Colorado Health Benefit Plan Description Form

UnitedHealthcare Insurance Company

Name of Carrier

Choice Plus Balanced 100 -
Plan C2Z
Name of Plan

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Preferred Provider Plan.
2. OUT-OF-NETWORK CARE COVERED?[1]	Yes, but patient pays more for out-of-network care.
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available only in the following areas: Adams, Alamosa, Arapahoe, Archuleta, Bent, Boulder, Broomfield, Chafee, Clear Creek, Conejos, Costilla, Crowley, Custer, Delta, Denver, Dolores, Douglas, Eagle, El Paso, Elbert, Fremont, Garfield, Gilpin, Grand, Gunnison, Huerfano, Jefferson, Kiowa, Kit Carson, La Plata, Lake, Larimer, Las Animas, Lincoln, Logan, Mesa, Moffat, Montezuma, Montrose, Morgan, Otero, Ouray, Park, Phillips, Pitkin, Prowers, Pueblo, Rio Blanco, Rio Grande, Routt, Saguache, 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 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 TYPE[2]	Policy Year	Policy Year
4A. ANNUAL DEDUCTIBLE[2a] a) Individual[2b] b) Family[2c]	a) $5,000 per year b) $15,000 per year > Member Copayments do not accumulate towards the Deductible. > All individual Deductible amounts will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount.	a) $6,000 per year b) $18,000 per year > Member Copayments do not accumulate towards the Deductible. > All individual Deductible amounts will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount.

	In-Network	Out-of-Network
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] a) Individual b) Family c) Is deductible included in the out-of-pocket maximum?	a) $5,000 per year b) $15,000 per year c) Yes > Member Copayments do not accumulate towards the Out-of-Pocket Maximum. > All individual Out-of-Pocket Maximum amounts will count toward the family Out-of-Pocket Maximum, but an individual will not have to pay more than the individual Out-of-Pocket Maximum amount.	a) $10,000 per year b) $20,000 per year c) Yes > Member Copayments do not accumulate towards the Out-of-Pocket Maximum. > All individual Out-of-Pocket Maximum amounts will count toward the family Out-of-Pocket Maximum, but an individual will not have to pay more than the individual Out-of-Pocket Maximum amount.
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum.	No lifetime maximum.
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 providers listed in 7A accessible to me through my primary care physician?	Yes	Not applicable.
8. MEDICAL OFFICE VISITS[4] a) Primary Care Providers b) Specialists	a) $30 Copayment per visit. b) $60 Copayment per visit. > In addition to the visit Copayment, the applicable Copayment and any Deductible/Coinsurance applies when these services are done: CT, PET, MRI, Nuclear Medicine; Scopic Procedures; Surgery; Therapeutic Treatments.	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) No copayment (100% covered) b) No copayment (100% covered) Lab, X-Ray or other preventive tests: No copayment (100% covered)	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.

	In-Network	Out-of-Network
10. MATERNITY a) Prenatal care	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. For services provided in the Physician's Office, a Copayment will only apply to the initial office visit.	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.
b) Delivery & inpatient well baby care[5]	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.	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. Prior Authorization 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.
11A. PHARMACEUTICAL PRODUCTS - OUTPATIENT	0% after Deductible has been met. This includes medications administered in an Outpatient setting, in the Physician's Office and by a Home Health Agency.	50% after Deductible has been met. This includes medications administered in an Outpatient setting, in the Physician's Office and by a Home Health Agency.
12. INPATIENT HOSPITAL	0% after Deductible has been met.	50% after Deductible has been met. Prior Authorization is required.
12A. PHYSICIAN FEES FOR SURGICAL AND MEDICAL SERVICES	0% after Deductible has been met.	50% after Deductible has been met.
12B. CONGENITAL HEART DISEASE (CHD) SURGERIES	0% after Deductible has been met.	50% after Deductible has been met. Benefits are limited to $30,000 per surgery. Prior Authorization is required.
13. OUTPATIENT/AMBULATORY SURGERY	0% after Deductible has been met.	50% after Deductible has been met.
13A. SCOPIC PROCEDURES - OUTPATIENT DIAGNOSTIC AND THERAPEUTIC	0% after Deductible has been met. Diagnostic scopic procedures include, but are not limited to: Colonoscopy, Sigmoidoscopy, or Endoscopy.	50% after Deductible has been met. Diagnostic scopic procedures include, but are not limited to: Colonoscopy, Sigmoidoscopy, or Endoscopy.

