COLORADO
Division of Human Resources
Department of Personnel & Administration

Summary Plan Description

The State of Colorado
Co-Pay Choice Plus Plan

Effective: July 1, 2018
Group Number: 718733

UnitedHealthcare
Healing health care. Together.

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SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance-Related and Addictive Disorders Administrator: (877) 283-5424;
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 30555, Salt Lake City, UT 84130-0555; and
- Online assistance: **www.myuhc.com**.

The State of Colorado is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members. It includes summaries of:

- who is eligible;
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

The State of Colorado intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice. This SPD is not to be construed as a contract of or for employment.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. The State of Colorado is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the State of Colorado Employee group health plan works. If you have questions contact your department's HR or benefits administrator or call the number on the back of your ID card.

How To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can request printed copies of your SPD and any future amendments by contacting your department's HR or benefits administrator or by going to the benefits website at www.colorado.gov/dhr/benefits.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- If there is a conflict between this SPD and any benefit summaries provided to you, this SPD will control.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan;
- The factors that impact your cost for coverage;
- Instructions and timeframes for enrolling yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Plan.

Eligibility

You are in an eligible class for coverage under the Plan if you are any person employed by the State of Colorado satisfying the requirements of C.R.S. 24-50-603(7).

An Employee has the meaning given to the term in the C.R.S. 24-50-603(7), "Definitions," as amended, but, for purposes of this Plan, includes only common law employees. An Employee means any officer or employee under the state personnel system of the State of Colorado whose salary is paid by state funds or any employee of the department of education, the Colorado commission on higher education, or the Colorado school for the deaf and the blind whose salary is paid by state funds, or any participant of the military employed pursuant to section 28-3-904 C.R.S. Employee includes any officer or employee of the legislative or judicial branch, any elected or appointed state official or employee who receives compensation other than expense reimbursement from the state funds, any elected state official who does not receive compensation other than expense reimbursement from state funds, and includes any participant of the board of assessment appeals.

Employee does not include persons employed on a temporary basis; except that it shall include a member of the military employed pursuant to C.R.S. 28-3-903 for more than 30 days. (Note: The State of Colorado reserves the right to amend or change the definition of Employee because of the ACA requirements).

"Dependent" has the meaning given to the term in C.R.S. §24-50-603(5) and (6.5),"Definitions", as amended and modified or further defined by other Colorado State Statutes (e.g., Title 10) or federal regulations (e.g., Affordable Care Act ACA, the Code on taxable income), and includes an Employee's Spouse (as defined in this plan), Civil Union Partner (as defined in this plan), Domestic Partner (as defined in this plan), and Child (as defined in this plan).

The categories of Dependent include:

A. Current Spouse, including Common Law Spouse:
   1. Spouse means a spouse as recognized under federal tax law.
   2. Common Law Spouse means an adult:
      a. Who is at least 18 years of age; and
      b. With whom the Employee cohabitates; and

c. Who represent themselves to the community as married to each other; and
d. There is no legal impediment to the marriage.

B. Current Civil Union Partner who is an adult:

1. Eighteen years of age or older who is not under guardianship, unless the party under guardianship has the written consent of his or her guardian to enter into a civil union as created by Article 15 of Title 14, C.R.S.; and
2. Who has entered into a civil union in accordance with the requirement of Article 15 of Title 14, C.R.S. or who has established a relationship legally entered into in other jurisdictions that are similar to civil unions created by Article 15 of Title 14, C.R.S. and that are not otherwise recognized pursuant to Colorado law; and
3. Who is of the opposite gender or same gender as the Employee; and
4. Who is not a party to another civil union; and
5. Who is not married to another person; and
6. Who is not a relative of the Employee.

Article 15 of Title 14, C.R.S. prohibits a person from entering into a civil union with an ancestor, descendant, brother, sister, uncle, aunt, niece or nephew, whether the relationship is by the half or whole blood.

C. Current Domestic Partner who is an adult:

1. Who is at least 18 years of age; and
2. Who is of the same gender as the Employee; and
3. With whom the Employee has shared an exclusive, committed relationship with that same person for at least one year prior to enrollment with the intent for the relationship to last indefinitely, and such relationship was verified by the acceptance of an affidavit of Domestic Partnership by the Department of Personnel and Administration prior to August 8, 2018; and
4. Who is not related to the Employee by blood to a degree that would prohibit marriage; and
5. Neither the Employee nor Domestic Partner is married to another person; and

6. Neither the Employee nor Domestic Partner is in a civil union with another person.

D. A Child until the end of the month in which the child turns age 26. The legal definition of child must be applied (e.g., first generation, parent-child relationship). As of July 1, 2011, marital status, student status, financial support, and residency are no longer factors under the ACA.

1. Biological or natural Child.
2. Legally adopted.
3. Legally placed for adoption or foster care.

4. Step-child as long as the Employee and parent are married.
5. Child of a Civil Union Partner.
6. Child of a Domestic Partner as long as the Employee and Domestic Partner are in the committed relationship.
7. Child for whom the Employee has a court order that specifies responsibility for health insurance coverage (legal custody or allocation of parental responsibility). To qualify for coverage under this provision, a court must determine there is a parent-child relationship for purposes of coverage.

E. A disabled child must be:

1. Unmarried; and
2. Medically certified as disabled prior to the age of 26; and
3. Dependent upon Employee or Spouse/Domestic Partner for financial support; and
4. Proof of disability and dependency must be provided before becoming covered under the group health plan(s) annually, if requested; and
5. Newly hired Employees will need to provide proof that the child's disability began prior to the child reaching age 26. If a child of a newly hired Employee or current Employee becomes disabled after the child reaches age 26, the child is ineligible for coverage under the group health plan(s).

Exclusions

The following are not entitled to coverage under the Plan except as required by law or court order: Ex-Spouses and their children, Civil Union ex-Partners and their children, Domestic ex-Partners and their children, parents, grandparents and grandchildren, siblings, aunts and uncles, nieces and nephews, cousins, and any other relatives or non-relatives in the household.

Benefits are not provided under this Plan for Dependents who are not Tax Dependents, as defined herein, except, for purposes of coverage under the group health plan(s), for a Civil Union Partner or Domestic Partner, who does not qualify as a Spouse, in which case the cost of any benefits will be taxable (unless the individual qualifies as a Tax Dependent of the Employee).

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. If you and your Spouse/Domestic Partner are both covered under the State of Colorado Employee group health plan, you may each be enrolled as an Employee or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse/Domestic Partner both make a separate election under the State of Colorado Employee group health plan, only one parent may enroll your child as a Dependent.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. Employees who meet eligibility requirements during a measurement period, as described in Affordable Care Act (ACA) regulations, will have been deemed to have met the eligibility requirements for the appropriate month (if a

monthly measurement period) or the resulting stability period as determined by the Plan Sponsor. If you have questions about these requirements, contact Human Resources.

Cost of Coverage

You and the State of Colorado share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks either on a before-tax or after-tax basis. Before-tax dollars come out of your pay before federal income and Medicare taxes are withheld - and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you. Because before-tax contributions can affect your PERA retirement benefits, the State permits after-tax contributions.

Contributions are withheld in arrears, which means your contribution for any month is withheld from the paycheck(s) that you receive during or at the end of that month.

Note: The Internal Revenue Service generally does not consider Domestic Partners/Civil Union Partners and their children eligible dependents under the tax code. Therefore, the value of the State of Colorado's cost in covering a Domestic Partner/Civil Union Partners and certain other non-tax dependents may be imputed to the Employee as income. You may elect to pay your entire medical Plan deduction with pre or post-tax dollars. You may not choose a combination of both.

Your contributions are subject to review and the State of Colorado reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by contacting your HR or benefits administrator or by going to the benefits website at: http://www.colorado.gov/dhr/benefits.

How to Enroll and When Coverage Begins

Eligible Employees may apply for coverage for themselves and their eligible Dependents by completing the online electronic enrollment within 31 days of the date of hire, during the annual Open Enrollment period or during certain qualified change in status events. The effective date will be (1) the first of the month following the Employee's date of hire, (2) if enrolling during the annual Open Enrollment period, the first of the next Plan year, or (3) if enrolling within 31 days of a qualified change in status event, the first of the month following either the date of the event or the date of online electronic enrollment, whichever is the latest, and receipt of any required documentation. If the online enrollment is not complete on or before the 31st day, you and your Dependents will be considered late enrollees and your enrollment or modification to your enrollment will be permitted only during the next annual Open Enrollment period.

Elections are irrevocable for the Plan year except in limited circumstances specified by law or regulations. Failure to enroll or change elections within deadlines is not a qualified change in status event.

Once you complete your electronic online enrollment, coverage will begin on the first day of the month following your date of hire. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse/Domestic Partner/Civil Union Partner/Dependent step child(ren) that you acquire via marriage or through a domestic partnership or a civil union partnership becomes effective the first of the month following the date of your electronic online enrollment provided you complete the enrollment within 31 days of the family status change. Coverage for a Dependent Child(ren) acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you have made the changes in the online enrollment system within 31 days of the birth, adoption, or placement.

Note: A newborn child is covered under your coverage effective the date of birth and for the first 31 days after birth. If the addition of a newborn necessitates a change of contribution tier, the change of contribution is effective the first of the month following the date of birth. **If you wish to continue coverage for your newborn child under this Plan beyond the first 31-day period, you must enroll your newborn child in the Plan by completing the online electronic enrollment within 31 days of the child's birth.** When charges for delivery are considered covered expenses for an expectant mother eligible for coverage under this Plan, any and all charges incurred by the newborn are to be considered as charges incurred by the mother until the mother is discharged.

During the first 31-day period after birth, coverage for a newborn child shall consist of care for Sickness and/or Injury including care and treatment of medically diagnosed Congenital Anomalies. However, services provided after the first 31 days of coverage are subject to the cost sharing requirements, limitations and exclusions that are applicable to other timely enrollments and conditions otherwise covered.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following July 1.

Important
If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must make your changes in the online benefits administration system (if you do not have computer access, please contact your department's HR or benefits administrator) within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections

Employee Responsibilities

Initial enrollments, changes to enrollment and terminations of enrollment require that you complete, date and sign the appropriate online electronic forms in accordance with criteria as defined in law and regulation, procedure and written directives. You also must provide supporting documentation, if required. The State reserves the right to request documentation to establish the eligibility of an Employee or Dependent.

By pressing the "I Agree" button at the completion of your online electronic enrollment, you attest that the information you have provided is true and correct to the best of your knowledge.

It is unlawful for any Employee or Dependent to intentionally provide false, incomplete, or misleading facts, information or documentation for the purpose of defrauding or attempting to defraud the State of Colorado. Investigation will occur when there is reason to believe an Employee or Dependent has or is committing or attempting to commit fraud against any state group benefit plan. If evidence of fraud or attempted fraud is found, the Employee, Dependent or both may be subject to any or all of the following sanctions: immediate termination of coverage; denial of future enrollment; requirement to reimburse the State contributions and claims costs during the time of ineligible coverage; filing of criminal charges and notice to the Employee's department which may take corrective or disciplinary action.

Once enrolled in the Plan, you must verify the accuracy of your enrollment elections and payroll deductions. Should you find an administrative error, you must notify your department's HR or benefits administrator within 10 days of the first payroll deduction. Failure to notify your department's HR or benefits administrator within the specified time period will result in having to maintain enrollment in the incorrect option until the next annual Open Enrollment period or qualified change in status event.

You are expected to know the eligibility rules of coverage for yourself and Dependents under the Plan. You are required to notify HR of any qualifying change in status or other change in your employment or the status of your Dependents, and taking timely action to disenroll anyone who is no longer eligible for coverage.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status that affects eligibility (e.g., you acquire a new Dependent through marriage, birth or adoption.). The following are considered family status changes for purposes of the Plan:

- your marriage, divorce, legal separation or annulment;
- registering a Civil Union Partner;
- filing an affidavit of Domestic Partnership;
- the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your Spouse/Domestic Partner/Civil Union Partner's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage under another employer's benefits plan;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;

- a change in your or your Spouse/Domestic Partner/Civil Union Partner's position or work schedule that impacts eligibility for health coverage;
- contributions were no longer paid by the employer (This is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer);
- you were enrolled in an HMO and you no longer live in that HMO's service area;
- termination of your or your Dependent's Medicaid coverage as a result of loss of eligibility (you must contact your department's HR or benefits administrator within 60 days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid (you must contact your department's HR or benefits administrator within 60 days of determination of subsidy eligibility);
- a strike or lockout involving you or your Spouse/Domestic Partner/Civil Union Partner; or
- a court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact your department's HR or benefits administrator within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Change in Family Status - Example
Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in the State of Colorado's medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under the State of Colorado's medical plan outside of annual Open Enrollment.

Special Change in Status Elections Permitted Under the Medical Plan.

There are two Change in Status elections that allow you to drop your coverage under the State of Colorado Group Medical Plan. The plan was amended to permit you to drop your existing medical coverage provided the following conditions are met:

Conditions for revocation due to reduction in hours of service

(1) You have been in an employment status where you were reasonably expected to average at least 30 hours of service per week and there is a change in that status so that you will reasonably be expected to average less than 30 hours of service per week even if that reduction in hours does not result in your ceasing to be eligible for medical coverage under the State of Colorado Group Medical Plan; ***and***

(2) The revocation of your election under the medical plan corresponds to your and any related dependents intended enrollment in another plan that provides minimum essential coverage with the new effective date no later than the first day of the second month following the month that includes the date you dropped your coverage under the State's plan.

Conditions for revocation due to enrollment in a Qualified Health Plan

(1) You are eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through the Marketplace/Exchange or you want to enroll in a Qualified Health Plan through the Marketplace/Exchange during the Marketplace/Exchange's annual open enrollment period; ***and***

(2) Dropping of your coverage under the State of Colorado Group Medical Plan corresponds to your and any related dependents intended enrollment in a Qualified Health Plan through the Marketplace/Exchange for new coverage that is effective beginning no later than the day immediately following the last day of your coverage under the State's plan.

All changes are prospective, in no event can you drop your coverage on a retroactive basis. The prospective election to drop coverage ***does not*** apply to health Flexible Spending Accounts (FSA).

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Network and Non-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Out-of-Pocket Maximum; and
- Coinsurance.

Network and Non-Network Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services. For facility services, these are Benefits for Covered Health Services that are provided at a Network facility under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network anesthesiologist, Emergency room Physician, consulting Physician, pathologist and radiologist. Emergency Health Services are always paid as Network Benefits.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network provider about their billed charges before you receive care. Emergency services received at a non-Network Hospital are covered at the Network level.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Savings Program in Section 14, *Glossary*, of the SPD for details about how the Shared Savings Program applies.

Non-Network Benefits Exception

You may be eligible to receive Benefits for certain non-Network Covered Health Services paid at the Network level if you do not have access to a Network provider within a 50 mile radius of your home zip code.

You can check a provider's Network status by visiting **myuhc.com** or by calling the toll-free number on your ID card. UnitedHealthcare must approve any Benefits payable under this exception before you receive care.

Looking for a Network Provider?
In addition to other helpful information, **www.myuhc.com**, UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information. Use **www.myuhc.com** to search for Physicians available in your Plan.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the toll-free number on your ID card or log onto **www.myuhc.com**.

Network providers are independent practitioners and are not employees of the State of Colorado or UnitedHealthcare.

UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Out-of-Town Care

If you are out of town and need non-Emergency care, you may be able to locate a Network provider by calling the phone number or by accessing the internet web address indicated on your medical identification card. Since the Plan's network is nationwide, you may be able to utilize a Network provider. Generally, Benefits will be payable at a higher level if services of a Network provider are used; although there may be additional Plan requirements.

Transition or Continuation of Care

If you are under the care of a non-Network provider on the effective date of this SPD, you may be eligible for reimbursement at the Network level of Benefits with that provider for a period of time for acute medical or pregnancy situations. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please call the toll-free number on your ID card.

Possible Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a Network Physician for you. In the event that you do not use the Network Physician to coordinate all of your care, any Covered Health Services you receive will be paid at the non-Network level.

Eligible Expenses

The State of Colorado has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UnitedHealthcare determines that UnitedHealthcare will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by UnitedHealthcare), you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below.

For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the SPD.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.

When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expensesare an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.**For Non-Network Benefits**, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
  - Negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion.
  - If rates have not been negotiated, then one of the following amounts:

- For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
- When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.

  When a rate is not published by *CMS* for the service, UnitedHealthcare uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable gap fill relative value scale information.

  IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.

Don't Forget Your ID Card
Remember to show your UnitedHealthcare ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Cost Sharing Requirements

Cost sharing refers to how the Plan and its Covered Persons share the cost of medical care services. It describes what the Plan is responsible for paying and what you are responsible for paying. You meet your cost sharing requirements through the payment of Copayments, Deductibles and Coinsurance (as described below). Cost sharing requirements depend upon the Plan design you select and the choices you make in accessing services. For example, if you choose to use a Network provider or Network facility, your out-of-pocket expenses may be less than if you choose a non-network provider or facility.

UnitedHealthcare has worked with Physicians, Hospitals, Pharmacies and other health care providers to control health care costs. As part of this effort, many providers agree to control costs by giving discounts to UnitedHealthcare. In their contracts, network providers agree to accept UnitedHealthcare's contracted rate as payment in full for covered services.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each plan year for Covered Health Services before you are eligible to begin receiving Benefits. There are separate Network and non-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the plan year.

Any amount you pay for medical expenses in the last three months of the previous plan year, that is applied to the previous Deductible, will be carried over and applied to the current Deductible. This carry-over feature applies only to the individual Deductible.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays count toward the Out-of-Pocket-Maximum. Copays do not count toward the Annual Deductible. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Coinsurance – Example
Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 80% after you meet the Annual Deductible, you are responsible for paying the other 10%. This 10% is your Coinsurance.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each plan year for Covered Health Services. There are separate Network and non-Network Out-of-Pocket Maximums for this Plan. If your eligible out-of-pocket expenses in a plan year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the plan year.

The following table identifies what does and does not apply toward your Network and non-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Copays, even those for Covered Health Services available in Section 15, *Prescription Drugs*	Yes	Yes

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments, even those for Covered Health Services available in Section 15, *Prescription Drugs*	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not notifying Personal Health Support	No	No
Charges that exceed Eligible Expenses	No	No

SECTION 4 - PERSONAL HEALTH SUPPORT

What this section includes:

- An overview of the Personal Health Support program; and
- Covered Health Services for which you need to contact Personal Health Support.

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Personal Health Support Nurse is notified when you or your provider calls the toll-free number on your ID card regarding an upcoming treatment or service.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components and notification requirements are subject to change without notice. As of the publication of this SPD, the Personal Health Support program includes:

- Admission counseling - Nurse Advocates are available to help you prepare for a successful surgical admission and recovery. Call the number on the back of your ID card for support.
- Inpatient care management - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- Readmission Management - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- Risk Management - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss

and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the toll-free number on your ID card.

Requirements for Notifying Personal Health Support

Network providers are generally responsible for notifying Personal Health Support before they provide certain services to you. However, there are some Network Benefits for which you are responsible for notifying Personal Health Support.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for notifying Personal Health Support before you receive these Covered Health Services. In many cases, your Non-Network Benefits will be reduced if Personal Health Support is not notified.

Services for which you are required to provide notification are identified in Section 6, *Additional Coverage Details*, within each Covered Health Service Benefit description. Please note that notification timelines apply. Refer to the applicable Benefit description to determine how far in advance you must provide notification and any applicable reductions in Benefits.

For notification timeframes, and reductions in Benefits that apply if you do not notify Personal Health Support, see Section 6, *Additional Coverage Details*.

