every ten years.
	1 age appropriate health maintenance visit every year.
	Males: Screening for lipid disorders in accordance with the “A” or “B” recommendations of the U.S. Preventive Services Task Force. ⁴
	Females: Screening for lipid disorders if at an increased risk for coronary heart disease in accordance with the “A” or “B” recommendations of the U.S. Preventive Services Task Force. ⁴
	Females: 1 screening mammogram and clinical breast exam every 1 to 2 years (annually, if high risk). ⁴
	Adults ages 65-75: Colorectal screening in accordance with the “A” or “B” recommendations of the U.S. Preventive Services Task Force. ⁴
Males: Prostate screening as specified in state law. (Not covered under the Basic Limited Mandate Health Benefit Plans and the Basic HSA Limited Mandate Health Benefit Plans.)	

¹ Not all preventive services and screenings are specifically listed, but the list is considered to include all services and screenings deemed to be preventive by the Federal Department of the Treasury for HSA (health savings account) compliant plans and, effective January 1, 2010, coverage includes all preventive services as set forth in §10 -16-104(18), C.R.S. in accordance with “A” and “B” recommendations of the U.S. Preventive Services Task Force, or any successor organization, sponsored by the Agency for Healthcare Research and Quality, the health services research arm of the federal Department of Health and Human Services.

^{1a} Colorectal screening shall be provided to all individuals who are at a high risk for colorectal cancer including covered persons who have a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn’s disease, or ulcerative colitis; or other predisposing factors as determined by the provider.

^{1b} Age limitations as recommended by the U.S. Department of Health and Human Services’ Advisory Committee on Immunization Practices.

^{1c} “ACIP” means the Advisory Committee on Immunization Practices to the Centers for Disease Control and Prevention in the federal Department of Health and Human Services.

² “Well-child visit” means a visit to a primary care provider that includes the following elements: age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age appropriate behaviors, etc.), and growth and development assessment. For older children, this also includes safety and health education counseling. The schedule of these visits, through age 12, is based on the recommendations of the American Academy of Pediatrics.

³ “Age appropriate health maintenance visit” means an exam which includes the following components: age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, discuss dietary issues, review health promotion activities of the patient, etc.), and exercise and nutrition counseling (including folate counseling for women of child bearing age).

^{3a} Appropriate copays apply to the provider services and cessation interventions, including drug interventions; however, deductibles and coinsurance do not apply.

⁴ Appropriate copays apply to the provider services; however, deductibles and coinsurance do not apply.