	In-Network	Out-of-Network
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. Prior Authorization is required.
14. DIAGNOSTICS a) Laboratory & x-ray b) MRI, nuclear medicine, and other high-tech services.	a) 0% Deductible does not apply. b) 0% after Deductible has been met.	a) 50% after Deductible has been met. b) 50% after Deductible has been met.
15. EMERGENCY CARE[7, 8]	$250 Copayment per visit.	$250 Copayment per visit. Prior Authorization is recommended if results in an Inpatient Stay.
16. AMBULANCE	Ground Transportation: 0% after Deductible has been met. Air Transportation: 0% after Deductible has been met.	Ground Transportation: 0% after In-Network Deductible has been met. Air Transportation: 0% after In-Network Deductible has been met. Prior Authorization is recommended for Non-Emergency Ambulance.
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	$75 Copayment per visit. > In addition to the visit Copayment, the applicable Copayment and any Deductible/Coinsurance applies when these services are done: CT, PET, MRI, Nuclear Medicine; Scopic Procedures; Surgery; Therapeutic Treatments.	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.	Coverage is no less extensive than the coverage provided for any other physical illness.

	In-Network	Out-of-Network
19. OTHER MENTAL HEALTH CARE	For groups with 50 or less total employees:	For groups with 50 or less total employees:
a) Inpatient care	a) 0% after Deductible has been met. In-Network and Out-of-Network Benefits for Mental Health Services are limited to 45 days (or 90 partial days) per Policy year.	a) 50% after Deductible has been met. In-Network and Out-of-Network Benefits for Mental Health Services are limited to 45 days (or 90 partial days) per Policy year.
b) Outpatient care	b) $60 Copayment per visit. In-Network and Out-of-Network Benefits for Mental Health Services are limited to 20 visits per Policy year.	b) 50% after Deductible has been met. In-Network and Out-of-Network Benefits for Mental Health Services are limited to 20 visits per Policy year.
	For groups with 51 or more total employees: Benefit limits do not apply. a) 0% after Deductible has been met. b) $30 Copayment per visit.	For groups with 51 or more total employees: Benefit limits do not apply. a) 50% after Deductible has been met. b) 50% after Deductible has been met. Prior Authorization is required from the Mental Health/Substance Use Disorder Designee.

	In-Network	Out-of-Network
20. ALCOHOL & SUBSTANCE ABUSE	For groups with 50 or less total employees: Inpatient care: 0% after Deductible has been met. In-Network and Out-of-Network Benefits for Substance Use Disorder Services are limited to 45 days (or 90 partial days) per Policy year. Outpatient care: $60 Copayment per visit. In-Network and Out-of-Network Benefits for Substance Use Disorder Services are limited to 20 visits, but in no event less than $500 per Policy year. For groups with 51 or more total employees: Benefit limits do not apply. Inpatient care: 0% after Deductible has been met. Outpatient care: $30 Copayment per visit.	For groups with 50 or less total employees: Inpatient care: 50% after Deductible has been met. In-Network and Out-of-Network Benefits for Substance Use Disorder Services are limited to 45 days (or 90 partial days) per Policy year. Outpatient care: 50% after Deductible has been met. In-Network and Out-of-Network Benefits for Substance Use Disorder Services are limited to 20 visits, but in no event less than $500 per Policy year. For groups with 51 or more total employees: Benefit limits do not apply. Inpatient care: 50% after Deductible has been met. Outpatient care: 50% after Deductible has been met. Prior Authorization is required from the Mental Health/Substance Use Disorder Designee.
21. PHYSICAL, OCCUPATIONAL & SPEECH THERAPY	$30 Copayment per visit. In-Network and Out-of-Network Benefits are subject to combined limits as follows: Physical Therapy - 20 visits per Policy year. Occupational Therapy - 20 visits per Policy year. Speech Therapy - 20 visits per Policy year.	50% after Deductible has been met. In-Network and Out-of-Network Benefits are subject to combined limits as follows: Physical Therapy - 20 visits per Policy year. Occupational Therapy - 20 visits per Policy year. Speech Therapy - 20 visits per Policy year. Prior Authorization is required for certain services.