Notification is required within 48 hours or as soon as reasonably possible after you are admitted to a non-Network Hospital or Alternate Facility as a result of an Emergency.

Contacting Personal Health Support is easy.
Simply call the toll-free number on your ID card.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to notify Personal Health Support before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 10, *Coordination of Benefits (COB)*.

SECTION 5 - PLAN HIGHLIGHTS

The table below provides an overview of Copays and Coinsurance that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Network	Non-Network
Copays[1]		
■ Emergency Health Services	$500	$500
■ Hospital - Inpatient Stay	$1,000	Not Applicable
■ Physician's Office Services - Primary Physician	$30	Not Applicable
■ Physician's Office Services - Specialist	$50	Not Applicable
■ Urgent Care Center Services	$75	Not Applicable
Annual Deductible[2]		
■ Individual	$1,500	$3,000
■ Family (not to exceed $1,500 per Covered Person for Network Benefits and $3,000 per Covered Person for Non-Network Benefits)	$3,000	$6,000
Annual Out-of-Pocket Maximum[2]		
■ Individual	$5,000	$10,000
■ Family (not to exceed $5,000 per Covered Person for Network Benefits and $10,000 per Covered Person for Non-Network Benefits)	$10,000	$20,000
Lifetime Maximum Benefit[3] There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	Unlimited	Unlimited

[1]In addition to these Copays, you may be responsible for additional Coinsurance and meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages. With the exception of Emergency Health Services, a Copay does not apply when you visit a non-Network provider.

[2]Copays apply toward the Out-of-Pocket Maximum. The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.

[3]Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act:
Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and Substance-Related and Addictive Disorders services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Covered Health Services[1]	**Percentage of Eligible Expenses Payable by the Plan:**	
	Network	**Non-Network**
Acupuncture Services (Copay is per visit) Up to 20 visits per plan year.	100% after you pay a $50 Copay	50% after you meet the Annual Deductible
Ambulance Services See Section 6, *Additional Coverage Details* for limits.		
■ Emergency Ambulance	80% after you meet the Annual Deductible	80% after you meet the Annual Network Deductible
■ Non-Emergency Ambulance	80% after you meet the Annual Deductible	80% after you meet the Annual Network Deductible
Autism Spectrum Disorders		
■ Hospital - Inpatient Stay (Copay is per admission)	80% after you pay a $1,000 Copay	50% after you meet the Annual Deductible
■ Physician's Office Services/Alternate Facility - Outpatient (Copay is per visit)	100% after you pay a $30 Copay ($50 Copay for Specialist Physician)	50% after you meet the Annual Deductible
Breast Reduction	Benefits will be the same as those stated under each Covered Health Service category in this section.	
Cancer Resource Services (CRS)[2]		
■ Hospital Inpatient Stay (Copay is per admission)	80% after you pay a $1,000 Copay	Not Covered

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Children's Dental Anesthesia		
■ Physician's Office Services (Copay is per visit)	100% after you pay a $30 Copay ($50 Copay for Specialist Physician)	50% after you meet the Annual Deductible
■ Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
■ Hospital - Inpatient Stay (Copay is per admission)	80% after you pay a $1,000 Copay	50% after you meet the Annual Deductible
Cleft Lip and Cleft Palate Treatment		
■ Physician's Office Services (Copay is per visit)	100% after you pay a $30 Copay ($50 Copay for Specialist Physician)	50% after you meet the Annual Deductible
■ Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
■ Hospital - Inpatient Stay (Copay is per admission)	80% after you pay a $1,000 Copay	50% after you meet the Annual Deductible
Clinical Trials	Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section.	
Congenital Heart Disease (CHD) Surgeries	80% after you pay a $1,000 Copay	50% after you meet the Annual Deductible
Dental Services - Accident Only	80% after you meet the Annual Deductible	80% after you meet the Annual Network Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Dental Services – Children's Dental Anesthesia	Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section.	
Diabetes Services		
Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under *Hospital – Inpatient Stay* and *Physician's Office Services – Sickness and Injury* in this section.	
■ Diabetes Self-Management Items	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* in this section and in Section 15, *Prescription Drugs*.	
Durable Medical Equipment (DME)	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Emergency and Non-Emergency Health Services - Outpatient	100% after you pay a $500 Copay	100% after you pay a $500 Copay
Enteral Nutrition	100%	50% after you meet the Annual Deductible
Hearing Aids for Adults Device and testing limited to $1,000 every 3 years. Benefits are further limited to one pair of hearing aids every 3 years.		
■ Testing	100% after you pay a $30 Copay ($50 Copay for Specialist Physician)	50% after you meet the Annual Deductible
■ Devices	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Hearing Aids for Minor Children		
■ Testing	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
■ Devices	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Home Health Care Up to 100 visits per Plan year.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Hospice Care	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Hospital - Inpatient Stay (Copay is per admission) No Copay is applicable when the patient is readmitted within 24 hours of a discharge for the same or related diagnosis.	80% after you pay a $1,000 Copay	50% after you meet the Annual Deductible
Infertility Services	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Kidney Resource Services (KRS) (These Benefits are for Covered Health Services provided through KRS only)	80% after you meet the Annual Deductible	Not Covered
Lab, X-Ray and Diagnostics - Outpatient	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Mental Health Services		
■ Inpatient (Copay is per admission)	80% after you pay a $1,000 Copay	50% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
■ Outpatient (Copay is per visit)	100% after you pay a $30 Copay	50% after you meet the Annual Deductible
■ Outpatient Medication Management	100%	50% after you meet the Annual Deductible
Neurobiological Disorders - Autism Spectrum Disorder Services		
■ Inpatient (Copay is per admission)	80% after you pay a $1,000 Copay	50% after you meet the Annual Deductible
■ Outpatient (Copay is per visit)	100% after you pay a $30 Copay	50% after you meet the Annual Deductible
■ Outpatient Medication Management	100%	50% after you meet the Annual Deductible
Nutritional Counseling (Copay is per visit)	100% after you pay a $30 Copay ($50 Copay for Specialist Physician)	50% after you meet the Annual Deductible
Obesity Surgery Up to $25,000 per Covered Person per lifetime. See Section 6, *Additional Coverage Details* for additional requirements.		
■ Physician's Office Services (Copay is per visit)	100% after you pay a $30 Copay ($50 Copay for Specialist Physician)	50% after you meet the Annual Deductible
■ Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	Not Covered

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
■ Hospital - Inpatient Stay (Copay is per admission)	80% after you pay a $1,000 Copay	Not Covered
■ Lab and x-ray	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Ostomy Supplies	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Phenylketonuria (PKU) Testing and Treatment		
■ Physician's Office Services (Copay is per visit)	100% after you pay a $30 Copay ($50 Copay for Specialist Physician)	50% after you meet the Annual Deductible
■ Lab and x-ray	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury (Copay is per visit)		
■ Primary Physician	100% after you pay a $30 Copay	50% after you meet the Annual Deductible
■ Specialist Physician	100% after you pay a $50 Copay	50% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
In addition to the Copay stated in this section, the Copays and Coinsurance and any Deductible for the following services apply when the Covered Health Service is performed in a Physician's office: ■ lab, radiology/x-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics – Outpatient*; ■ major diagnostic and nuclear medicine described under Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine – Outpatient; ■ diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*; ■ outpatient surgery procedures described under *Surgery – Outpatient*; ■ outpatient therapeutic procedures described under *Therapeutic Treatments – Outpatient*; and ■ rehabilitation therapy procedures described under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.		
Pregnancy – Maternity Services A 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.	Benefits will be the same as those stated under each Covered Health Service category in this section.	
Preventive Care Services Physician Office Services		
■ Primary Physician	100%	50%

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
■ Specialist Physician	100%	50%
Lab, X-ray or Other Preventive Tests		
■ Primary Physician	100%	*Well child services, mammograms, prostate cancer screenings and Child Health Supervision Services:* 50% *All other services:* 50% after you meet the Annual Deductible
■ Specialist Physician	100%	*Well child services, mammograms, prostate cancer screenings and Child Health Supervision Services:* 50% *All other services:* 50% after you meet the Annual Deductible
Prosthetic Devices Prosthetic bras and pads are limited to 2 per Plan year. See Section 6, *Additional Coverage Details* for additional limitations.	80% after you meet the Annual Deductible	*Prosthetic arms, legs, hands and feet:* 80% after you meet the Annual Deductible *All other services:* 50% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Reconstructive Procedures (Copay is per visit)		
■ Physician's Office Services (Copay is per visit)	100% after you pay a $30 Copay ($50 Copay for Specialist Physician)	50% after you meet the Annual Deductible
■ Hospital - Inpatient Stay (Copay is per admission)	80% after you pay a $1,000 Copay	50% and after you meet the Annual Deductible
■ Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
■ Prosthetic Devices	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
■ Surgery - Outpatient	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment (Copay is per visit) See Section 6, *Additional Coverage Details*, for visit limits.	100% after you pay a $50 Copay	50% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic Diagnostic scopic procedures include but are not limited to: colonoscopy, sigmoidoscopy, or endoscopy. For preventive scopic procedures, refer to the Preventive Care Services section. (Any future procedures may become diagnostic if the physician recommends that they occur more frequently than the preventive recommendations due to finding an issue during the initial screening.)	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Scopic Procedures – Surgical Scopic procedures that may result in another surgical procedure being performed that is not scopic in nature.	80% after you meet the Annual Deductible	50%after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Skilled Nursing Facility services are limited to 30 days per Plan year. Inpatient Rehabilitation Facility services are not limited.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Spine and Joint Surgeries Network Benefits include services received from a Network provider that is not a Designated Provider.	*Designated Network* 100% after you meet the Annual Deductible *Network* 80% after you meet the Annual Deductible	Not Covered
See Section 6, *Additional Coverage Details*, for limits.		

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Substance-Related and Addictive Disorders Services		
■ Inpatient (Copay is per admission)	80% after you pay a $1,000 Copay	50% after you meet the Annual Deductible
■ Outpatient (Copay is per visit)	100% after you pay a $30 Copay	50% after you meet the Annual Deductible
■ Outpatient Medication Management	100%	50% after you meet the Annual Deductible
Surgery - Outpatient	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Therapeutic Treatments - Outpatient	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Transgender Disorder	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Transplantation Services (If services rendered by a Designated Provider)	80% after you pay a $1,000 Copay	Not Covered
Travel and Lodging (If services rendered by a Designated Provider)	For patient and companion(s) of patient undergoing cancer, Congenital Heart Disease treatment, bariatric surgery or transplant procedures	
Urgent Care Center Services (Copay is per visit)	100% after you pay a $75 Copay	50% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
In addition to the Copay stated in this section, the Copays and Coinsurance and any Deductible for the following services apply when the Covered Health Service is performed at an Urgent Care Center: ■ lab, radiology/x-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*; ■ major diagnostic and nuclear medicine described under Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient; ■ diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*; ■ outpatient surgery procedures described under *Surgery - Outpatient*; ■ outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*; and ■ rehabilitation therapy procedures described under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.		

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Virtual Visits Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling the telephone number on your ID card.	100% after you pay a $30 Copay	Not Covered
Vision Examinations Limited to one (1) exam per Covered Person every 12 months.	100% after you pay a $50 Copay	Not Covered
Wigs Limited to one (1) per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Network Annual Network Deductible

[1]You must notify Personal Health Support, as described in Section 4, *Personal Health Support* to receive full Benefits before receiving certain Covered Health Services from a non-Network provider. In general, if you visit a Network provider, that provider is responsible for notifying Personal Health Support before you receive certain Covered Health Services. See Section 6, *Additional Coverage Details* for further information.

[2]These Benefits are for Covered Health Services provided through CRS at a Designated Provider. For oncology services not provided through CRS, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury, Physician Fees for Surgical and Medical Services*, *Hospital - Inpatient Stay*, *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic* Lab, *X-Ray and Diagnostics – Outpatient*, and *Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient*.

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:
- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to notify Personal Health Support before you receive them, and any reduction in Benefits that may apply if you do not call Personal Health Support.

This section supplements the second table in Section 5, *Plan Highlights*.

While the table provides you with benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call Personal Health Support. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions*.

Acupuncture Services

The Plan pays for acupuncture services for pain therapy provided that the service is performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine;
- Doctor of Osteopathy;
- Chiropractor; or
- Acupuncturist.

Covered Health Services include treatment of nausea as a result of:

- chemotherapy;
- Pregnancy; and
- post-operative procedures.

All services rendered by an acupuncturist are limited to 20 visits per Plan year.

Did you know…
You generally pay less out-of-pocket when you use a Network provider?

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 14, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

The Plan also covers transportation provided by a licensed professional ambulance, other than air ambulance, (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- from a non-Network Hospital to a Network Hospital;
- to a Hospital that provides a higher level of care that was not available at the original Hospital;
- to a more cost-effective acute care facility; or
- from an acute facility to a sub-acute setting.

Please remember for Non-Network Benefits, you must notify the Claims Administrator for non-Emergency ambulance services as soon as possible prior to transport. If the Claims Administrator is not notified, you will be responsible for all charges and no Benefits will be paid.

Autism Spectrum Disorders

Benefits for psychiatric treatment for Autism Spectrum Disorders (including Applied Behavioral Analysis) are described under *Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorder* in this section.

- well-baby and well-child screening for diagnosing the presence of Autism Spectrum Disorders; and
- treatment of Autism Spectrum Disorders through speech therapy, occupational therapy, and physical therapy. The visit limits described under *Rehabilitation Services – Outpatient Therapy and Manipulative Treatment* in this section do not apply to Autism Spectrum Disorders.

Benefits are limited to treatment that is prescribed by the Covered Person's treating Physician in accordance with a treatment plan. The treatment plan must include, but is not limited to, the following:

- the diagnosis;
- the proposed treatment by types;
- the frequency and duration of treatment;
- the anticipated outcomes stated as goals;
- the frequency with which the treatment plan will be updated;
- the signature of the treating Physician; and
- evaluation and assessment services.

Breast Reduction

The Plan pays Benefits for Breast Reduction Surgery with documentation of the following functional impairments:

- Shoulder grooving or excoriation resulting from the brassiere shoulder straps, due to the weight of the breasts;
- Documentation from medical records of medical services related to complaints of the shoulder, neck or back pain attributable to macromastia; and
- Determined not to be cosmetic by Care Coordination.

Other documentation may be required to prove medical necessity.

Note: Breast Reduction Surgery is not a covered health service when performed to improve appearance or for the purpose of improving athletic performance. Breast Reduction Surgery is covered when a reconstruction has been performed on the other breast (as part of the federal mandate).

Please remember for Non-Network Benefits, you must notify the Claims Administrator five business days before undergoing breast reduction surgery. When you provide notification, Personal Health Support can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage. If the Claims Administrator is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by Designated Providers participating in the Cancer Resource Services (CRS) program. Designated Provider is defined in Section 14, *Glossary*.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- be referred to CRS by a Personal Health Support Nurse;
- call CRS toll-free at (866) 936-6002; or
- visit www.urncrs.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Provider. If you receive oncology services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with cancer-related services received at a Designated Provider.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Children's Dental Anesthesia

Benefits are available for general anesthesia and associated Hospital and facility charges provided to an enrolled Dependent child when, in the opinion of the treating dentist, at least one of the following criteria is met:

- the child has a physical, mental or medically compromising condition;
- the child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy;
- the child is extremely uncooperative, unmanageable or uncommunicative and has dental needs deemed sufficiently important that the dental care cannot be deferred; or
- the child has sustained extensive orofacial and dental trauma.

Cleft Lip and Cleft Palate Treatment

The following services are covered when provided by or under the direction of a Physician in connection with cleft lip and/or cleft palate:

- orthodontic services;
- oral and facial surgery;
- habilitative speech therapy;
- prosthetic devices such as obturators, speech appliances and feeding appliances;
- otolaryngological services;

- surgical management;
- follow-up care by plastic surgeons or oral surgeons;
- audiological services; and
- prosthodontic services.

If a dental insurance policy is in effect at the time of the birth, or is purchased after the birth of a child with cleft lip or cleft palate or both, no Benefits will be provided for any orthodontics or dental care needed as a result of the cleft lip or cleft palate or both.

Clinical Trials

The Plan pays for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:

- cancer;
- cardiovascular disease (cardiac/stroke);
- surgical musculoskeletal disorders of the spine, hip, and knees;
- a clinical trial or study approved under the September 19, 2000, *Medicare National Coverage Decision* regarding clinical trials, as amended; and
- other diseases or disorders for which, as determined by UnitedHealthcare, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in a qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the Clinical Trial as defined by the researcher. Benefits are not available for preventive Clinical Trials.

Routine patient care costs for Clinical Trials include:

- Covered Health Services for which Benefits are typically provided absent a Clinical Trial;
- Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered Health Services needed for reasonable and necessary care arising from the provision of an investigational item or service.

Routine costs for Clinical Trials do not include:

- the Experimental or Investigational Service or item. The only exceptions to this are:
  - certain Category B devices;
  - certain promising interventions for patients with terminal illnesses; or

  - other items and services that meet specified criteria in accordance with the Claims Administrator's medical policy guidelines.
- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
- items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be a qualifying Clinical Trial, a Clinical Trial must meet all of the following criteria:

- be sponsored and provided by a cancer center that has been designated by the National Cancer Institute (NCI) as a Clinical Cancer Center or Comprehensive Cancer Center or be sponsored by any of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
  - Centers for Disease Control and Prevention (CDC);
  - Agency for Healthcare Research and Quality (AHRQ);
  - Centers for Medicare and Medicaid Services (CMS);
  - Department of Defense (DOD); or
  - Veterans Administration (VA).
- have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial to confirm that the Clinical Trial meets current standards for scientific merit and has the relevant IRB approvals; and
- the subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Benefits include Covered Health Services provided in accordance with the Covered Person's treating Physician who is providing Covered Health Services after determining that participating in the Clinical Trial has the potential to provide a therapeutic health benefit to the Covered Person and meets all of the following criteria:

- the clinical trial or study is approved under the September 19, 2000 Medicare National Coverage Decision regarding Clinical Trials, as amended;
- the patient care is provided by a certified, registered, or licensed health care provider practicing within the scope of his or her practice and the facility and personnel providing the treatment have the experience and training to provide the treatment in a competent manner;
- prior to participation in a Clinical Trial or study, the Covered Person has signed a statement of consent indicating that the Covered Person has been informed of the procedure to be undertaken, alternative methods of treatment, and the general nature and extent of the risks associated with participation in the Clinical Trial or study; and
- the Covered Person suffers from a condition that is disabling, progressive, or life-threatening.

Coverage does not include:

- any portion of the Clinical Trial or study that is paid for by a government or a biotechnical, pharmaceutical, or medical industry;
- coverage for any drug or device that is paid for by the manufacturer, distributor, or provider of the drug or device;
- extraneous expenses related to participation in the Clinical Trial or study including, but not limited to, travel, housing, and other expenses that a participant or person accompanying a participant may incur;
- any item or service that is provided solely to satisfy a need for data collection or analysis that is not directly related to the clinical management of the participant;
- cost for the management of research relating to the Clinical Trial or study; and
- health care services that, except for the fact that they are being provided in a Clinical Trial, are otherwise specifically excluded from coverage under the Covered Person's health plan.

Please remember for Non-Network Benefits, you must notify the Claims Administrator as soon as the possibility of participation in a clinical trial arises. If the Claims Administrator is not notified, you will be responsible for all charges and no Benefits will be paid.

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician and received at a CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the following CHD services:

- outpatient diagnostic testing;
- evaluation;
- surgical interventions;
- interventional cardiac catheterizations (insertion of a tubular device in the heart);
- fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology); and
- approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by United Resource Networks or Personal Health Support to be proven procedures for the involved diagnoses. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the toll-free number on your ID card for information about CHD services.