	In-Network	Out-of-Network
21A. CARDIAC & PULMONARY REHABILITATION, & POST-COCHLEAR IMPLANT AURAL THERAPY	$30 Copayment per visit. In-Network and Out-of-Network Benefits are subject to combined limits as follows: Cardiac Rehabilitation - 36 visits per Policy year. Pulmonary Rehabilitation - 20 visits per Policy year. Post-Cochlear Implant Aural Therapy - 30 visits per Policy year.	50% after Deductible has been met. In-Network and Out-of-Network Benefits are subject to combined limits as follows: Cardiac Rehabilitation - 36 visits per Policy year. Pulmonary Rehabilitation - 20 visits per Policy year. Post-Cochlear Implant Aural Therapy - 30 visits per Policy year. Prior Authorization is required for certain services.
21B. REHABILITATION SERVICES – OUTPATIENT THERAPY (CONGENITAL DEFECTS AND BIRTH ABNORMALITIES)	$30 Copayment per visit. 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. Prior Authorization is required for certain services.
21C. THERAPEUTIC TREATMENTS - OUTPATIENT	0% after Deductible has been met. Therapeutic treatments include, but are not limited to: Dialysis, intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.	50% after Deductible has been met. Therapeutic treatments include, but are not limited to: Dialysis, intravenous chemotherapy or other intravenous infusion therapy and radiation oncology. Prior Authorization is required for certain services.
21D. 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. Prior Authorization is required.

	In-Network	Out-of-Network
22. DURABLE MEDICAL EQUIPMENT	0% after Deductible has been met. In-Network and Out-of-Network Benefits for Durable Medical Equipment are limited to $2,500 per Policy year. This benefit category contains services/ devices that may be Essential or non-Essential Health Benefits as defined by the Patient Protection and Affordable Care Act depending upon the service or device delivered. A benefit review will take place once the dollar limit is exceeded. If the service/device is determined to be rehabilitative or habilitative in nature, it is an Essential Health Benefit and will be paid. If the benefit/device is determined to be non-essential, the maximum will have been met and the claim will not be paid.	50% after Deductible has been met. In-Network and Out-of-Network Benefits for Durable Medical Equipment are limited to $2,500 per Policy year. This benefit category contains services/ devices that may be Essential or non-Essential Health Benefits as defined by the Patient Protection and Affordable Care Act depending upon the service or device delivered. A benefit review will take place once the dollar limit is exceeded. If the service/device is determined to be rehabilitative or habilitative in nature, it is an Essential Health Benefit and will be paid. If the benefit/device is determined to be non-essential, the maximum will have been met and the claim will not be paid. Prior Authorization is required for Durable Medical Equipment in excess of $1,000.
22A. DIABETES SERVICES	Diabetes Self Management and Training Diabetic Eye Examinations / Foot Care 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. Diabetes Self Management Items 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.	Diabetes Self Management and Training Diabetic Eye Examinations / Foot Care 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. Diabetes Self Management Items 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. Prior Authorization is required for Durable Medical Equipment and Diabetes Equipment in excess of $1,000.
22B. OSTOMY SUPPLIES	0% after Deductible has been met. In-Network and Out-of-Network Benefits for Ostomy Supplies are limited to $2,500 per Policy year.	50% after Deductible has been met. In-Network and Out-of-Network Benefits for Ostomy Supplies are limited to $2,500 per Policy year.