If you receive Congenital Heart Disease services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments – Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

Please remember for Non-Network Benefits, you must notify United Resource Networks or the Claims Administrator as soon as CHD is suspected or diagnosed. If United Resource Networks or the Claims Administrator is not notified, you will be responsible for all charges and no Benefits will be paid.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with CHD services received at a Congenital Heart Disease Resource Services program.

Dental Services - Accident Only

Dental services are covered by the Plan when all of the following are true:

- treatment is necessary because of accidental damage;
- dental damage does not occur as a result of normal activities of daily living or extraordinary use of the teeth;
- dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry; and
- the dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- dental services related to medical transplant procedures;
- initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
- direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental services for final treatment to repair the damage caused by accidental Injury must be started within three months of the accident, or if not a Covered Person at the time of the

accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan.

The Plan pays for treatment of accidental Injury only for:

- emergency examination;
- necessary diagnostic x-rays;
- endodontic (root canal) treatment;
- temporary splinting of teeth;
- prefabricated post and core;
- simple minimal restorative procedures (fillings);
- extractions;
- post-traumatic crowns if such are the only clinically acceptable treatment; and
- replacement of lost teeth due to the Injury by implant, dentures or bridges.

See also *Children's Dental Anesthesia* in this section.

Please remember for Non-Network Benefits, you should notify the Claims Administrator as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. You do not have to provide notification before the initial Emergency treatment. When you provide notification, the Claims Administrator can determine whether the service is a Covered Health Service. If Personal Health Support is not notified, you will be responsible for all charges and no Benefits will be paid.

Diabetes Services

The Plan pays Benefits for the Covered Health Services identified below.

Covered Diabetes Services	
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals. Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes.

Covered Diabetes Services	
Diabetic Self-Management Items	Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based uponyour medical needs. An insulin pump is subject to all the conditions of coverage stated under Durable Medical Equipment (DME). Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described in Section 15, *Outpatient Prescription Drug*s. Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are not subject to the limit stated under *Durable Medical Equipment* in this section.

Please remember for Non-Network Benefits, you must notify Personal Health Support before obtaining any Durable Medical Equipment for the management and treatment of diabetes if the purchase, rental, repair or replacement of DME will cost more than $1,000. You must purchase or rent the DME from the vendor Personal Health Support identifies. If Personal Health Support is not notified, you will be responsible for all charges and no Benefits will be paid.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
- not consumable or disposable;
- not of use to a person in the absence of a Sickness, Injury or disability;
- durable enough to withstand repeated use;
- medical supplies (i.e. syringes, needles, surgical dressings, splints and other similar items) are covered to treat a medical condition. Medical supplies are not subject to a maximum; and
- appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you may be responsible for

any cost difference between the piece you rent or purchase and the piece UnitedHealthcare has determined is the most Cost-Effective.

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- delivery pumps for tube feedings;
- burn garments;
- insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- shoes (limited to two pairs of shoes per Plan year);
- shoe orthotics when prescribed and designed specifically for the Covered Person;
- orthopedic shoes;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section;
- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are also excluded from coverage; and
- equipment for the treatment of chronic or acute respiratory failure or conditions.

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Note: DME is different from prosthetic devices – see *Prosthetic Devices* in this section.

Oxygen and equipment needed to administer oxygen is limited to one stationary and one portable unit per Covered Person every three years.

Shoe orthotics are covered and limited. Lifts, inserts, molds, etc. are not covered. Shoe orthotics are covered at the plan level deductible and coinsurance.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every three plan years.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the

Covered Person's medical condition occurs sooner than the three year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three year timeline for replacement.

Please remember for Non-Network Benefits, you must notify the Claims Administrator if the purchase, rental, repair or replacement of DME will cost more than $1,000. If the Claims Administrator is not notified, you will be responsible for all charges and no Benefits will be paid.

Emergency and Non-Emergency Health Services - Outpatient

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

Health care services provided at a Network facility, including services provided by a Non-Network Provider, are to be provided to you at no greater cost than if the services were obtained by a Network provider.

In the case of an Emergency, you may call the 911 emergency telephone access number or its local equivalent. The Plan provides Benefits for Eligible Expenses resulting from the use of Emergency telephone access numbers in case of an Emergency.

Please remember for Non-Network Benefits, you must notify the Claims Administrator within two business days of the admission or on the same day of admission if reasonably possible if you are admitted to a Hospital as a result of an Emergency.

Enteral Nutrition

The Plan pays Benefits for enteral nutrition and supplies required for enteral feedings when all of the following conditions are met:

- It is necessary to sustain life or health;
- It is used in the treatment of, or in association with, a demonstrable disease, condition or disorder;
- It requires ongoing evaluation and management by a physician; and
- It is the sole source of nutrition or a significant percentage of the daily caloric intake.

Hearing Aids for Adults

The Plan pays Benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:

- craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Any combination of Network Benefits and Non-Network Benefits for hearing testing and hearing aid devices is limited to $1,000 every three years. This limit does not apply to children under the age of 18. Benefits are further limited to one pair (including repair/replacement) every three Plan years.

Hearing Aids for Minor Children

Hearing aids for a minor child, which is a person under the age of 18 years, who has a hearing loss that has been verified by a licensed Physician and by an audiologist are covered. The hearing aids shall be medically appropriate to meet the needs of the child according to accepted professional standards. Coverage shall include the purchase of the following:

- initial hearing aids and replacement hearing aids not more frequently than every three years;
- a new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child;
- services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

"Hearing aid" means amplification technology that optimizes audibility and listening skills in the environments commonly experienced by the patient, including wearable instrument or device designed to aid or compensate for impaired human hearing. "Hearing aid" shall include any parts or ear molds.

Benefits are limited to one pair (including repair/replacement) every three Plan years.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- ordered by a Physician; and

- provided in your home by a registered nurse, certified nurse aid or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Home health services are to be covered when services are necessary as an alternative to hospitalization, or in place of hospitalization.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when Skilled Care is required. Home health services are to be covered when services are necessary as an alternative to hospitalization, or in place of hospitalization. Prior hospitalization is not required.

Home health care visits may be included but are not limited to:

- skilled nursing visits;
- home health aide services visits that provide supportive care in the home which are reasonable and necessary to the Covered Person's Sickness or Injury;
- physical, occupational or speech therapy that is provided on a per visit basis;
- medical supplies, Durable Medical Equipment; and
- infusion therapy medications and supplies and laboratory services as prescribed by a provider to the extent such services would be covered by the Plan had the Covered Person remained in the Hospital, rehabilitation or Skilled Nursing Facility.

"Medical social services" are those services provided by an individual who possesses a baccalaureate degree in social work, psychology or counseling or the documented equivalent in a combination of education, training and experience, which services are provided at the recommendation of a Physician for the purposes of assisting the Covered Person or the family in dealing with a specific medical condition.

The Claims Administrator will decide if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Any combination of Network Benefits and Non-Network Benefits is limited to 100 visits per Plan year. One visit equals four hours of Skilled Care services.

> Please remember for Non-Network Benefits, you must notify the Claims Administrator five business days before receiving services or as soon as reasonably possible. If the Claims Administrator is not notified, you will be responsible for all charges and no Benefits will be paid.

Hospice Care

Hospice services are covered for Covered Persons with a terminal Sickness, defined as a medical condition resulting in a prognosis of life expectancy of six months or less, if the disease follows its natural course. Hospice services are provided pursuant to the plan of care developed by the Covered Person's interdisciplinary team, which includes, but is not limited

to, the Covered Person, the Covered Person's Physician, a registered nurse, a social worker and a spiritual caregiver.

Benefits are available when hospice services are received from a hospice agency that is licensed and regulated by the Colorado Department of Public Health and Environment.

Hospice services include:

- skilled nursing services, certified home health aide services and homemaker services under the supervision of a qualified registered nurse and nursing services delegated to other assistants;
- bereavement services;
- social services/counseling services;
- medical direction;
- volunteer services;
- drugs and biologicals;
- prosthesis and orthopedic appliances;
- oxygen and respiratory supplies;
- diagnostic testing;
- rental or purchase or Durable Medical Equipment;
- transportation;
- Physician services;
- nutritional counseling by a nutritionist or dietitian;
- medical equipment and supplies that are reasonable and necessary for the palliation and management of the terminal Sickness and related conditions; and
- physical and occupational therapy and speech-language pathology services for purposes of symptom control, or to enable the Covered Person to maintain activities of daily living and basic functional skills.

Covered hospice services are available in the home on a 24-hour basis during periods of crisis, when a Covered Person requires continuous care to achieve palliation or management of acute medical symptoms. Home is defined as a place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility. Inpatient hospice services are provided in an appropriately licensed hospice facility when the Covered Person's interdisciplinary team has determined that the Covered Person's care cannot be managed at home because of acute complications or when it is necessary to relieve the family members or other persons caring for the Covered Person ("respite care"). Respite care is limited to an occasional basis and to no more than five consecutive days at a time.

Services and charges incurred in connection with an unrelated Sickness will be processed in accordance with policy coverage provisions applicable to all other Sicknesses and/or Injuries.

Please remember for Non-Network Benefits, you must notify the Claims Administrator five business days before receiving services. If the Claims Administrator is not notified, you will be responsible for all charges and no Benefits will be paid.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- non-Physician services and supplies received during an Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for anesthesiologists, Emergency room Physicians, consulting Physicians, pathologists and radiologists.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient, Scopic Procedures - Diagnostic and Therapeutic Services*, and *Therapeutic Treatments - Outpatient*, respectively.

Please remember for Non-Network Benefits, you must notify the Claims Administrator as follows:
- for elective admissions: five business days before admission or as soon as reasonably possible;
- for Emergency admissions (also termed non-elective admissions): within two business days, or as soon as is reasonably possible.

If the Claims Administrator is not notified, you will be responsible for all charges and no Benefits will be paid.

What is Coinsurance?
Coinsurance is the amount you pay for a Covered Health Service, not including the Copay and/or the Deductible.

For example, if the Plan pays 80% of Eligible Expenses for care received from a Network provider, your Coinsurance is 20%.

Infertility Services

Benefits are provided to diagnose and treat the actual cause of infertility.

Please remember for Non-Network Benefits, you must notify the Claims Administrator as soon as the possibility of the need for infertility services arises. If the Claims Administrator is not notified, then no benefits will be paid on services rendered.

Kidney Resource Services (KRS)

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) disease provided by Designated Providers participating in the Kidney Resource Services (KRS) program. Designated Provider is defined in Section 14, *Glossary*.

In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self-refer to a Network provider participating in the program. Notification is required:

- prior to vascular access placement for dialysis; and
- prior to any ESRD services.

You or a covered Dependent may:

- be referred to KRS by Personal Health Support; or
- call KRS toll-free at (888) 936-7246 and select the KRS prompt.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include, but are not limited to:

- lab and radiology/x-ray; and
- mammography.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Mental Health Services

Mental Health Services include those received on an inpatient basis in a Hospital or at an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility, including services to treat Biologically Based Mental Illness and Mental Disorders.

Benefits include treatment of Mental Illness whether treatment is voluntary on the part of the Covered Person or court ordered as the result of contact with the criminal justice or legal system.

Benefits include the following services provided on either an outpatient or inpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.

- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.

Services include the following:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.
- Intensive Outpatient Treatment.
- Crisis intervention.

The Claims Administrator provides administrative services for all levels of care.

You are encouraged to contact the Claims Administrator for referrals to providers and coordination of care.

Please remember for Non-Network Benefits, you must notify the Claims Administrator to receive these Benefits. For a scheduled admission for Mental Health Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility) you must provide notification five business days in advance of the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, for Non-Network Benefits you must provide notification before the following services are received: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

Please call the phone number that appears on your ID card. Without notification, you will be responsible for paying all charges and no Benefits will be paid.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder.
- Provided by a Board Certified Applied Behavior Analyst (BCBA) or other qualified provider under the appropriate supervision.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available as described under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Claims Administrator provides administrative services for all levels of care.

You are encouraged to contact the Claims Administrator for referrals to providers and coordination of care.

Please remember for Non-Network Benefits, you must notify the Claims Administrator to receive these Benefits. For a scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility) you must provide advance notification five business days prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, for Non-Network Benefits you must provide notification before the following services are received: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management. Pre-service notification is also required for Intensive Behavioral Therapy, including Applied Behavior Analysis (ABA).

Please call the phone number that appears on your ID card. Without notification, you will be responsible for paying all charges and no Benefits will be paid.

Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional when:

- education is required for a disease in which patient self-management is an important component of treatment; and
- there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Some examples of such medical conditions include:

- coronary artery disease;
- congestive heart failure;
- severe obstructive airway disease;
- gout (a form of arthritis);
- renal failure;
- phenylketonuria (a genetic disorder diagnosed at infancy); and
- hyperlipidemia (excess of fatty substances in the blood).

Obesity Surgery

The Plan covers surgical treatment of obesity provided by or under the direction of a Physician when either of the following are true:

- you have a minimum Body Mass Index (BMI) of 40; or
- you have a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by obesity.

In addition to meeting the above criteria, the following must also be true:

- you have documentation from a Physician of a diagnosis of morbid obesity for a minimum of five years;
- you are over the age of 21;
- you have completed a 6-month Physician supervised weight loss program;
- you have completed a pre-surgical psychological evaluation; and
- the surgery is performed at a Bariatric Resource Service (BRS) Designated Provider by a Network surgeon even if there are no BRS Designated Providers near you.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 14, *Glossary* and are not Experimental or Investigational or Unproven Services.

Network Benefits are limited to $25,000 during the entire period you are covered under the Plan. Benefits for excess skin removal following obesity surgery apply toward this limit.

Coverage is available for lap band. A second procedure is not covered.

You will have access to a certain Network of Designated Providers and Physicians participating in the Bariatric Resource Services (BRS) program, as defined in Section 14, *Glossary*, for obesity surgery services.

For obesity surgery services to be considered Covered Health Services under the BRS program, you must contact Bariatric Resource Services and speak with a nurse consultant prior to receiving services. You can contact Bariatric Resource Services by calling toll-free at (888) 936-7246.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with obesity-related services received at a Designated Provider.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and ostomy irrigation catheters; and
- skin barriers.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

Phenylketonuria (PKU) Testing and Treatment

Testing for phenylketonuria (PKU) is covered to prevent the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU enzyme deficiency. Medical foods, for the purpose of this Benefit, refer exclusively to prescription metabolic formulas and their modular counterparts, obtained through a pharmacy. Medical foods are specifically designated and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects.

Coverage for inherited enzymic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids shall include, but not be limited to the following diagnosed conditions:

- phenylketonuria;
- maternal phenylketonuria;
- maple syrup urine disease;
- tyrosinemia;
- homocystinuria;
- histidinemia;
- urea cycle disorders;
- hyperlysinemia;
- glutaric acidemias;
- methylmalonic academia; and
- propionic academia.

Covered care and treatment of such conditions shall include, to the extent medically appropriate, medical foods for home use for which a participating Physician has issued a written, oral or electronic prescription. Benefits for medical foods are described in Section 14, *Prescription Drugs*.

The maximum age to receive this Benefit is 21, except that the maximum age for women who are of child-bearing age is 35.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility, or for Physician house calls.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services received in a Primary or Specialist Physician's office for the evaluation and treatment of a Sickness or Injury provided by a general pediatrician, internist, family practitioner or general practitioner. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Benefits for preventive services are described under *Preventive Care* in this section

[2]Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services.

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/x-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.

Please Note
Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

Private Room charges related to Maternity will be covered. Semi-Private Room rates will not be applied.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery. If 48 hours following delivery falls after 8:00 p.m., coverage will continue until 8:00 a.m. the following morning; or
- 96 hours for the mother and newborn child following a cesarean section delivery. If 96 hours following delivery falls after 8:00 p.m., coverage will continue until 8:00 a.m. the following morning.

These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. Benefits include genetic counseling and testing when there is a reasonable probability that, because of family history, parental age, or exposure to an agent which might cause birth defects or cancer in the fetus, the results will affect medical decisions involving the existing pregnancy. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

Benefits are provided for well-baby care in the Hospital, including a newborn pediatric visit and newborn hearing screening.

Please remember for Non-Network Benefits, you must notify the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above. If the Claims Administrator is not notified, you will be responsible for all charges and no Benefits will be paid.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Clinical Programs and Resources*, for details.

Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under Section 5, *Plan Highlights,* under *Covered Health Services.*

Benefits are only available if breast pumps are obtained from a DME provider or Physician.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. The Claims Administrator will determine the following:

- Which pump is the most cost effective;
- Whether the pump should be purchased or rented;
- Duration of a rental;
- Timing of an acquisition;

In addition to the services listed above, this preventive care benefit includes certain:

- Routine lab tests;
- Diagnostic consults to prevent disease and detect abnormalities;

- Diagnostic radiology and nuclear imaging procedures to screen for abnormalities;
- Breast cancer screening and genetic testing; and
- Tests to support cardiovascular health.
- Obesity screening.

These additional services are paid under the preventive care benefit when billed by your provider with a wellness diagnosis. Call the number on the back of your ID card with questions or for additional information regarding coverage available for specific services.

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

Prosthetic Devices

Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

- prosthetic arms and legs are based on criteria that will be covered in accordance with Medicare guidelines and criteria. Bionic, myoelectric, microprocessor-controlled and computerized prosthetics are covered in accordance with Medicare guidelines and criteria;
- artificial arms, legs, feet and hands;
- artificial face, eyes, ears and nose; and
- breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device every three Plan years.

Benefits are provided for the replacement of a type of prosthetic device once every three to six months. Standard or indwelling tracheo-esophageal prostheses are considered medically necessary if the following criteria are met:

- recommended by an otolaryngologist or speech/language pathologist;

- Covered Person has undergone a total laryngectomy; and
- Covered Person or caregiver is willing and able to maintain and replace the device.

The replacement is considered medically appropriate if there is evidence of leakage or increased airflow pressure is present.

Benefits are provided for the replacement of other types of prosthetic device once every three Plan years.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

Any combination of Network Benefits and Non-Network Benefits for prosthetic bra /pads is limited to 2 per Plan year.

Any combination of Network Benefits and Non-Network Benefits for shoes is limited to 2 pair per Plan year.

Any combination of Network Benefits and Non-Network Benefits for Standard or indwelling tracheoesophageal voice prostheses are limited as follows:

- Every three to six months; or
- There is evidence of leakage; or
- Increased airflow pressure is present

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required by the Women's Health and Cancer Rights

Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please remember that for Non-Network Benefits, you must notify the Claims Administrator five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. When you provide notification the Claims Administrator can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage. If the Claims Administrator is not notified, you will be responsible for all charges and no Benefits will be paid.

In addition, for Non-Network Benefits you must the Claims Administrator 24 hours before admission for an Inpatient Stay.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services for the following types of therapy:

- physical therapy;
- occupational therapy;
- Manipulative Treatment;
- speech therapy;
- post-cochlear implant aural therapy;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

Services for Manipulative Treatment, Physical, Occupational and Speech Therapy are not subject to the therapy limits for enrolled dependents who have been diagnosed with Autism Spectrum Disorders.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services.

Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

The Plan will pay Benefits for speech therapy only when the speech impediment or dysfunction results from Injury, Sickness, stroke, cancer, Autism Spectrum Disorders or a Congenital Anomaly, or is needed following the placement of a cochlear implant.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Covered Health Services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is provided to maintain a Covered Person's current condition or to prevent or slow further decline.
- It is ordered by a Physician and provided and administered by a licensed provider.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided on an outpatient basis for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or Physician.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, the Plan may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this benefit, "habilitative services" means health care services that help a person keep, learn or improve skills and functioning for daily living.Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices* in this section.

Benefits are limited to:

- 30 visits per Plan year for physical therapy;
- 20 visits per Plan year for occupational therapy;
- 20 visits per Plan year for speech therapy; and
- 20 visits per Plan year for Manipulative Treatment (all services by a Chiropractor).

These visit limits apply to Network Benefits and Non-Network Benefits combined.

Congenital Anomaly and Birth Abnormalities for Children Age 3 to 6

Physical , occupational and speech therapy for the care and treatment of congenital defect and birth abnormalities for children age 3 to 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.

Short-term outpatient rehabilitation services are limited to physical therapy, occupational therapy and speech therapy. Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

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.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- non-Physician services and supplies received during the Inpatient Stay; and
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for anesthesiologists, consulting Physicians, pathologists and radiologists.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if:

- the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost-effective alternative to an Inpatient Stay in a Hospital; and
- you will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

- it is delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;
- it is ordered by a Physician;
- it is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair; and
- it requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 14, *Glossary*.

Any combination of Network Benefits and Non-Network Benefits for Skilled Nursing Facility Benefits is limited to 30 days per Plan year. Benefits for an Inpatient Rehabilitation Facility are not limited.

Please remember for Non-Network Benefits, you must notify the Claims Administrator as follows:
- for elective admissions: five business days before admission;
- for Emergency admissions (also termed non-elective admissions): within two business days, or as soon as is reasonably possible.

If the Claims Administrator is not notified, you will be responsible for all charges and no Benefits will be paid.

Spine and Joint Surgeries

Benefits for spine and joint surgeries which are ordered by a Physician. Spine and joint surgical procedures include the following:

- Spine fusion surgery.
- Spine disc surgery.

- Total knee replacement.
- Total hip replacement.

Designated Network Benefits include Physician fees, the facility charge and the charge for supplies and equipment.

Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Spine and Joint Solutions Program

For Designated Network Benefits, you must enroll in the *SJS Program* to receive services from a Designated Provider. To enroll you can call the Claims Administrator at the telephone number on your ID card or you can call the *SJS Nurse Team* at 888-936-7246.

Substance-Related and Addictive Disorders Services

Substance Use Disorder Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include treatment of Substance Use whether treatment is voluntary on the part of the Covered Person or court ordered as the result of contact with the criminal justice or legal system

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.

Services include the following:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.
- Intensive Outpatient Treatment.
- Crisis intervention.

The Claims Administrator provides administrative services for all levels of care.

You are encouraged to contact the Claims Administrator for referrals to providers and coordination of care.

Please remember for Non-Network Benefits, you must notify the Claims Administrator to receive these Benefits [7]in advance of any treatment. For a scheduled admission for Substance-Related and Addictive Disorders Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility) you must provide advance notification five business days prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, for Non-Network Benefits you must provide notification before the following services are received: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

Please call the phone number that appears on your ID card. Without notification, you will be responsible for paying all charges and no Benefits will be paid.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment;
- certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy); and
- Physician services for anesthesiologists, pathologists and radiologists.

Health care services provided at a Network facility, including services provided by a non-Network provider, are to be provided at no greater cost than if the services were obtained by a Network provider.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

For Non-Network Benefits for blepharoplasty, uvulopalatopharyngoplasty, vein procedures and sleep apnea surgeries, cochlear implant and orthognathic surgeries you must notify the Claims Administrator five business days before scheduled services are received or for non-scheduled services, within one business day or as soon as is reasonably possible. If the Claims Administrator is not notified, you will be responsible for all charges and no Benefits will be paid.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including but not limited to dialysis

(both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- education is required for a disease in which patient self-management is an important component of treatment; and
- there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- the facility charge and the charge for related supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please remember for Non-Network Benefits, you must notify the Claims Administrator for all outpatient therapeutics five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as reasonably possible. Services that require notification: dialysis, IV infusion, radiation oncology, intensity modulated radiation therapy and MR-guided focused ultrasound. If the Claims Administrator is not notified, you will be responsible for all charges and no Benefits will be paid.

Transgender Disorder

The Plan pays Benefits for Transgender Disorder. The Covered Person must meet all of the following eligibility qualifications for genital surgery and/or surgery to change specified secondary sex characteristics (in addition to the plan's overall eligibility requirements as shown in the plan document):

- The surgery must be performed by a qualified provider at a facility with a history of treating individuals with gender identity disorder;
- The treatment plan must conform to the World Professional Association for Transgender Health Association (WPATH) standards (WPATH 6th edition)*;
- The Covered Person must be age 18 years or older for irreversible surgical interventions;
- The Covered Person must complete 12 months of successful continuous full time real life experience in the desired gender; and
- The Covered Person may be required to complete continuous hormone therapy (for those without contraindications). In consultation with the patient's physician, this should be determined on a case-by-case basis through the Notification process. Note the following clarifications:

- A biologic female patient that is only requesting a bilateral mastectomy does not need to complete hormone therapy in order to qualify for the mastectomy. However, UnitedHealthcare recommends that the patient complete at least 3 months of psychotherapy before having the mastectomy.

  (Note: WPATH Version 6 recommends that the patient complete 3 months of psychotherapy and/or 3 months of hormone therapy.)

- A biologic male patient that is able to take female hormones and is considering breast augmentation surgery should take the female hormones for at least 18 months before being considered for bilateral breast augmentation since the patient may achieve adequate breast development without surgery.

Transplantation Services

Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures must be ordered by a Network Provider and received at a Centers of Excellence Facility for network benefits to apply. Benefits are available to the donor and the recipient when the recipient is covered under this Plan. The transplant must meet the definition of a Covered Health Service and cannot be Experimental or Investigational, or Unproven. Examples of transplants for which benefits are available include but are not limited to:

- heart;
- heart/lung;
- lung;
- kidney;
- kidney/pancreas;
- liver;
- liver/kidney;
- liver/intestinal;
- pancreas;
- intestinal; and
- bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service

Benefits are also available for cornea transplants. You are not required to notify United Resource Networks or Personal Health Support of a cornea transplant nor is the cornea transplant required to be performed at a Designated Provider.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Plan has specific guidelines regarding Benefits for transplant services. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the telephone number on your ID card for information about these guidelines.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with transplant services received at a Designated Provider.

Travel and Lodging

Your Plan Sponsor may provide you with Travel and Lodging assistance. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the distance from your home address to the facility. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding Travel and Lodging, please call the Travel and Lodging office at 1-800-842-0843.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The cancer, obesity surgery services, congenital heart disease and transplant programs offers a combined overall lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.
- The spine and joint programs provides a maximum of $2,000 per Covered Person per procedure for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem rate, up to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries.
- Alcoholic beverages.
- Personal or cleaning supplies.
- Meals.
- Over-the-counter dressings or medical supplies.
- Deposits.
- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, or movie rentals.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider.
- Taxi fares (not including limos or car services).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section.

Virtual Visits

Virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

Please Note: Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary.

Benefits under this section do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (*CMS* defined originating facilities).

Vision Examinations

The Plan pays Benefits for:

- vision screenings, which could be performed as part of an annual physical examination in a provider's office (vision screenings do not include refractive examinations to detect vision impairment); and
- one routine vision exam, including refraction, to detect vision impairment by a Network provider in the provider's office once per Plan year but not more frequently than each 365 days.

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis only for loss of hair resulting from chemotherapy, radiation therapy or similar treatment. Benefits are limited to one wig per Covered Person per lifetime.

SECTION 7 - CLINICAL PROGRAMS AND RESOURCES

What this section includes:
Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools;
- Disease and Condition Management Services; and
- Wellness Programs.

The State of Colorado believes in giving you the tools you need to be an educated health care consumer. To that end, the State of Colorado has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

NOTE:
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and the State of Colorado are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

Consumer Solutions and Self-Service Tools

Health Survey

You are invited to learn more about your health and wellness at **www.myuhc.com** and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way.

To find the health survey, log in to **www.myuhc.com**. After logging in, access your personalized *Health & Wellness* page. If you need any assistance with the online survey, please call the number on the back of your ID card.

Health Improvement Plan

You can start a Health Improvement Plan at any time. This plan is created just for you and includes information and interactive tools, plus online health coaching recommendations based on your profile.

Online coaching is available for:

- nutrition;
- exercise;
- weight management;
- stress;
- smoking cessation;
- diabetes; and
- heart health.

To help keep you on track with your Health Improvement Plan and online coaching, you'll also receive personalized messages and reminders – the State of Colorado's way of helping you meet your health and wellness goals.

NurseLine℠

NurseLine is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that the State of Colorado has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take Prescription Drugs safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

NurseLine gives you another convenient way to access health information. By calling the same toll-free number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine is available to you at no cost.

Note: If you have a medical emergency, call 911 instead of calling NurseLine.

Your child is running a fever and it's 1:00 AM. What do you do?
Call NurseLine toll-free, any time, 24 hours a day, seven days a week. You can count on NurseLine to help answer your health questions.

With NurseLine, you also have access to nurses online. To use this service, log onto **www.myuhc.com** and click "Live Nurse Chat" in the top menu bar. You'll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

Note: If you have a medical emergency, call 911 instead of logging onto **www.myuhc.com**.

Reminder Programs

To help you stay healthy, UnitedHealthcare may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

- mammograms for women;
- pediatric and adolescent immunizations;
- cervical cancer screenings for women between the ages of 20 and 64;
- comprehensive screenings for individuals with diabetes; and
- influenza/pneumonia immunizations for enrollees age 65 and older.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

Treatment Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Treatment Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- access to accurate, objective and relevant health care information;
- coaching by a nurse through decisions in your treatment and care;
- expectations of treatment; and
- information on high quality providers and programs.

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;
- prostate cancer;
- benign uterine conditions;
- breast cancer;

- coronary disease; and
- bariatric surgery.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

UnitedHealth Premium℠ Program

UnitedHealthcare designates Network Physicians and facilities as UnitedHealth Premium Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth Premium Program was designed to:

- help you make informed decisions on where to receive care;
- provide you with decision support resources; and
- give you access to Physicians and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria.

For details on the UnitedHealth Premium Program including how to locate a UnitedHealth Premium Physician or facility, log onto **www.myuhc.com** or call the toll-free number on your ID card.

Real Appeal Program

UnitedHealthcare provides the Real Appeal program which represents a practical solution for weight related conditions, with the goal of helping people at risk from obesity-related diseases and those who want to maintain a healthy lifestyle. This program is designed to support individuals over the age of 18. This intensive, multi-component behavioral intervention provides a 52-week virtual approach that includes one-on-one coaching and online group participation with supporting video content, delivered by a live virtual coach. The experience will be personalized for each individual through an introductory call.

This program will be individualized and may include, but not limited to, the following:

- Online support and self-help tools: Personal 1:1 coaching, group support sessions, including integrated telephonic support, and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change guidance and counseling by a specially trained health coach for clinical weight loss.

Participation is completely voluntary and without any additional charge or cost share. There are no Copays, Coinsurance, or Deductibles that need to be met when services are received as part of the Real Appeal program. If you would like to participate, or if you would like any additional information regarding the program, please call Real Appeal at 1-844-344-REAL (1-844-344-7325).

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With **www.myuhc.com** you can:

- research a health condition and treatment options to get ready for a discussion with your Physician;
- search for Network providers available in your Plan through the online provider directory;
- access all of the content and wellness topics from NurseLine including Live Nurse Chat 24 hours a day, seven days a week;
- complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com
If you have not already registered as a **www.myuhc.com** subscriber, simply go to **www.myuhc.com** and click on "Register Now." Have your UnitedHealthcare ID card handy. The enrollment process is quick and easy.

You must register on **www.myuhc.com** to access information relating directly to State of Colorado Employees.

Visit **www.myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Copays and Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or, print a temporary ID card.

Periodically, **www.myuhc.com** hosts live events with leading health care professionals. After viewing a presentation, you can chat online with the experts. Topics include:

- weight control;
- parenting;
- heart disease;

- relationships; and
- depression.

For details, or to participate in a live event, log onto **www.myuhc.com**.

Want to learn more about a condition or treatment?
Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease and Condition Management Services

Cancer Support Program

UnitedHealthcare provides a program that identifies, assesses, and supports members who have cancer. The program is designed to support you. This means that you may be called by a registered nurse who is a specialist in cancer and receive free educational information through the mail. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to advise you and to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer education on cancer, and self-care strategies and support in choosing treatment options.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card or call the program directly at (866) 936-6002.

For information regarding specific Benefits for cancer treatment within the Plan, see Section 6, *Additional Coverage Details* under the heading *Cancer Resource Services (CRS)*.

Bariatric Resource Services (BRS)

Bariatric Resource Services (BRS) is a surgical weight loss solution for those individual(s) who qualify clinically for bariatric surgery. Specialized nurses provide support through all stages of the weight loss surgery process. Our program is dedicated to providing support both before and after surgery. Nurses help with decision support in preparation for surgery, information and education important in the selection of a bariatric surgery program, and post-surgery and lifestyle management. Nurses can provide information on the nation's leading obesity surgery centers, known as Centers of Excellence. Access the Bariatric Resource Services Centers of Excellence programs at **1-888-936-7246** or visit www.myoptumhealthcomplexmedical.com

All authorization information and enrollment for bariatric surgery must be initiated through United Resource Networks (U.R.N.). Covered participants seeking coverage for bariatric surgery should notify us U.R.N. as soon as the possibility of a bariatric surgery procedure arises (and before the time a pre-surgical evaluation is performed) at a bariatric surgery center by calling U.R.N., at 1-888-936-7246 to enroll in the program.

Wellness Programs

Maternity Support Program

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the medical Plan, you can get valuable educational information, advice and comprehensive case management by calling the number on your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

- Enrollment by an OB nurse.
- Pre-conception health coaching.
- Written and online educational resources covering a wide range of topics.
- First and second trimester risk screenings.
- Identification and management of at- or high-risk conditions that may impact pregnancy.
- Pre-delivery consultation.
- Coordination with and referrals to other benefits and programs available under the medical plan.
- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.
- Post-partum depression screening.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on the back of your ID card.

As a program participant, you can always call your nurse with any questions or concerns you might have.

SECTION 8 - EXCLUSIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, *Additional Coverage Details*.

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the SPD says "this includes," or "including but not limiting to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Alternative Treatments

1. acupressure
2. aromatherapy;
3. hypnotism;
4. massage therapy;
5. rolfing (holistic tissue massage); and
6. art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complimentary 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 6, *Additional Coverage Details*.

Dental

1. dental care, except as identified under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*;

   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.

2. diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include:

   - extractions (including wisdom teeth);
   - restoration and replacement of teeth;
   - medical or surgical treatments of dental conditions; and
   - services to improve dental clinical outcomes;

   This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*.

3. 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 6, *Additional Coverage Details*.

4. dental braces (orthodontics) except as part of treatment for cleft lip or cleft palate as described in Section 6, *Additional Coverage Details*;

5. 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 6, *Additional Coverage Details* (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 as described above; and

   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 Plan, or for children's dental anesthesia as identified in Section 6, *Additional Coverage Details*.

6. treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (extra) teeth, except if part of a Congenital Anomaly such as cleft lip or cleft palate as described in Section 6, *Additional Coverage Details*.

Devices, Appliances and Prosthetics

1. devices used specifically as safety items or to affect performance in sports-related activities;

2. orthotic appliances and devices, except when all of the following are met:

   - prescribed by a Physician for a medical purpose; and
   - custom manufactured or custom fitted to an individual Covered Person.

Examples of excluded orthotic appliances and devices include but are not limited to, cranial bands, or any braces that can be obtained without a Physician's order. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.

3. the following items are excluded, even if prescribed by a Physician:

   - blood pressure cuff/monitor;
   - enuresis alarm;
   - non-wearable external defibrillator;
   - trusses;
   - ultrasonic nebulizers;

4. the repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect;

5. the replacement of lost or stolen prosthetic devices;

6. devices and computers to assist in communication and speech except for speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Prosthetic Devices* in Section 6, *Additional Coverage Details* ; and

7. oral appliances for snoring.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See Section 15, *Prescription Drugs*, for coverage details and exclusions.

1. Prescription Drugs for outpatient use that are filled by a prescription order or refill;

2. self-injectable medications (This exclusion does not apply to medications which, due to their characteristics, as determined by UnitedHealthcare, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting);

3. growth hormone therapy;

4. non-injectable medications given in a Physician's office except as required in an Emergency and consumed in the Physician's office; and

5. over the counter drugs and treatments.

6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 6, *Additional Coverage Details*.

7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

9. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

10. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year; and

11. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services and Unproven Services, unless the Plan has agreed to cover them as defined in Section 14, *Glossary*.

   This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition. 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 6, *Additional Coverage Details*.

Foot Care

1. routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*. Routine foot care services that are not covered include:

- cutting or removal of corns and calluses;
- nail trimming or cutting; and
- debriding (removal of dead skin or underlying tissue);

2. hygienic and preventive maintenance foot care. Examples include:

   - cleaning and soaking the feet;
   - applying skin creams in order to maintain skin tone; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot;

   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.

3. treatment of flat feet;

4. shoe inserts; and

5. arch supports.

Gender Dysphoria

Cosmetic Procedures, including the following:

- Abdominoplasty.
- Blepharoplasty.
- Breast enlargement, including augmentation mammoplasty and breast implants.
- Body contouring, such as lipoplasty.
- Brow lift.
- Calf implants.
- Cheek, chin, and nose implants.
- Injection of fillers or neurotoxins.
- Face lift, forehead lift, or neck tightening.
- Facial bone remodeling for facial feminizations.
- Hair removal.
- Hair transplantation.
- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.

- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple).
- Voice modification surgery.
- Voice lessons and voice therapy.

Medical Supplies and Equipment

1. tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment;

2. the repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect;

3. the replacement of lost or stolen Durable Medical Equipment; and

4. deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.

Mental Health/Substance-Related and Addictive Disorders

In addition to all other exclusions listed in this Section 8, *Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services*, *Neurobiological Disorders - Autism Spectrum Disorder Services* and/or *Substance-Related and Addictive Disorders Services* in Section 6, *Additional Coverage Details*.

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, , gambling disorder, and paraphilic disorders.

3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder and paraphilic disorder.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.