	In-Network	Out-of-Network
22C. PROSTHETIC DEVICES	0% after Deductible has been met. In-Network and Out-of-Network Benefits for Prosthetic Devices are limited to $2,500 per Policy year. This limit does not apply to prosthetic arms, legs, feet and hands. This benefit category contains services/ devices that may be Essential or non-Essential Health Benefits as defined by the Patient Protection and Affordable Care Act depending upon the service or device delivered. A benefit review will take place once the dollar limit is exceeded. If the service/device is determined to be rehabilitative or habilitative in nature, it is an Essential Health Benefit and will be paid. If the benefit/device is determined to be non-essential, the maximum will have been met and the claim will not be paid.	50% after Deductible has been met, except the Benefit for prosthetic arms, legs, feet and hands is 20%. In-Network and Out-of-Network Benefits for Prosthetic Devices are limited to $2,500 per Policy year. This limit does not apply to prosthetic arms, legs, feet and hands. This benefit category contains services/ devices that may be Essential or non-Essential Health Benefits as defined by the Patient Protection and Affordable Care Act depending upon the service or device delivered. A benefit review will take place once the dollar limit is exceeded. If the service/device is determined to be rehabilitative or habilitative in nature, it is an Essential Health Benefit and will be paid. If the benefit/device is determined to be non-essential, the maximum will have been met and the claim will not be paid.
22D. HEARING AIDS FOR ADULTS	0% after Deductible has been met. In-Network and Out-of-Network Benefits for Hearing Aids are limited to $2,500 per Policy year. Benefits are limited to a single purchase (including repair/replacement) every three years.	50% after Deductible has been met. In-Network and Out-of-Network Benefits for Hearing Aids are limited to $2,500 per Policy year. Benefits are limited to a single purchase (including repair/replacement) every three years.
23. OXYGEN	Included under Durable Medical Equipment.	Included under Durable Medical Equipment.
24. ORGAN TRANSPLANTS	0% after Deductible has been met. For In-Network Benefits, transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive In-Network Benefits.	50% after Deductible has been met. Out-of-Network Benefits are limited to $30,000 per transplant. Prior Authorization is required.
25. HOME HEALTH CARE	0% after Deductible has been met. In-Network and Out-of-Network Benefits are limited to 60 visits for skilled care services per Policy year.	50% after Deductible has been met. In-Network and Out-of-Network Benefits are limited to 60 visits for skilled care services per Policy year. Prior Authorization is required.
26. HOSPICE CARE	0% after Deductible has been met. Bereavement support services are limited to a maximum of $1,400 during the 12-month period following the Covered Person's death.	50% after Deductible has been met. Bereavement support services are limited to a maximum of $1,400 during the 12-month period following the Covered Person's death. Prior Authorization is required for Inpatient Stays.

	In-Network	Out-of-Network
27. SKILLED NURSING FACILITY CARE	0% after Deductible has been met. In-Network and Out-of-Network Benefits are limited to 60 days per Policy year.	50% after Deductible has been met. In-Network and Out-of-Network Benefits are limited to 60 days per Policy year. Prior Authorization is required.
28. DENTAL CARE	ACCIDENTAL ONLY 0% after Deductible has been met. In-Network and Out-of-Network are limited as follows: $3,000 maximum per Policy year. $900 maximum per tooth.	ACCIDENTAL ONLY 0% after In-Network Deductible has been met. In-Network and Out-of-Network are limited as follows: $3,000 maximum per Policy year. $900 maximum per tooth. Prior Authorization is required.
29. VISION CARE	$30 Copayment per visit. In-Network Benefits are limited to 1 exam every 2 Policy years.	Out-of-Network Benefits are not available.
30. CHIROPRACTIC CARE	$30 Copayment per visit. In-Network and Out-of-Network Benefits are limited to 20 visits per Policy year.	50% after Deductible has been met. In-Network and Out-of-Network Benefits are limited to 20 visits per Policy year. Prior Authorization is required for certain services.