6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

7. Transitional Living services.

Nutrition

1. nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy;

2. nutritional counseling for either individuals or groups, except as identified under *Diabetes Services*, and except as defined under *Nutritional Counseling* in Section 6, *Additional Coverage Details*;

3. food of any kind. Foods that are not covered include:

   - foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
   - oral vitamins and minerals;
   - meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
   - other dietary and electrolyte supplements; and

4. health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. television;

2. telephone;

3. beauty/barber service;

4. guest service;

5. supplies, equipment and similar incidentals for personal comfort. Examples include:

   - air conditioners;
   - air purifiers and filters;
   - batteries and battery chargers;
   - dehumidifiers and humidifiers;
   - ergonomically correct chairs;
   - non-Hospital beds, comfort beds, motorized beds and mattresses;
   - breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement;
   - car seats;
   - chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners;

- electric scooters;
- exercise equipment and treadmills;
- hot tubs, Jacuzzis, saunas and whirlpools;
- medical alert systems;
- music devices;
- personal computers;
- pillows;
- power-operated vehicles;
- radios;
- strollers;
- safety equipment;
- vehicle modifications such as van lifts;
- video players; and
- home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

Physical Appearance

1. Cosmetic Procedures, as defined in Section 14, *Glossary*, are excluded from coverage. Examples include:

   - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
   - pharmacological regimens;
   - nutritional procedures or treatments;
   - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
   - hair removal or replacement by any means;
   - treatments for skin wrinkles or any treatment to improve the appearance of the skin;
   - treatment for spider veins;
   - skin abrasion procedures performed as a treatment for acne;
   - treatments for hair loss;
   - varicose vein treatment of the lower extremities, when it is considered cosmetic; and
   - replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure;
2. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments, and diversion or general motivation;

3. wigs regardless of the reason for the hair loss except for hair loss due to chemotherapy, radiation therapy or similar treatment; and

4. treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. biofeedback;

2. medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer);

3. 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;

4. speech therapy to treat stuttering, stammering, or other articulation disorders;

5. speech therapy, except:

   - as described under *Rehabilitation Services – Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details;*
   - therapy for the care and treatment of a Congenital Anomaly 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 6, *Additional Coverage Details;*

6. a procedure or surgery to remove fatty tissue such as abdominoplasty, thighplasty, brachioplasty, or mastopexy;

7. excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty), except following obesity surgery;

8. psychosurgery (lobotomy);

9. chelation therapy, except to treat heavy metal poisoning;

10. Manipulative Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, alignment of the vertebral column, such as asthma or allergies;

11. 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;

12. the following treatments for obesity:

    - non-surgical treatment, even if for morbid obesity; and
    - surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section 6, *Additional Coverage Details*;

13. medical and surgical treatment of hyperhidrosis (excessive sweating);

14. upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumor or cancer Orthognathic surgery (procedure to correct underbite or overbite), jaw alignment and treatment for the temporomandibular joint, except as treatment of obstructive sleep apnea;

15. Habilitative services for maintenance/preventive treatment;

16. services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered medical or dental in nature; and

17. breast reduction surgery that is determined to be a Cosmetic Procedure.

    This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

Providers

Services:

1. performed by a provider who is a family member by birth or marriage, including your Spouse/Domestic Partner, brother, sister, parent or child;

2. a provider may perform on himself or herself;

3. performed by a provider with your same legal residence;

4. ordered or delivered by a Christian Science practitioner;

5. performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license;

6. provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider;

7. which are self-directed to a free-standing or Hospital-based diagnostic facility; and

8. ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care:

   - prior to ordering the service; or
   - after the service is received.

   This exclusion does not apply to mammography testing.

Reproduction

1. 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 as described in *Infertility Services* in Section 6: *Additional Coverage Details* for more details.

2. storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue);

3. surrogate parenting, donor eggs, donor sperm and host uterus;

4. the reversal of voluntary sterilization;

5. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;

6. elective surgical, non-surgical or drug induced Pregnancy termination, except when necessary to prevent death of either a pregnant woman or her unborn child under circumstances where every reasonable effort is made to preserve the life of each;

   This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).

7. oral contraceptive supplies and services (these are covered under the Prescription Drug Plan as described in Section 15, *Prescription Drugs);*

8. services provided by a doula (labor aide); and

9. parenting, pre-natal or birthing classes.

Services Provided under Another Plan

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB)*;

2. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;

3. while on active military duty; and

4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

Transplants

1. health services for organ and tissue transplants, except as identified under *Transplantation Services* in Section 6*, Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;

2. mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available);

3. transplants that are not performed at a Designated Provider (this exclusion does not apply to cornea transplants); and

4. donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

Travel

1. health services provided in a foreign country, unless required as Emergency Health Services; and

2. travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 6, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services received from a Designated Provider may be reimbursed at the Plan's discretion.

Types of Care

1. Custodial Care as defined in Section 14, *Glossary* or maintenance care;

2. Domiciliary Care, as defined in Section 14, *Glossary;*

3. multi-disciplinary pain management programs provided on an inpatient basis;

4. Private Duty Nursing;

5. 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 6, *Additional Coverage Details*;

6. rest cures;

7. services of personal care attendants; and

8. work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. implantable lenses used only to correct a refractive error (such as Intacs corneal implants);

2. purchase cost and associated fitting charges for eyeglasses or contact lenses;

3. 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; or
   - for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid;

   The Plan will not pay for 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 in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions;

4. eye exercise or vision therapy; and

5. surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. autopsies and other coroner services and transportation services for a corpse;

2. charges for:

   - missed appointments;
   - room or facility reservations;
   - completion of claim forms; or
   - record processing.

3. charges prohibited by federal anti-kickback or self-referral statutes;

4. diagnostic tests that are:

   - delivered in other than a Physician's office or health care facility; and
   - self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests;

5. expenses for health services and supplies:

   - that do not meet the definition of a Covered Health Service in Section 14, *Glossary*. This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement;
   - that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force 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 a non-war zone;
- that are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends;
- 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 this Benefit Plan; or
- that exceed Eligible Expenses or any specified limitation in this SPD;
- for which a non-Network provider waives the Copay, Annual Deductible or Coinsurance amounts;

6. foreign language and sign language services;

7. long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products; and

8. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

   - required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption. This exclusion does not apply to treatments for Injuries resulting from a Covered Persons' casual or nonprofessional participation in motorcycling, snowmobiling, off-highway vehicle riding, skiing or snowboarding;
   - as a result of incarceration;
   - conducted for purposes of medical research;
   - related to judicial or administrative proceedings or orders, except as described under *Substance-Related and Addictive Disorders Services* in Section 6, *Additional Coverage Details*; or
   - required to obtain or maintain a license of any type.

9. 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; and

10. consultation provided by a Provider by telephone or facsimile.

SECTION 9 - CLAIMS PROCEDURES AND GRIEVANCE

What this section includes:
- How Network and non-Network claims work; and
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Copay or Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Copay or Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

Prescription Drug Benefit Claims

If you wish to receive reimbursement for a prescription, you may submit a post-service claim as described in this section if:

- you are asked to pay the full cost of the Prescription Drug when you fill it and you believe that the Plan should have paid for it; or
- you pay a Copay and you believe that the amount of the Copay was incorrect.

If a pharmacy (retail or mail order) fails to fill a prescription that you have presented and you believe that it is a Covered Health Service, you may submit a pre-service request for Benefits as described in this section.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the toll-free number on your ID card or contacting Human Resources. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- your name and address;
- the patient's name, age and relationship to the Employee;

- the number as shown on your ID card;
- the name, address and tax identification number of the provider of the service(s);
- a diagnosis from the Physician;
- the date of service;
- an itemized bill from the provider that includes:
  - the Current Procedural Terminology (CPT) codes;
  - a description of, and the charge for, each service;
  - the date the Sickness or Injury began; and
  - a statement indicating either that you are, or you are not, enrolled for coverage under any other group health plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card. When filing a claim for outpatient Prescription Drug Product Benefits, submit your claim to the pharmacy benefit manager claims address noted on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

Payment of Benefits

When you assign your Benefits under the Plan to a non-Network provider with UnitedHealthcare's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

To be recognized as a valid assignment of Benefits under the Plan, the assignment must reflect the Covered Person's agreement that the non-Network provider will be entitled to all the Covered Person's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person's Benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form does not comply with this requirement, but directs that your benefit payment should be made directly to the provider, UnitedHealthcare may in its discretion make payment of the benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim. If Benefits are assigned or payment to a [3]non-Network provider is made, The State of Colorado reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes The State of Colorado (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan) pursuant to *Refund of Overpayments* in Section 10, *Coordination of Benefits*.

UnitedHealthcare will pay Benefits to you unless:

- The provider submits a claim form to UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider.
- You make a written request for the non-Network provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your provider purports to have assigned Benefits to that third party.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 14, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Claims
All claim forms must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Grievance

A grievance is any complaint expressing dissatisfaction with UnitedHealthcare's products, services, operations and/or protocol from a customer, state insurance department or other

party on behalf of an individual. Grievance issues are usually adverse service experiences including, but not limited to:

- accessibility of care/services;
- quality of care/services;
- physician demeanor and/or behavior;
- adverse experience;
- Benefit coverage;
- involuntary disenrollment;
- continued dissatisfaction after the appeal process is exhausted; or
- any other aspect of UnitedHealthcare's service.

UnitedHealthcare provides all individuals with a copy of their "Rights and Responsibilities" in their Plan information. All individuals and/or their representatives have the right to lodge a grievance, verbally or in writing. A grievance may be received by any department, such as Personal Health Support (PHS), provider relations and customer care.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing. This communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of medical service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

You or your enrolled Dependent may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, UT 84130-0432

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- urgent care request for Benefits;
- pre-service request for Benefits;
- post-service claim; or
- concurrent claim.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. UnitedHealthcare will review all claims in accordance with the rules established by the *U.S. Department of Labor*. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- as otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision.

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Person's name, address, and insurance ID number;
- your designated representative's name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- a standard external review; and
- an expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- a preliminary review by UnitedHealthcare of the request;
- a referral of the request by UnitedHealthcare to the IRO; and
- a decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided;
- has exhausted the applicable internal appeals process; and

- has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.
UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- all relevant medical records;
- all other documents relied upon by UnitedHealthcare; and
- all other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- an adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the

individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or

- a final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.
You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care request for Benefits- a request for Benefits provided in connection with Urgent Care services, as defined in Section 14, *Glossary*;

- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed request for Benefits to UnitedHealthcare within:	**48 hours** after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	**72 hours**
If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care request for Benefits.

Pre-Service and Post-Service Claim Appeals

A first appeal is the initial appeal request for Benefit coverage after an adverse determination has been made. First-appeal determinations may authorize the requested care/service(s) or uphold the initial adverse determination and are conducted within 45 days after receipt of the claimant's first appeal request.

A second appeal is a request for benefit coverage made subsequent to a first appeal determination that upheld the original adverse determination. Second-appeal determinations may authorize the requested care/service(s) or uphold the previous first appeal and initial adverse determinations. Second appeals are conducted within 7 days after completion of a review meeting.

We provide a written notification of the appeal determination within one day of the determination and must mail the determination to the attending physician or designated

representative, the participant (if not hospitalized) or designated representative and, as applicable, the facility's billing or business office and any other ancillary professional.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days**
If UnitedHealthcare denies your initial request for Benefits, they must notify you of the denial:	
■ if the initial request for Benefits is complete, within:	**15 days**
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal the request for Benefits denial no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

*UnitedHealthcare may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**

Post-Service Claims	
Type of Claim or Appeal	**Timing**
UnitedHealthcare must notify you of the denial:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against the State of Colorado or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against the State of Colorado or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against the State of Colorado or the Claims Administrator.

You cannot bring any legal action against the State of Colorado or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against the State of Colorado or the Claims Administrator you must do so within three years of the date

you are notified of our final decision on your appeal or you lose any rights to bring such an action against the State of Colorado or the Claims Administrator.

SECTION 10 - COORDINATION OF BENEFITS (COB)

Warning: If you are insured under a separate group medical insurance policy, you may be subject to coordination of benefits as explained in this booklet.

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans;
- How coverage is affected if you become eligible for Medicare; and
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you or your Dependent are covered by more than one health benefits plan, including any one of the following:

- another employer sponsored health benefits plan;
- a medical component of a group long-term care plan, such as skilled nursing care;
- no-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit including PERA.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term, "allowable expense," is further explained below.

Don't forget to update your Dependents' Medical Coverage Information
When a claim is received and information is required regarding other coverage your Dependents might have, the claim, regardless of the dollar amount, will not be paid until you respond to UnitedHealthcare with updated COB information.

Just log on to **www.myuhc.com** or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

Order of Benefit Determination Rules

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;
- your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - the parents are married or living together whether or not they have ever been married and not legally separated; or
  - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;
- if two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - the parent with custody of the child; then
  - the Spouse/Domestic Partner of the parent with custody of the child; then
  - the parent not having custody of the child; then
  - the Spouse/Domestic Partner of the parent not having custody of the child;
- plans for active employees pay before plans covering laid-off or retired employees;
- the plan that has covered the individual claimant the longest will pay first; The expenses must be covered in part under at least one of the plans; and
- finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan – Examples
1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as an Employee under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.
2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- the Plan determines the amount it would have paid had it been the only plan involved.
- the Plan pays the entire difference between the allowable expense and the amount paid by the primary plan – as long as this amount is not more than the Plan would have paid had it been the only plan involved.

You will be responsible for any Copay, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the total allowable expense. See the textbox below for the definition of allowable expense.

Determining the Allowable Expense When This Plan is Secondary

What is an allowable expense?
For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled *Determining the Allowable Expense When This Plan is Secondary to Medicare*.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses/Domestic Partners age 65 or older; and
- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program (as opposed to a provider who does not accept assignment of Medicare benefits), Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, for administrative convenience UnitedHealthcare will treat the provider's billed charges for covered services as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan Administrator may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

The Plan Administrator does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If you do not provide UnitedHealthcare

the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- the Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
- all or some of the payment the Plan made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future benefits that are payable in connection with services provided to persons under other plans for which UnitedHealthcare makes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right

to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 11 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this *Subrogation and Reimbursement* section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation – Example
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement – Example
Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the participant, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the plan year Deductible.
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the plan year.

- Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.
- If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:
- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the plan year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end; and
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date coverage ends.

When your coverage ends, the State of Colorado will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

Your coverage under the Plan will end on the earliest of:

- the last day of the month your employment with the State ends;
- the date the Plan ends;
- the last day of the month you stop making the required contributions;
- the last day of the month you are no longer an Eligible Employee under CRS 24-50-603(7);
- the last day of the month UnitedHealthcare receives written notice from the State of Colorado to end your coverage, or the date requested in the notice, if later; or
- the last day of the month you retire or are pensioned under the Plan, unless you are rehired and work at least one day per month.

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the last day of the month you stop making the required contributions;
- the last day of the month UnitedHealthcare receives written notice from the State of Colorado to end coverage for you or a Dependent, or the date requested in the notice, if later; or
- the last day of the month your Dependents no longer qualify as Dependents under this Plan.

Other Events Ending Your Coverage

The Plan will provide at least thirty days' prior written notice to you that your coverage will end on the date identified in the notice if you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.

Note: If UnitedHealthcare and The State of Colorado find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact The State of Colorado has the right to demand that you pay back all The State of Colorado paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Child

An unmarried child who is 26 years of age or older, medically certified as disabled prior to the age of 26, and financially dependent on the parent, can be covered under the terms of this Plan. A completed Mentally or Physically Disabled Dependent Form must be submitted for the disabled Dependent to be eligible for, or to continue, coverage. First proof of incapacity must be given to the Plan (at your expense) within 31 days of the child's 26th birthday.

Completion of the Mentally or Physically Disabled Dependent Form does not guarantee continued coverage unless such request is approved by the Plan. The Employee and the disabled Dependent's Physician must complete this form and submit it to UnitedHealthcare at the address on the form. UnitedHealthcare will approve or deny your request and send their decision to the Employee and to the State of Colorado.

You may obtain a Mentally or Physically Disabled Dependent Form from the Benefits website at www.colorado.gov/dhr/benefits.

Extended Medical Care Benefits on Termination of Coverage

If you or your Dependent is confined as a Hospital inpatient when coverage ends, Benefits will be payable for the Injury or Sickness until you or your Dependent is discharged from the Hospital.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined in Section 14, *Glossary*.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if the State of Colorado is subject to the provisions of COBRA.

Continuation Coverage under COBRA

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- an Employee;

- an Employee's enrolled Dependent, including with respect to the Employee's children, a child born to or placed for adoption with the Employee during a period of continuation coverage under federal law, step-child, Child of a civil union partner, child of a domestic partner (as long as the Employee and parent are in a committed relationship); or a Child for whom the Employee has a court order that specifies responsibility for health insurance coverage (legal custody or allocation of parental responsibility); or
- an Employee's former Spouse, Common Law Spouse, Civil Union Partner or Domestic Partner.

Important Notice:

There may be other coverage options for you and your family. You may be able to buy coverage through the Health Insurance Marketplace (Exchange). In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit you eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment within 30 days.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1]	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible Dependent (e.g., reaches the maximum age limit)	N/A	N/A	36 months

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
You become entitled to Medicare	N/A	See table below	See table below

[1]Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

[2]This is a qualifying event for any retired Employee and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

[3]From the date of the Employee's death if the Employee dies during the continuation coverage.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

* Your work hours are reduced or your employment is terminated.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Employee and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- during Open Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2*, Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide Human Resources with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 16, *Important Administrative Information: ERISA*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If an Employee qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Employee must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Employee will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

When COBRA Ends

COBRA coverage will end, before the maximum continuation period, on the earliest of the following dates:

- the date, after electing continuation coverage, that coverage is first obtained under any other group health plan;
- the date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare;
- the date coverage ends for failure to make the first required premium payment (premium is not paid within 45 days);
- the date coverage ends for failure to make any other monthly premium payment (premium is not paid within 30 days of its due date);
- the date the entire Plan ends; or

- the date coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

Uniformed Services Employment and Reemployment Rights Act

An Employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Employee and the Employee's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on an Employee's behalf. If an Employee's Military Service is for a period of time less than 31 days, the Employee may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

An Employee may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Employee's absence from work; or
- the day after the date on which the Employee fails to apply for, or return to, a position of employment.

Regardless of whether an Employee continues health coverage, if the Employee returns to a position of employment, the Employee's health coverage and that of the Employee's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an Employee or the Employee's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children;
- Your relationship with UnitedHealthcare and the State of Colorado;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- The future of the Plan; and
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare and the State of Colorado

In order to make choices about your health care coverage and treatment, the State of Colorado believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit Plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- The State of Colorado and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions;
- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this SPD); and

- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

The State of Colorado and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. The State of Colorado and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. The State of Colorado and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between the State of Colorado, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not the State of Colorado's agents or employees, nor are they agents or employees of UnitedHealthcare. The State of Colorado and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees agents or employees of Network providers.

The State of Colorado and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, the State of Colorado and UnitedHealthcare arranges for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not the State of Colorado's employees nor are they employees of UnitedHealthcare. The State of Colorado and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. The State of Colorado and UnitedHealthcare are not liable for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

The State of Colorado and the Plan Administrator are solely responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);
- the timely payment of Benefits; and
- notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own provider;

- are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your provider, the cost of any non-Covered Health Service;
- must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and
- must decide with your provider what care you should receive.

Interpretation of Benefits

The State of Colorado and UnitedHealthcare have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

The State of Colorado and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, the State of Colorado may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that the State of Colorado does so in any particular case shall not in any way be deemed to require the State of Colorado to do so in other similar cases.

Information and Records

The State of Colorado and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. The State of Colorado and UnitedHealthcare may request additional information from you to decide your claim for Benefits. The State of Colorado and UnitedHealthcare will keep this information confidential. The State of Colorado and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the State of Colorado and UnitedHealthcare with all information or copies of records relating to the services provided to you. The State of Colorado and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Employee's enrollment form. The State of Colorado and UnitedHealthcare agree that such information and records will be considered confidential.

The State of Colorado and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as the State of Colorado is required to do by law or regulation. During and after the term of the Plan, the State of Colorado and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements the State of Colorado recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or
- a practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons, enhanced Benefits, or other incentives to encourage you to participate in various wellness programs or certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to participate is yours alone but State of Colorado recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on your ID card if you have any questions. Additional information may be found in Section 7, *Clinical Programs and Resources*.

Rebates and Other Payments

The State of Colorado and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. The State of Colorado and UnitedHealthcare may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Copays or Coinsurance.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Future of the Plan

Although the State of Colorado expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The State of Colorado decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or Employee Retirement Income Security Act of 1974 (ERISA), or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the State of Colorado does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and State of Colorado decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the State of Colorado and others as may be required by any applicable law.

Plan Document

This Summary Plan Description (SPD) represents an overview of your Benefits.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UnitedHealthcare accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in UnitedHealthcare's Network through UnitedHealthcare's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

UnitedHealthcare may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Care Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, UnitedHealthcare will use a comparable methodology(ies). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable methodology.

SECTION 14 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Addendum – any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

Advisory Committee on Immunization Practices (ACIP) – the advisory committee on immunization practices to the Centers for Disease Control and Prevention in the Federal Department of Health and Human Services, or any successor entity.

Alternate Facility – a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- surgical services;
- Emergency Health Services; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance-Related and Addictive Disorders Services on an outpatient basis or inpatient basis.

Amendment – any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) – the amount you must pay for Covered Health Services in a plan year before the Plan will begin paying Benefits in that plan year. The Deductible is shown in the first table in Section 5, *Plan Highlights*.

Any amount you pay for medical expenses in the last three months of the previous plan year, that is applied to the previous Deductible, will be carried over and applied to the current Deductible. This carry-over feature applies only to the individual Deductible.

Applied Behavioral Analysis – includes the use of behavioral analytic methods and research findings to change socially important behaviors in meaningful ways.

A Recommendation – a recommendation adopted by the Task Force that strongly recommends that clinicians provide a preventive health care service because the Task Force found there is a high certainty that the net benefit of the preventive health care service is substantial.

Autism Spectrum Disorders - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Bariatric Resource Services (BRS) – a program administered by UnitedHealthcare or its affiliates made available to you by the State of Colorado. The BRS program provides:

- specialized clinical consulting services to Employees and enrolled Dependents to educate on obesity treatment options; and
- access to specialized Network facilities and Physicians for obesity surgery services.

Benefits – Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Biologically Based Mental Illnesses – the following conditions as described in the current *Diagnostic and Statistical Manual of the American Psychiatric Association:* schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder and panic disorder.

Body Mass Index (BMI) – a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

BMI – see Body Mass Index (BMI).

B Recommendation – a recommendation adopted by the Task Force that recommends that clinicians provide a preventive health service because the Task Force found there is a high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.

Cancer Resource Services (CRS) – a program administered by UnitedHealthcare or its affiliates made available to you by the State of Colorado. The CRS program provides:

- specialized consulting services, on a limited basis, to Employees and enrolled Dependents with cancer;
- access to cancer centers with expertise in treating the most rare or complex cancers; and
- education to help patients understand their cancer and make informed decisions about their care and course of treatment.

CHD – see Congenital Heart Disease (CHD).

Child Health Supervision Services – those preventive services and immunizations required to be provided to Dependent children up to age 13 as follows:

- 0-12 months: one newborn home visit during the first week of life if the newborn is released from the Hospital less than 48 hours following delivery; unlimited well-child visits including PKU tests;
- 13-35 months: three well-child visits;
- 3-6 years: four well-child visits;
- 7-12 years: four well-child visits;
- 0-12 years: immunizations. Immunization deficient children are not bound by "recommended ages."

Civil Union - means a relationship established by two eligible persons in accordance with Colorado law for the purpose of entitling them to receive the benefits and protections and be subject to the responsibilities of spouses. A civil union will be legally recognized if:

- The two parties to the civil union satisfy all of the following criteria:
  - Both parties are adults, regardless of the gender of either party;
  - Neither party is a party to another civil union;
  - Neither party is married to another person;
  - The parties are not related to each other as an ancestor, descendant, brother, sister, uncle, aunt, niece, or nephew, whether the relationship is by the half or the whole blood; and
  - Neither party is under 18 years of age or 18 years of age or older and under guardianship, unless the party under guardianship has the written consent of his or her guardian.
- The civil union is certified and registered with a county clerk and recorder in the State of Colorado.

Claims Administrator – UnitedHealthcare (also known as United HealthCare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial – a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA – see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance – the percentage of Eligible Expenses you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Congenital Anomaly – a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD) – any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- be passed from a parent to a child (inherited);
- develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy; or
- have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – a federal and state law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Copayment (or Copay) – the set dollar amount you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Cosmetic Procedures – procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function like breathing.

Cost-Effective – the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services – those health services, including services, supplies or Pharmaceutical Products, which the State of Colorado determines to be:

- provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, Substance-Related and Addictive Disorders, or their symptoms;
- consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below;
- not provided for the convenience of the Covered Person, Physician, facility or any other person;
- included in Sections 5 and 6, Plan Highlights and Additional Coverage Details;
- provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*; and
- not identified in Section 8, *Exclusions*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" have the following meanings:

- "scientific evidence" means the results of controlled Clinical Trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community; and

- "prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

The Claims Administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on **www.myuhc.com** or by calling the number on the back of your ID card. This information is available to Physicians and other health care professionals on UnitedHealthcareOnline.

Covered Person – either the Employee or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

CRS – see Cancer Resource Services (CRS).

Custodial Care – services that do not require special skills or training and that:

- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible – see Annual Deductible.

Dependent – an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting the Claims Administrator at **www.myuhc.com** or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

DME – see Durable Medical Equipment (DME).

Domestic Partner – an individual of the same sex with whom you have established a domestic partnership as described below.

A domestic partnership is a relationship between an Employee and one other person of the same sex. Pursuant to CRS 24-50-603(6.5), both persons must:

- not be so closely related that marriage would otherwise be prohibited;
- not be legally married to, or the Domestic Partner of, another person under either statutory or common law;
- be at least 18 years old; and
- have shared an exclusive, committed relationship for at least one year with the intent for the relationship to last indefinitely.

The Employee and Domestic Partner must jointly sign an affidavit of domestic partnership available on the benefits website at: http://colorado.gov/dhr/benefits.

Domiciliary Care – living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) – medical equipment that is all of the following:

- used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- not disposable;
- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

Early Intervention Services (EIS) – services as defined by the Colorado Department of Human Services in accordance with part C of the Individuals with Disabilities Education Act (IDEA) that are authorized through an eligible child's Individualized Family Service Plan (IFSP). EIS are intended for children from birth up to age three, who have significant delays

in development or have a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development as defined by State law.

The following are not considered EIS:

- respite care;
- non-emergency medical transportation;
- service coordination, as defined by federal law; and
- assistive technology.

Eligible Expenses – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UnitedHealthcare as stated below and as detailed in Section 3, *How the Plan Works*.

Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- as indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS);
- as reported by generally recognized professionals or publications;
- as used for Medicare; or
- as determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accepts.

Emergency – a sudden and, at the time, unexpected onset of a health condition that a prudent lay person would assume requires immediate attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

Emergency Health Services – with respect to an Emergency, both of the following:

- A medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd)* that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).*

Employee – an Employee of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. An Employee must live and/or work in the United States.

Employer – The State of Colorado.

EOB – see Explanation of Benefits (EOB).

Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational); or
- the subject of an ongoing Clinical Trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described under Section 6, *Additional Coverage Details,* and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) – a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

Gender Dysphoria - A disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*:

- Diagnostic criteria for adults and adolescents:
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
    - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
    - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
    - A strong desire for the primary and/or secondary sex characteristics of the other gender.
    - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
    - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
    - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
  - The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.
- Diagnostic criteria for children:
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
    - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
    - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
    - A strong preference for cross-gender roles in make-believe play or fantasy play.
    - A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
    - A strong preference for playmates of the other gender.
    - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
    - A strong dislike of one's sexual anatomy.
    - A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

- The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

Health Statement(s) – a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

Home Health Agency – a program or organization authorized by law to provide health care services in the home.

Hospital – an institution, operated as required by law, which is:

- primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, Substance-Related and Addictive Disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; and
- has 24 hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a Skilled Nursing Facility, convalescent home or similar institution.

Injury – bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility – a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides physical therapy, occupational therapy and/or speech therapy on an inpatient basis, as authorized by law.

Inpatient Stay – an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) – outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI).*

Intensive Outpatient Treatment – a structured outpatient Mental Health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care – skilled nursing care that is provided or needed either:

- fewer than seven days each week; or
- fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Kidney Resource Services (KRS) – a program administered by UnitedHealthcare or its affiliates made available to you by the State of Colorado. The KRS program provides:

- specialized consulting services to Employees and enrolled Dependents with ESRD or chronic kidney disease;
- access to dialysis centers with expertise in treating kidney disease; and
- guidance for the patient on the prescribed plan of care.

Manipulative Treatment – the therapeutic application of chiropractic and/or manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medicaid – a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medicare – Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Administrator – the organization or individual designated by the State of Colorado who provides or arranges Mental Health and Substance-Related and Addictive Disorders Services under the Plan.

Mental Illness – those mental health or psychiatric diagnostic categories listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Network – when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - description of how Benefits are paid for Covered Health Services provided by Network provider. Refer to Section 5, *Plan Highlights* for details about how Network Benefits apply.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year.

Non-Network Benefits - description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 5, *Plan Highlights* for details about how Non-Network Benefits apply.

Open Enrollment – the period of time, determined by the State of Colorado, during which eligible Employees may enroll themselves and their Dependents under the Plan. The State of Colorado determines the period of time that is the Open Enrollment period.

Out-of-Pocket Maximum – the maximum amount you pay every plan year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment – a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Personal Health Support – programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Personal Health Support Nurse – the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Pharmaceutical Product(s) – U.S. Food and Drug Administration (FDA)-approved prescription medications or products administered in connection with a Covered Health Service by a Physician.

Physician – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan – The State of Colorado Employee group health plan.

Plan Administrator – The State of Colorado or its designee.

Plan Sponsor – The State of Colorado.

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with Pregnancy.

Primary Physician – a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing – nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or a home setting when any of the following are true:

- no skilled services are identified;
- skilled nursing resources are available in the facility;
- the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose; or
- the service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.

Reconstructive Procedure – a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment – treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.

- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program – a program in which UnitedHealthcare may obtain a discount to a non-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider. When this happens, you may experience lower out-of-pocket amounts. Plan coinsurance and deductibles would still apply to the reduced charge. Sometimes Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by UnitedHealthcare. In this case the non-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness, or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness, or substance-related and addictive disorder.

Skilled Care – skilled nursing, teaching, and rehabilitation services when:

- they are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- a Physician orders them;
- they are not delivered for the purpose of assisting with activities of daily living, including, but not limited to, dressing, feeding, bathing or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

Skilled Nursing Facility – a nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spouse – an individual to whom you are legally married as recognized under federal tax law or a Common Law Spouse who is at least 18 years of age, with whom the Employee cohabitates and who represent themselves to the community as married to each other and there is no legal impediment to the marriage.

Substance-Related and Addictive Disorders Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Task Force – 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.

Transitional Living - Mental Health Services/Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

UnitedHealth Premium Program – a program that identifies network Physicians or facilities that have been designated as a UnitedHealth Premium Program Physician or facility for certain medical conditions.

To be designated as a UnitedHealth Premium provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium Program Physician or facility.

Unproven Services – health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.myuhc.com**.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care – care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center – a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

SECTION 15 - PRESCRIPTION DRUGS

What this section includes:

- Benefits available for Prescription Drugs;
- How to utilize the retail and mail order service for obtaining Prescription Drugs;
- Any benefit limitations and exclusions that exist for Prescription Drugs; and
- Definitions of terms used throughout this section related to the Prescription Drug Plan.

Prescription Drug Coverage Highlights

The table below provides an overview of the Plan's Prescription Drug coverage. It includes Copay amounts that apply when you have a prescription filled at a Pharmacy. For detailed descriptions of your Benefits, refer to *Retail* and *Mail Order* in this section.

You are responsible for paying any amounts due to the pharmacy at the time you receive your prescription drugs.

Covered Health Services[1, 2,3]	**Percentage of Prescription Drug Cost Payable by the Plan:**	**Percentage of Out-of-Network Reimbursement Rate Payable by the Plan:**
	Network	**Non-Network**
Retail - up to a 31-day supply	100% after you pay a:	
■ Tier 1	$10 Copay	$10 Copay
■ Tier 2	$30 Copay	$30 Copay
■ Tier 3	$50 Copay	$50 Copay
Retail Specialty Prescription Drugs - up to a 31-day supply	80% of the Prescription Drug Charge. However, you will not pay more than $100 per Prescription Order or Refill.	80% of the Out-of-Network Reimbursement Rate. However, you will not pay more than $100 per Prescription Order or Refill.
Mail Order - up to a 90-day supply	100% after you pay a:	
■ Tier 1	$20 Copay	Not Covered
■ Tier 2	$60 Copay	Not Covered

Covered Health Services[1, 2,3]	Percentage of Prescription Drug Cost Payable by the Plan:	Percentage of Out-of-Network Reimbursement Rate Payable by the Plan:
	Network	**Non-Network**
■ Tier 3	$100 Copay	Not Covered
Mail Order Specialty Prescription Drugs - up to a 90-day supply	80% of the Prescription Drug Charge. However, you will not pay more than $100 per Prescription Order or Refill.	Not Covered

[1]You must obtain prior authorization from UnitedHealthcare to receive full Benefits for certain Prescription Drugs. Otherwise, you may pay more out-of-pocket. See *Prior Authorization Requirements* in this section for details.

[2]You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

[3]Tier-1, Tier-2 and Tier-3 Copays apply toward the Out-of-Pocket Maximum in Section 5 – *Plan Highlights*. Ancillary charges do not count towards the Annual Deductible or Out-of-Pocket Maximum in Section 5 – *Plan Highlights*.

Note: The Coordination of Benefits provision described in Section 10, *Coordination of Benefits (COB)* applies to covered Prescription Drugs as described in this section. Benefits for Prescription Drugs will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in this SPD.

Identification Card (ID Card) – Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by the Claims Administrator during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy.

You may seek reimbursement from the Plan as described in Section 9, *Claims Procedures*, under the heading, *How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Copayment and/or Coinsurance, and any deductible that applies.

Submit your claim to:

Optum Rx
P.O. Box 29077
Hot Springs, AR 71903

Benefit Levels

Benefits are available for outpatient Prescription Drugs that are considered Covered Health Services.

The Plan pays Benefits at different levels for Tier 1, Tier 2 and Tier 3 Prescription Drugs. All Prescription Drugs covered by the Plan are categorized into these three categories on the Preferred Drug List (PDL). The category status of a Prescription Drug can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List Management Committee's periodic category decisions. When that occurs, you may pay more or less for a Prescription Drug, depending on its category assignment. Since the PDL may change periodically, you can visit **www.myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card for the most current information.

Each category is assigned a Copay, which is the amount you pay when you visit the pharmacy or order your medications through mail order. Your Copay will also depend on whether or not you visit the pharmacy or use the mail order service - see the table shown at the beginning of this section for further details. Here's how the categories work:

- Tier 1 is your lowest Copay option. For the lowest out-of-pocket expense, you should consider Tier 1 drugs if you and your Physician decide they are appropriate for your treatment.
- Tier 2 drugs are your middle Copay option. Tier 2 drugs are Brand-name Drugs that are on the Preferred Drug List. Consider a Tier 2 drug if no Tier 1 drug is available to treat your condition.
- Tier 3 drugs are your highest Copay option. Tier 3 drugs are Brand-name Drugs that are not on the Preferred Drug List. Tier 3 drugs are usually more costly. Sometimes there are Tier 1 and Tier 2 alternatives.

Diabetic drugs and supplies are covered at the Tier 1 level. Supplies include insulin syringes, pen needles, blood glucose test strips and lancets. You can visit **www.myuhc.com** to view the Diabetes Therapy Preferred Drug List or call UnitedHealthcare at the toll-free number on your ID card for the most current information.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following:

- The applicable Copayment and/or Coinsurance.
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product.
- The Prescription Drug Cost for that Prescription Drug Product.

For Prescription Drugs from a mail order Network Pharmacy, you are responsible for paying the lower of:

- the applicable Copay and/or Coinsurance; or
- the Prescription Drug Cost for that particular Prescription Drug.

Retail

The Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting UnitedHealthcare at the toll-free number on your ID card or by logging onto **www.myuhc.com**.

To obtain your prescription from a retail pharmacy, simply present your ID card and pay the Copay and/or Coinsurance. The Plan pays Benefits for certain covered Prescription Drugs:

- as written by a Physician;
- up to a consecutive 31-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits;:
- when a Prescription Drug is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copay and/or Coinsurance that applies will reflect the number of days dispensed; and
- a one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay a Copay for each cycle supplied.

Note: Pharmacy Benefits apply only if your prescription is for a Covered Health Service, and not for Experimental or Investigational, or Unproven Services. Otherwise, you are responsible for paying 100% of the cost.

Mail Order

The mail order service may allow you to purchase up to a 90-day supply of a covered maintenance drug through the Prescription Solutions Mail Order Pharmacy. Maintenance drugs help in the treatment of chronic illnesses, such as heart conditions, allergies, high blood pressure, and arthritis.

To use the mail order service, choose the method that works best for you:

1. Call (**800) 562-6223**, 24 hours a day, 7 days a week. Keep your medication name and dosage handy. You'll also need your Physician's name and phone number. Prescription Solutions will call your Physician to get a new prescription.
2. Mail your original prescription, payment and completed order form to the address listed on the form. Write your date of birth on each prescription.
3. Your Physician can call in your prescription to (**800) 791-7658** or fax it to (**800) 491-7997**. Faxed prescriptions will only be accepted from a Physician's office.

Your medication, plus instructions for obtaining refills, will arrive by mail in approximately 5 – 10 business days after your order is received. If you need an order form or have any questions, you can reach UnitedHealthcare at the toll-free number on your ID card. Mail-order forms are also available at the State benefits website: www.colorado.gov/dhr/benefits.

The Plan pays mail order Benefits for certain covered Prescription Drugs:

- as written by a Physician; and
- up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.

Note: To maximize your benefit, ask your Physician to write your prescription order or refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copay and/or Coinsurance for any prescription order or refill if you use the mail order service, regardless of the number of days' supply that is written on the order or refill. Be sure your Physician writes your mail order or refill for a 90-day supply, not a 30-day supply with three refills.

Benefits for Preventive Care Medications

Benefits under the Prescription Drug Plan include those for Preventive Care Medications as defined under *Glossary – Prescription Drugs*. You may determine whether a drug is a Preventive Care Medication through the internet at **www.myuhc.com** or by calling UnitedHealthcare at the toll-free telephone number on your ID card.

Ancillary Charge

An Ancillary Charge will apply when a covered Prescription Drug is dispensed at your (or your provider's) request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the lower tier drug.

If a higher tiered drug is needed because your condition cannot be safely managed with an available lower tiered drug and the condition is life or limb threatening, you or your physician may make a request to UnitedHealthcare to consider approval of a waiver of the difference in cost between the drugs. If the waiver is approved, you will be responsible for payment of the applicable drug copayment only. The Food and Drug Administration (FDA) requires lower tiered drugs to have the same quality, strength, purity and stability as higher tiered drugs. Your physician will need to send in back-up documentation to support possible approval of a waiver. Contact UnitedHealthcare toll-free at 1-877-283-5424, to inquire about further information.

If you purchase a Prescription Drug from a Non-Network Pharmacy, you are responsible for any difference between what the Non-Network Pharmacy charges and the amount charged for the same Prescription Drug dispensed by a Network Pharmacy.

Designated Pharmacy

If you require Specialty Prescription Drugs, UnitedHealthcare may direct you to a Designated Pharmacy with whom it has an arrangement to provide those Specialty Prescription Drugs.

Specialty Prescription Drug Products

You may fill a prescription for Specialty Prescription Drugs up to two times at a Pharmacy. However, after that you will be directed to a Designated Pharmacy and if you choose not to obtain your Specialty Prescription Drugs from a Designated Pharmacy, no Benefits will be paid and you will be responsible for paying all charges.

Please see the *Prescription Drug Glossary* in this section for definitions of Specialty Prescription Drug and Designated Pharmacy.