	In-Network	Out-of-Network
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5) 1) CHILDREN'S DENTAL ANESTHESIA	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.	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. Prior Authorization is required.
2) CLEFT LIP AND CLEFT PALATE	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.	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. Prior Authorization is required.
3) TELEMEDICINE	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.	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) PHENYLKETONURIA (PKU) TESTING AND TREATMENT	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.	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. Prior Authorization is required.
5) HEARING AIDS (MINOR CHILDREN)	5) 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.	5) 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

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED[10]	Six months for all pre-existing conditions; (and for business groups of one the limitation period may not exceed 12 months).
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)?	No	Yes
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.
40. Whom do I write/call if I have a complaint or want to file a grievance?[11]	Contact the Customer Service Department at the toll free number listed on your ID card. Central Escalation Unit P.O. Box 30573 Salt Lake City, UT 84130-0573
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
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.I.07.CO Group--all sizes
43. Does the plan have a binding arbitration clause?	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., “$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.

[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 illness” 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 you 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.

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; hypnotism; massage therapy; rolfing; art therapy, music therapy, dance therapy, 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 Manipulative Treatment and non-manipulative 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 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 acute traumatic Injury, 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 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; non-wearable external defibrillator; trusses and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for speech generating devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC. 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. The drug has been approved by the FDA for the treatment of cancer but has not been approved by the FDA for the treatment of the specific type of cancer for the which the drug is prescribed if: The drug is recognized for treatment of that cancer in the authoritative reference compendia as indicated by the secretary of the U.S. Department of Health and Human Services; and the treatment is for a Covered Health Service. 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 in Section 1 of the COC.

Mental Health

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 as treatments for V-code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias. Educational/behavioral services that are focused

on primarily building skills and capabilities in communication, social interaction and learning. 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. Mental retardation and autism spectrum disorder as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Benefits for autism spectrum disorder as a primary diagnosis are described under Neurobiological Disorders-Autism Spectrum Disorder Services in Section 1 of the COC. Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder 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 a measurable and beneficial health outcome, and therefore considered experimental.

Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.

Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

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. 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 and paraphilias. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder for Enrolled Dependent children 19 years of age or older. Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/ Substance Use Disorder 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 a measurable and beneficial health outcome, and therefore considered experimental.

Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.

Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

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. Enteral feedings (tube feedings), provided as part of a Home Health Care plan of care provided or arranged for by a home health agency, as described under Home Health Care in Section 1 of the COC. 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; 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). 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. 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,

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.

including but not limited to routine, long-term or maintenance/ preventive treatment. Speech therapy except as described under Rehabilitation Services - Outpatient Therapy in Section 1 of the COC; or Speech therapy 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. 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. 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.

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.

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.

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.

Substance Use Disorders

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder 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 a measurable and beneficial health outcome, and therefore considered experimental.

Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.

Not clinically appropriate for the patient's substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

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 or maintenance care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are 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). 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. 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 then 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 in Section 1 of the COC.

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.

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 school, sports or camp, travel, career or 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 Substance Use Disorder Services. 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. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones. 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. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived. 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. 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.

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 covered Persons under age 19. Pregnancy is not considered a Preexisting Condition, as indicated in the definition of Preexisting Condition in Section 9 of the COC.

Colorado Health Benefit Plan Description Form Addendum

UnitedHealthcare Insurance Company

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

	In-Network	Out-of-Network
Routine Cancer Screening Coverage -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.

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