Want to lower your out-of-pocket Prescription Drug costs?
Consider Tier 1 Prescription Drugs, if you and your Physician decide they are appropriate.

Assigning Prescription Drugs to the PDL

UnitedHealthcare's Preferred Drug List (PDL) Management Committee makes the final approval of Prescription Drug placement in categories. In its evaluation of each Prescription Drug, the PDL Management Committee takes into account a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include:

- evaluations of the place in therapy;
- relative safety and efficacy; and
- whether supply limits or prior authorization requirements should apply.

Economic factors may include:

- the acquisition cost of the Prescription Drug; and
- available rebates and assessments on the cost effectiveness of the Prescription Drug.

When considering a Prescription Drug for category placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

The PDL Management Committee may periodically change the placement of a Prescription Drug among the categories. Placement of drugs on a higher tier will only occur once a year; January 1. You will be notified sixty days in advance if you are taking one of the impacted drugs. Placement of drugs on a lower tier may occur throughout the year without prior notice to you.

Prescription Drug, Preferred Drug List (PDL), and Preferred Drug List (PDL) Management Committee are defined at the end of this section.

Preferred Drug List (PDL)
The Preferred Drug List (PDL) is a tool that helps guide you and your Physician in choosing the medications that allow the most effective and affordable use of your Prescription Drug benefit.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to obtain prior authorization from UnitedHealthcare or its designee. The reason for obtaining prior authorization from UnitedHealthcare or its designee is to determine if the Prescription Drug Product, in accordance with UnitedHealthcare's approved guidelines, is each of the following:

- a Covered Health Service as defined by the Plan; and
- not Experimental or Investigational or Unproven, as defined in Section 14, *Glossary*.

The Plan may also require you to obtain prior authorization from UnitedHealthcare or its designee so UnitedHealthcare can determine whether the Prescription Drug Product, in accordance with UnitedHealthcare's approved guidelines, was prescribed by a Specialist Physician.

Network Pharmacy Prior Authorization

When Prescription Drugs are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from the Claims Administrator.

Non-Network Pharmacy Prior Authorization

When Prescription Drugs are dispensed at a non-Network Pharmacy, you or your Physician are responsible for obtaining prior authorization from the Claims Administrator.

If you do not obtain prior authorization before the Prescription Drug is dispensed, you may pay more for that Prescription Drug order or refill. You will be required to pay for the Prescription Drug at the time of purchase. The contracted pharmacy reimbursement rates (the Prescription Drug Cost) will not be available to you at a non-Network Pharmacy. If you do not obtain prior authorization before you purchase the Prescription Drug, you can request reimbursement after you receive the Prescription Drug - see Section 9, *Claims Procedures*, for information on how to file a claim.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from the Claims Administrator before the Prescription Drug was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost (for Prescription Drugs from a Network Pharmacy)or the Out-of-Network Reimbursement Rate (for Prescription Drugs from a non-Network Pharmacy), less the required Copayment and/or Coinsurance, Ancillary Charge, and any Deductible that applies.

To determine if a Prescription Drug requires prior authorization, either visit **www.myuhc.com** or call the toll-free number on your ID card. The Prescription Drugs requiring prior authorization are subject to UnitedHealthcare's periodic review and modification.

Benefits may not be available for the Prescription Drug after the Claims Administrator reviews the documentation provided and determines that the Prescription Drug is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

UnitedHealthcare may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at **www.myuhc.com** or by calling the number on your ID card.

Prescription Drug Benefit Claims

For Prescription Drug claims procedures, please refer to Section 9, *Claims Procedures*.

Limitation on Selection of Pharmacies

If the Claims Administrator determines that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, you may be required to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date the Plan Administrator notifies you, the Claims Administrator will select a single Network Pharmacy for you.

Maintenance Medication Program

If you require certain Maintenance Medications, UnitedHealthcare may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications.

Supply Limits

Some Prescription Drugs are subject to supply limits that may restrict the amount dispensed per prescription order or refill. To determine if a Prescription Drug has been assigned a maximum quantity level for dispensing, either visit **www.myuhc.com** or call the toll-free number on your ID card. Whether or not a Prescription Drug has a supply limit is subject to UnitedHealthcare's periodic review and modification.

Note: Some products are subject to additional supply limits based on criteria that the Plan Administrator and the Claims Administrator have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per prescription order or refill and/or the amount dispensed per month's supply.

If a Brand-name Drug Becomes Available as Tier 1

If a Brand-name Prescription Drug becomes available as a Generic drug, the category placement of the Brand-name Drug may change and an Ancillary Charge may apply. As a result, your Copay may change. You will pay the Copay applicable for the category to which the Prescription Drug is assigned.

Prescription Drugs that are Chemically Equivalent

If two drugs are chemically equivalent (they contain the same active ingredient) and you choose not to substitute a lower tiered drug for the higher tiered drug, you will pay the difference between the higher tiered drug and the lower tiered drug, in addition to the lower tiered drug's Copayment. This difference in cost is called an Ancillary Charge. An Ancillary Charge may apply when a covered Prescription Drug is dispensed at your request and there is another drug that is chemically the same available at a lower tier.

Special Programs

The State of Colorado and UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced benefit based on your actions such as adherence/compliance to medication regimens. You may access information on these programs through the Internet at **www.myuhc.com** or by calling the number on the back of your ID card.

Step Therapy

Certain Prescription Drugs for which Benefits are described in this section or Pharmaceutical Products for which Benefits are described under your medical Benefits are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drugs or Pharmaceutical Products you are required to use a different Prescription Drug(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug or Pharmaceutical Product is subject to step therapy requirements by visiting **www.myuhc.com** or by calling the number on the back of your ID card.

Rebates and Other Discounts

UnitedHealthcare and The State of Colorado may, at times, receive rebates for certain drugs included on the PDL , including those drugs that you purchase prior to meeting any applicable deductible. As determined by UnitedHealthcare, the Plan may pass a portion of these rebates on to you. When rebates are passed on to you they may be taken into account in determining your Copayment and/or Coinsurance.

The Claims Administrator and a number of its affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this Prescription Drug section. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Prescription Drug section. The Claims Administrator is not required to pass on to you, and does not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, UnitedHealthcare may send mailings or provide other communications to you, your Physician or your pharmacy that communicate a variety of messages, including information about Prescription Drug Products. These communications may include offers that enable you, at your discretion, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

UnitedHealthcare may not permit certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at **www.myuhc.com** or by calling the number on your ID card.

Exclusions - What the Prescription Drug Plan Will Not Cover

Exclusions from coverage listed under Section 8, *Exclusions* also apply to this section, except that any preexisting condition exclusion in Section 8, *Exclusions* is not applicable to this section. In addition, the following exclusions apply.

Medications that are:

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

2. any Prescription Drug for which payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law;

3. Pharmaceutical Products for which Benefits are provided in the medical (not in Section 15, *Prescription Drugs*) portion of the Plan;

4. available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless the Claims Administrator has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a prescription order or refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug that was previously excluded under this provision.

5. Compounded drugs that contain certain bulk chemicals. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to

Tier-3.) Compounded drugs that are available as a similar commercially available Prescription Drug Product;

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

7. for smoking cessation drugs available over the counter which do not require a prescription;

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

9. the amount dispensed (days' supply or quantity limit) which exceeds the supply limit;

10. certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Claims Administrator's Prescription Drug List (PDL) Management Committee;

11. prescribed, dispensed or intended for use during an Inpatient Stay;

12. prescribed for appetite suppression, and other weight loss products;

13. prescribed to treat infertility;

14. Prescription Drugs, including new Prescription Drugs or new dosage forms, that the State of Colorado determines do not meet the definition of a Covered Health Service;

15. typically administered by a qualified provider or licensed health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception;

16. unit dose packaging of Prescription Drugs;

17. Experimental or Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by UnitedHealthcare to be experimental, investigational or unproven. This does not include Prescription Drug Products that have been approved by the *U.S. Food and Drug Administration (FDA)* for use in the treatment of cancer but have not been approved by the *FDA* for the treatment of the specific type of cancer for 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.

18. used for cosmetic purposes;

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

20. any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except for Medical Foods prescribed for the treatment of Inherited Enzymic Disorders as specified under *Glossary – Prescription Drugs* in this section;

21. vitamins, except for the following which require a prescription:

    - prenatal vitamins;
    - vitamins with fluoride; and
    - single entity vitamins.

22. dental products, including but not limited to prescription fluoride topicals.

23. Health services and supplies that do not meet the definition of a Covered Health Service as defined in this Section 15, *Outpatient Prescription Drugs*, under *Glossary – Outpatient Prescription Drugs*. Covered Health Services are those health services including services, supplies, Prescription Drug Products, which UnitedHealthcare determines to be all of the following:

    - Medically Necessary as defined in this Section 15, *Outpatient Prescription Drugs*, under *Glossary – Outpatient Prescription Drugs*.
    - Described as a Covered Health Service in this SPD under the Schedule of Benefits Prescription Drug Coverage Highlights in this Section 15, *Outpatient Prescription Drugs*.
    - Not otherwise excluded in this SPD.

24. a Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision;

25. a Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision;

26. a Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision; and

27. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by UnitedHealthcare. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

Glossary - Prescription Drugs

Ancillary Charge – a charge, in addition to the Copayment , that you are required to pay when a covered Prescription Drug is dispensed at your or the provider's request, when a chemically equivalent Prescription Drug is available on a lower tier. For Prescription Drugs from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Cost or MAC List price for Network Pharmacies for the Prescription Drug on the higher tier, and the Prescription Drug Cost or MAC List price of the chemically equivalent Prescription Drug available on the lower tier. For Prescription Drugs from non-Network Pharmacies, the Ancillary Charge is calculated as the difference between the Out-of-Network Reimbursement Rate or MAC List price for non-Network Pharmacies for the Prescription Drug on the higher tier, and the Out-of-Network Reimbursement Rate or MAC list price of the chemically equivalent Prescription Drug available on the lower tier.

Brand-name (Tier 2) - a Prescription Drug that is either:

- manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- identified by UnitedHealthcare as a Brand-name Drug based on available data resources including, but not limited to, First DataBank, that classify drugs as either Brand-name (Tier 2) or Generic (Tier 1) based on a number of factors.

You should know that all products identified as "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by the Claims Administrator.

Covered Health Services – those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Medically Necessary.
- Described as a Covered Health Service under the *Schedule of Benefits* in this Section 15, *Outpatient Prescription Drugs*.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described in this SPD under *Eligibility* in Section 2, *Introduction*.
- Not otherwise excluded in this Section 15, *Outpatient Prescription Drugs* or under Section 8, *Exclusions and Limitations* of this SPD.

Designated Pharmacy – a pharmacy that has entered into an agreement with UnitedHealthcare or with an organization contracting on its behalf, to provide specific Prescription Drugs including, but not limited to, Specialty Prescription Drugs. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic (Tier 1) - a Prescription Drug that is either:

- chemically equivalent to a Brand-name; or
- identified by UnitedHealthcare as a Generic (Tier 1) based on available data resources including, but not limited to, First DataBank, that classify drugs as either Brand-name (Tier 2) or Generic (Tier 1) based on a number of factors.

You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by the Claims Administrator.

Inherited Enzymic Disorder – A disorder caused by single gene defects involved in the metabolism of amino, organic, and fatty acids including, but not limited to the following diagnosed conditions:

- phenylketonuria in female Covered Persons who are less than 21 years of age;
- maternal phenylketonuria in female covered persons of child bearing age who are less than 35 years of age;
- maple syrup urine disease;
- tyrosinemia;
- histidinemia;
- urea cycle disorders;
- hyperlysinemia;
- glutaric acidemias;
- methylmalonic acidemia; and
- proprionic acidemia.

Maintenance Medication – a Prescription Drug Product anticipated to be used for six months or more to treat or prevent a chronic condition. You may determine whether a Prescription Drug Product is a Maintenance Medication through the Internet at **www.myuhc.com** or by calling the telephone number on your ID card.

Maximum Allowable Cost (MAC) List – a list of Tier 1 Prescription Drugs that will be covered at a price level that the Claims Administrator establishes. This list is subject to periodic review and modification.

Medical Foods – prescription metabolic formulas and their modular counterparts that are:

- obtained through a pharmacy;
- specifically designated and manufactured for the treatment of Inherited Enzymic Disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and for which medically standard methods of diagnosis, treatment and monitoring exist; and

- specially processed or formulated to be deficient in one or more nutrients and are to be consumed or administered enterally either via tube or oral route under the direction of a Physician.

The term "Medical Foods" does not include foods for cystic fibrosis patients or lactose or soy intolerant patients.

Medically Necessary – health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, Substance-Related and Addictive Disorder, condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorder, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on **www.myuhc.com** or by calling the number on your ID card, and to Physicians and other health care professionals on **www.UnitedHealthcareOnline.com**.

Network Pharmacy - a retail or mail order pharmacy that has:

- entered into an agreement with the Claims Administrator to dispense Prescription Drugs to Covered Persons;
- agreed to accept specified reimbursement rates for Prescription Drugs; and
- been designated by the Claims Administrator as a Network Pharmacy.

Non-preferred Brand-name Drug (Tier 3) - a Brand-name Drug that is not identified by the Claims Administrator as being on the Preferred Drug List (PDL).

Out-of-Network Reimbursement Rate – the amount the Plan will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Out-of-Network Reimbursement Rate for a particular Prescription Drug Product dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax.

PDL - see Preferred Drug List (PDL).

PDL Management Committee - see Preferred Drug List (PDL) Management Committee.

Preferred Brand-name Drug (Tier 2) - a Brand-name Drug that is identified by the Claims Administrator as being on the Preferred Drug List (PDL).

Prescription Drug Cost – the rate the Plan has agreed to pay UnitedHealthcare on behalf of its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug (or Prescription Drug Product) - a medication, or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of Benefits under this Plan, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - Standard insulin syringes with needles.
  - Blood-testing strips - glucose.
  - Urine-testing strips - glucose.
  - Ketone-testing strips and tablets.
  - Lancets and lancet devices.
  - Glucose meters. This does not include continuous glucose monitors. Benefits for continuous glucose monitors are provided as described in your *SPD*.

Preferred Drug List (PDL) - a list that categorizes into categories medications, products or devices that have been approved by the *U.S. Food and Drug Administration*. This list is subject to periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which category a particular Prescription Drug has been

assigned by contacting UnitedHealthcare at the toll-free number on your ID card or by logging onto **www.myuhc.com**.

Preferred Drug List (PDL) Management Committee - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Prescription Drugs into specific categories.

Preventive Care Medications – the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Prescription Drug Deductible or Specialty Prescription Drug Annual Deductible) as required by applicable law under any of the following:

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force*;*
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; or
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

You may determine whether a drug is a Preventive Care Medication through the internet at **www.myuhc.com** or by calling at the toll-free telephone number on your ID card.

Specialty Prescription Drug – a Prescription Drug that is generally a high-cost product used to treat rare or complex conditions. These drugs may be infused, inhaled, injectable and oral forms. You may access a complete list of Specialty Prescription Drugs through the Internet at **www.myuhc.com** or by calling the number on the back of your ID card.

Usual and Customary Charge – the usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

SECTION 16 - IMPORTANT ADMINISTRATIVE INFORMATION

What this section includes:
- Plan administrative information.

This section includes information on the administration of the medical Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Additional Plan Description

Claims Administrator: The company which provides certain administrative services for the Plan Benefits described in this Summary Plan Description.

United HealthCare Services, Inc.
Attn: Claims
185 Asylum Street
Hartford, CT 06103

The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Claims Appeal and Fiduciary: The Plan Sponsor has delegated responsibility of claims appeal and claims fiduciary to UnitedHealthcare.

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. For Benefits as described in this Summary Plan Description, the Plan Sponsor also has selected a provider network established by United HealthCare Services, Inc. The named fiduciary of the Plan is the State of Colorado, the Plan Sponsor.

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated claims appeals to UnitedHealthcare or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

ATTACHMENT I

Patient Protection and Affordable Care Act ("PPACA")

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

ATTACHMENT II – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to United HealthCare Services, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Claims Administrator Civil Rights Coordinator
United HealthCare Services, Inc. Civil Rights Coordinator UnitedHealthcare Civil Rights Grievance P.O. Box 30608 Salt Lake City, UT 84130 The toll-free member phone number listed on your health plan ID card, TTY 711 UHC_Civil_Rights@UHC.com

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

ATTACHMENT III – GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Language	Translated Taglines
1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	□□ □□□ □□□ □□□□□ □□□□□ □□□ □□□□□ □□□ □□□□□ □□□□□□ □□□□□□□□ □□□□ □□□ □□□ □□□□□□□ □□ □□□ □□□ □□□□ □□□ □□□ □□□□□ 0□ □□□□ TTY 711
3. Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711
4. Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների հէռախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদকরে অনুরো·ধ থাকলে, আপনার স্বাস্থ্য পরকিল্পনার আই ডি কার্ড এ তালকিাভূক্ত ও কর দতিে হবে না এমন টলেফিো·ন নম্বরে ফো·ন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃសំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Ꮎ ᎠᏎᏯ ᏥᏁ ᏗᏣᏃᎮᏗ ᏗᏎᏍᏗ ᏥᎪᏪᎳ ᎥᏳ ᏣᏤᏁ ᏙᎯ ᏥᏒ ᏗᏗᎪᏙᏗ ᎠᏣᏍᏙᏗ ᏆᎾᏂᏍᏗᎢ, ᏉᏐᏅᏍᏓ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711

Language	Translated Taglines
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, ૦ દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo pono‘ī me ka uku ʻole ʻana. E kama‘ilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधकिार है। दुभाषएि के लएि अनुरोध करने के लएि, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwughị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711

Language	Translated Taglines
27. Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は 711です。
28. Karen	နအိဉ်ဒီးတါ်ခွဲးတါ်ယာ်လၢနကဒီးနူ၊်ဘဉ်တါ်မၤစၢၤဒီးတါ်ဂ့ၢ်တါ်ကျိၤလၢနကျိုဉ်ဒဉ်နဲဝဲလၢတဖလိဉ်ဟုဉ်အ ပူၤဘဉ်နူဉ်လီၤ.လၢတါ်ကဃ့နူ၊်ပှၤ်ကတိၤကျိုးထံတါ်တကၤအစိၣ်ကဒီးဘဉ်လီတဲစိအကျိၤလၢကရၢဖိအတလိဉ်ဟုဉ်အပှၤ်လၢအအိဉ်လၢနတါ်အိဉ်ဆူဉ်အိဉ်ချအတါ်ရဲဉ်တါ်ကျဲၤ အကၢ်းအလိၤဒီးဆိဉ်လိၤနိၣ်ဂ်ၢ် 0 တကှ်.TTY 711
29. Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
30. Kru- Bassa	Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711
31. Kurdish-Sorani	مافەی ئەوت هەیە کە بێبەرامبەر، یارمەتی و زانیاری پێویست بە زمانی خۆت وەرگریت. بۆ داواکردنی وەرگێڕێکی زارەکی، پەیوەندی بکە بە ژمارە تەلەفۆنی نووسراو لەناو ئای دی کارتی پیناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە .TTY 711
32. Laotian	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສຳລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711
33. Marathi	आपल्याला आपल्या भाषेत वनिामूल्य मदत आणि माहिती मळिण्याचा अधकिार आहे. दूभाषकास वनिंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबध्द केलेल्या सदस्यास वनिामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711
34. Marshallese	Eor aṃ maroñ ñan bok jipañ im meḷeḷe ilo kajin eo aṃ ilo ejjeḷọk wōṇāān. Ñan kajjitōk ñan juon ri-ukok, kūrḷok nōṃba eo eṃōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711
35. Micronesian-Pohnpeian	Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan

Language	Translated Taglines
	me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.
36. Navajo	T'áá jíík'eh doo bą́ą́h 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í ła yíníkeedgo, ninaaltsoos nit‘iz7 ‘ats’77s bee baa’ahay1 bee n44hozin7g77 bik11’ b44sh bee hane’7 t’11 j77k’eh bee hane’7 bik1’7g77 bich’8’ hodíilnih dóó 0 bił 'adidíílchił. TTY 711
37. Nepali	तपाईले आफ्नो भाषामा नःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधकिार तपाईसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईको स्वास्थ्य योजना परचिय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थचि्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਚਿ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਕਿਾਰ ਹੈ| ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦੱਤਿੇ ਗਏ ਟੱਲ ਫ਼ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕੱਲ ਕਰੋ, 0 ਦੱਬੋ|
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711

Language	Translated Taglines
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
46. Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711
47. Samoan-Fa'asamoa	E iai lou āiā tatau e maua atu ai se fesoasoani ma fa'amatalaga i lau gagana e aunoa ma se totogi. Ina ia fa'atalosagaina se tagata fa'aliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.
48. Serbo-Croation	Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.
49. Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711
50. Sudanic-Fulfulde	Ɗum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo'u 0. TTY 711.
51. Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
52. Syriac-Assyrian	ܠܥܠ ܐܝܬ ܠܟ ܙܟܘܬܐ ܕܬܫܡܫ ܒܠܫܢܟ ܕܝܠܝ ܒܠܐ ܡܨܪܦ. ܠܡܬܚܢܢ ܡܬܪܓܡܢܐ، ܩܪܝ ܠܡܣܦܪ ܕܛܠܦܘܢ ܕܚܢܡ ܕܟܬܘܒ ܥܠ ܟܪܛܝܣ ܕܗܘܝܬܟ ܕܒܝܛܘܚ ܕܐܝ ܐܬ ܠܟ ܒܬܘܒ ܘܠܚܘܢ 0. TTY 711
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సాయంబు మరియు సమా

Language	Translated Taglines
	చూర పొందడానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాషి కావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితా చేయబడ్డ టోల్ ఫ్రీ నంబరుకు ఫోన్ చేసి, 0 ప్రెస్ చేసేక్కో. TTY 711
55. Thai	คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711
56. Tongan-Fakatonga	‘Oku ke ma’u ‘a e totonu ke ma’u ’a e tokoni mo e ‘u fakamatala ‘i ho’o lea fakafonua ta’etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta’etotongi ma’ae kau memipa ‘a ee ‘oku lisi ‘I ho’o kaati ID ki ho’o palani ki he mo’uilelei, Lomi’I ‘a e 0. TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0’a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל , דרוקט 0. TTY 711

Language	Translated Taglines
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ògbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ '0'. TTY 711

ADDENDUM - UNITEDHEALTH ALLIES

Introduction

This Addendum to the Summary Plan Description provides discounts for select non-Covered Health Services from Physicians and health care professionals.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

> *Important*:
> UnitedHealth Allies is not a group health plan. You are responsible for the full cost of any services purchased, minus the applicable discount. Always use your group health plan for Covered Health Services described in the Summary Plan Description (see Section 5, *Plan Highlights*) when a benefit is available.

What is UnitedHealth Allies?

UnitedHealth Allies is a health value program that offers savings on certain products and services that are not Covered Health Services under your health plan.

Because this is not a group health plan, you are not required to receive a referral or submit any claim forms.

Discounts through UnitedHealth Allies are available to you and your Dependents as defined in the Summary Plan Description in Section 14, *Glossary*.

Selecting a Discounted Product or Service

A list of available discounted products or services can be viewed online at **www.Unitedhealthallies.com** or by calling the number on the back of your ID card.

After selecting a health care professional and product or service, reserve the preferred rate and print the rate confirmation letter. If you have reserved a product or service with a customer service representative, the rate confirmation letter will be faxed or mailed to you.

> *Important*:
> You must present the rate confirmation at the time of receiving the product or service in order to receive the discount.

Visiting Your Selected Health Care Professional

After reserving a preferred rate, make an appointment directly with the health care professional. Your appointment must be within ninety (90) days of the date on your rate confirmation letter.

Present the rate confirmation and your ID card at the time you receive the service. You will be required to pay the preferred rate directly to the health care professional at the time the service is received.

Additional UnitedHealth Allies Information

Additional information on the UnitedHealth Allies program can be obtained online at **www.Unitedhealthallies.com** or by calling the toll-free phone number on the back of your ID card.

ADDENDUM - PARENTSTEPS®

Introduction

This Addendum to the Summary Plan Description illustrates the benefits you may be eligible for under the ParentSteps program.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

> *Important*:
> ParentSteps is not a group health plan. You are responsible for the full cost of any services purchased. ParentSteps will collect the provider payment from you online via the ParentSteps website and forward the payment to the provider on your behalf. Always use your group health plan for Covered Health Services described in the Summary Plan Description 5, *Plan Highlights*) when a benefit is available.

What is ParentSteps?

ParentSteps is a discount program that offers savings on certain medications and services for the treatment of infertility that are not Covered Health Services under your health plan.

This program also offers:

- guidance to help you make informed decisions on where to receive care;
- education and support resources through experienced infertility nurses;
- access to providers contracted with UnitedHealthcare that offer discounts for infertility medical services; and
- discounts on select medications when filled through a designated pharmacy partner.

Because this is not a group health plan, you are not required to receive a referral or submit any claim forms.

Discounts through this program are available to you and your Dependents. Dependents are defined in the Summary Plan Description in Section 14, *Glossary*.

Registering for ParentSteps

Prior to obtaining discounts on infertility medical treatment or speaking with an infertility nurse you need to register for the program online at www.myoptumhealthparentsteps.com or by calling ParentSteps toll-free at 1-877-801-3507.

Selecting a Contracted Provider

After registering for the program you can view ParentSteps facilities and clinics online based on location, compare IVF cycle outcome data for each participating provider and see the

specific rates negotiated by ParentSteps with each provider for select types of infertility treatment in order to make an informed decision.

Visiting Your Selected Health Care Professional

Once you have selected a provider, you will be asked to choose that clinic for a consultation. You should then call and make an appointment with that clinic and mention you are a ParentSteps member. ParentSteps will validate your choice and send a validation email to you and the clinic.

Obtaining a Discount

If you and your provider choose a treatment in which ParentSteps discounts apply, the provider will enter in your proposed course of treatment. ParentSteps will alert you, via email, that treatment has been assigned. Once you log in to the ParentSteps website, you will see your treatment plan with a cost breakdown for your review.

After reviewing the treatment plan and determining it is correct you can pay for the treatment online. Once this payment has been made successfully ParentSteps will notify your provider with a statement saying that treatments may begin.

Speaking with a Nurse

Once you have successfully registered for the ParentSteps program you may receive additional educational and support resources through an experienced infertility nurse. You may even work with a single nurse throughout your treatment if you choose.

For questions about diagnosis, treatment options, your plan of care or general support, please contact a ParentSteps nurse via phone (toll-free) by calling 1-866-774-4626.

ParentSteps nurses are available from 8 a.m. to 5 p.m. Central Time; Monday through Friday, excluding holidays.

Additional ParentSteps Information

Additional information on the ParentSteps program can be obtained online at www.myoptumhealthparentsteps.com or by calling 1-877-801-3507 (toll-free).

ADDENDUM - LEGAL COMPLIANCE AND IMPORTANT NOTICES

The State's Right

The State reserves the right to add, modify or discontinue the State Benefit Plans as deemed necessary.

Funding and Compliance with Applicable Law

The State of Colorado sponsors the Employee group health plan for Eligible Employees and their Dependents. The Medical and Prescription Drug coverage provided under the Plan as described in this summary are funded and provided by the State of Colorado. Effective July 1, 2005, the Plan is self-funded by the State; the State also obtains an insurance protection against Plan's excess claim liability under an Excess Loss Policy issued by UnitedHealthcare Insurance Company.

The Plan is not subject to regulation by the Colorado Division of Insurance since the Plan is self-funded. The Employee Benefits Act, C.R.S. 24-50-605(f) requires that any Benefit plan comply with the mandated coverage required by C.R.S. 10-16-104. The Plan is a governmental plan and exempt from complying with the requirements of the Employee Retirement Income Security Act (ERISA) and COBRA, however, the Plan is subject to the continuation of coverage rules under the Public Health Services Act (PHSA). References in this Summary to COBRA shall mean and include continuation of coverage under the PHSA.

HIPAA Portability Rules

The Plan is required to comply with the portability and special enrollment rules of the Health Insurance Portability and Accountability Act (HIPAA). Refer to the Special Enrollment provisions in the Eligibility section of this Summary. When you or a covered Dependent terminates coverage under the Plan, the Plan will send you a certificate of coverage that identifies the length of coverage under the Plan. The HIPAA Certificate of Coverage may be needed if you enroll in another health plan that imposes a pre-existing condition waiting period. If you are eligible for Medicare and did not enroll in the Medicare drug card program, Medicare Part D, during the initial Open Enrollment in November, 2005, you are also entitled to a notice of creditable Prescription Drug coverage. You will need this notice to later enroll in Medicare Part D without penalty.

HIPAA Privacy & Security

The Plan is subject to federal privacy rules and restrictions under the Health Insurance Portability and Accountability Act (HIPAA) regarding use and disclosure of protected health information. Generally, these rules and restrictions provide Plan Participants with certain protections and rights against improper use and disclosure of protected health information. In order to provide you with information regarding your privacy rights with respect to protected health information, the Plan is required to provide you with a notice describing the Plan's privacy practices and other required information. This notice is provided to all new Plan participants at time of enrollment and to all Plan participants within 60 days of any material revision of the notice. The HIPAA Notice of Privacy Practices is included at the

back of this Summary Plan Description. Copies of the notice will also be available at all times at the State Employee Benefits Unit and the DHR Benefits website.

The Plan is subject to HIPAA rules and restrictions regarding the security of electronic protected health information. These security provisions require the Plan to implement administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of electronic protected health information.

Women's Health and Cancer Rights Act

The State of Colorado Employee Health Plan provides coverage for certain reconstructive services under the Women's Health and Cancer Rights Act. These services include:

- reconstruction of the breast upon which a mastectomy has been performed;
- surgery /reconstruction of the other breast to produce a symmetrical appearance;
- prostheses;
- treatment related to physical complications during all stage of mastectomy, including lymphedemas.

Newborns' and Mothers' Health Protection Act

The Plan may not under this federal law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of these periods.

The State of Colorado reserves the right to add, modify or discontinue the State group Benefits plans as deemed necessary. The State of Colorado Employee health plan is controlled by contracts, rules and statutes. In the event of a conflict between this Summary and the governing laws or regulations, the governing laws or regulations will prevail.

It is unlawful for any Employee or Dependent to provide false, incomplete or misleading facts or information on any state group Benefit enrollment form, affidavit, claim or other document for the purpose of defrauding or attempting to defraud the State of Colorado or the Plan. Any Employee or Dependent who provides false, incomplete or misleading facts or information on any document shall be reviewed by the State of Colorado. If the State of Colorado has reasonable suspicion to believe that an Employee or Dependent has defrauded or attempted to defraud any state group Benefit plan, coverage shall be terminated, and the Employee or Dependent may be denied future enrollment and may be subject to other action.

ADDENDUM – STATE OF COLORADO HIPAA NOTICE OF PRIVACY PRACTICES EFFECTIVE JULY 1, 2011

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Colorado Department of Personnel & Administration (DPA), on behalf of the State of Colorado (State), is committed to protecting the privacy of health information maintained by the self-funded group health Plan Sponsored by the State. In this notice, the terms your "medical information" or your "health information" mean personal information that identifies you and that relates to your past, present, or future physical or mental health; the provisions of health care services to you; or the payment of health care services provided to you. The terms "we," "us," and "our" in this notice refer to the following State of Colorado group health plan options:

- UnitedHealthcare Choice Plus,
- UnitedHealthcare High Deductible Health Plan with HSA,
- Flexible Spending Accounts (Medical and Dependent Care) and,
- Delta Dental Basic and Basic Plus Plans

The group health plan does not have Employees. It is administered by select State Employees and a third party administrator. For a more detailed explanation of the limited ways that State employees provide plan administration functions, please see the section below on Plan Sponsor.

This notice explains how we use your health information and when we can share that information with others. It also informs you of your rights with respect to your health information and how you can exercise those rights. We are required to follow the terms of this notice until the notice is replaced. We reserve the right to change the terms of this notice and to make the new notice effective for all protected health information we maintain. Once revised, we will provide you with a copy of the new notice.

How We May Use Or Disclose Your Health Information

Federal law allows us to use or disclose protected health information without your authorization for the purposes of treatment, payment, and health care operations.

Treatment. We may use and disclose information when communicating with your Physicians to help them provide medical care to you. For example, we might suggest to your Physician a disease management or wellness program that could improve your health.

Payment. We may use and disclose information about you so that the medical services you receive can be properly billed and paid. For example, we may need to give your insurance information to health care providers so they can bill us for treating you.

Operations. We may use and disclose information about you for our business operations. For example, we may disclose information about you to consultants who provide legal, actuarial, or auditing services. We will not disclose your health information to outside groups unless they agree in writing to keep it protected.

Research. We may use or disclose information to conduct research as permitted by the HIPAA privacy rule.

We may also use or disclose your health information for other health-related Benefits and services. For example, we may send you appointment reminders or information about programs that may be of interest to you, such as smoking cessation or weight loss.

There are also state and federal laws that may require or allow DPA to use or disclose your health information without your authorization. The examples below are provided to describe generally the ways in which we may use or disclose your information.

- To state and federal regulatory agencies;
- For public health activities;
- To public health agencies if we believe there is a serious health or safety threat;
- With a health oversight agency for certain activities such as audits and examinations;
- To a court or administrative agency pursuant to a court order or search warrant;
- For law enforcement purposes;
- To a government authority regarding child abuse, neglect, or domestic violence;
- With a coroner or medical examiner, or with a funeral director;
- For procurement, banking or transplantation of organs, eyes, or tissue;
- For specialized government functions, such as military activities and national security;
- Due to the requirements of state worker compensation laws.

The Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. Genetic information as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. In general, this notice revises the HIPAA privacy regulation so it is consistent with the following:

(1) Genetic information shall be treated as health information described in Section 1171 (4) (B) of the regulation;

(2) The use or disclosure, by a covered entity that is a group health plan, health insurance issuer, or issuer of a supplemental policy, of protected health information that is genetic information about an individual for underwriting purposes under the group health plan, health insurance coverage, or supplemental policy shall not be a permitted use or disclosure; and

(3) Employer-sponsored group health plans are prohibited from collecting genetic information prior to an individual's enrollment in a health plan (i.e., first day of coverage).

This does not include any requirements for genetic information imposed by plans for medical case management and claim adjudication. Plans may request only the minimum information necessary (for example, the plan may need to know that a participant underwent a specific genetic test – but may not need to know the actual test results in order to adjudicate a claim or progress to the next intervention in medical management).

Additional exceptions where plans or other covered entities or business associates can collect or require genetic information include:

- For purposes of certifying leave under the Family and Medical Leave Act (FMLA);
- To monitor workplace safety in appropriate industries;
- Under certain other circumstances presumably predicated on workplace safety or fitness-for-duty requirements specific to an occupational environment; and
- While conducting clinical research projects when health plans follow specific guidelines and notify the Secretary of Health and Human Services.

Plan Sponsor

Health information may be disclosed to or used by the State, as Plan Sponsor. For example, We may disclose to the State, information on whether you are participating in, enrolled in, or dis-enrolled from a group health plan. We may also disclose to the State, as Plan Sponsor, health information necessary to administer the group health plans. For example, the State may need your health information to review denied claims, to audit or monitor the business operations of the group health plans, or to ensure that the group health plans are operating effectively and efficiently. We will not use or disclose your health information to the State for any employment-related functions. State employees who perform services to administer the group health plans are primarily, but not exclusively, in DPA's Division of Human Resources, Employee Benefits Unit. When State employees are conducting plan administration functions, they are acting as an administrator of the group health plans. Group health plan administrators will keep your health information separate from employment information and will not share it with anyone not involved in plan administration.

For us to use or disclose your health information for any reason other than those identified in this section ("How We May Use or Disclose Your Health Information"), we must get written authorization from you. You may revoke the authorization at any time, but your revocation must also be in writing. The revocation will not affect any uses or disclosures consistent with the authorization made prior to receipt of the revocation by DPA's HIPAA Compliance Officer.

Your Rights

The following are your rights with respect to your health information.

You have the right to ask us to restrict how we use or disclose your information for treatment, payment, or health care operations. All requests must be made in writing and state the specific restriction requested. We will try to honor your request, but we are not required to agree to a restriction.

You have the right to ask to receive confidential communications of information. For example, if you believe you would be harmed if we send information to your current mailing address (for example, in situations involving domestic disputes or violence), you can ask us to send the information by alternative means (for example, by telephone) or to an alternative address. We will accommodate a reasonable request if the normal method or disclosure could endanger you and you state that in your request. Any such request must be made in writing.

You have the right to inspect and obtain a copy of information that we maintain about you in your designated record set. A "designated record set" is a group of records that may include enrollment, payment, claims adjudication, and case or medical management records. *However, you do not have the right to access certain types of information* such as psychotherapy notes and information compiled for legal proceedings. If we deny your request, we will notify you in writing and may provide you with a right to have the denial reviewed.

You have the right to ask us to amend the information we maintain about you in your designated record set (as defined above). Your request must be made in writing and you must provide a reason for the request. If we agree to your request, we will amend our records accordingly. We will also provide the amendment to any person that we know has received your health information from us, and to other persons identified by you. If we deny your request, we will notify you in writing of the reason for the denial. Reasons may include that the information was not created by us, is not part of the designated record set, is not information that is available for inspection, or that the information is accurate and complete.

You have the right to receive an accounting of certain disclosures of your information made by us during the six years prior to your request, but no earlier than July 1, 2005. We are not required to account for certain disclosures, such as disclosures made for purposes of treatment, payment, or health care operations, and disclosures made to you or authorized by you. Your request must be made in writing. Your first accounting in a 12-month period will be free. We may charge you a fee for additional accountings made within 12 months of the free accounting. We will inform you in advance of the fee and provide you with an opportunity to withdraw or modify your request.

You have a right to receive a copy of this notice upon request at any time.

Contacts

To exercise your rights, please contact UnitedHealthcare by calling the toll-free number on the back of your ID card. UnitedHealthcare will send you the appropriate form to exercise your rights and respond to your request.

For further information, to receive a copy of this notice, or if you believe your privacy rights may have been violated and you want to file a complaint, please contact Department of Personnel & Administration's HIPAA Compliance Officer by U.S. mail or by e-mail, as follows:

U.S. Mail: HIPAA Compliance Officer
Colorado Department of Personnel & Administration
Division of Human Resources
1525 Sherman Street
Denver, CO 80203

E-mail: state_benefits@state.co.us

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint.

No action will be taken against you for exercising your rights or for filing a complaint.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) OFFER FREE OR LOW-COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	GEORGIA – Medicaid

The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/	Website: http://www.dhhs.nh.gov/oii/documents/hippapp

Phone: 1-785-296-3512	.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	NORTH DAKOTA – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	OKLAHOMA – Medicaid and CHIP

Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	OREGON – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthipprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	RHODE ISLAND – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473

TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration www.dol.gov/ebsa 1-866-444-EBSA (3272)	U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services www.cms.hhs.gov 1-877-267-2323, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the

PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.
The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)