Colorado Health Benefit Plan Description Form
Golden Rule Insurance Company

Name of Carrier

Plan 100®

Name of Plan

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Preferred provider plan
2. OUT-OF-NETWORK CARE COVERED?[1]	Yes, but patient pays more for out-of-network care.
3. AREA OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado.

PART B: SUMMARY OF BENEFITS

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

	IN-NETWORK	OUT-OF-NETWORK
4. DEDUCTIBLE TYPE[2]	Calendar year	Calendar year
4A. ANNUAL DEDUCTIBLE[2a] a) Individual[2b]	a) Select only one of the following optional individual annual deductible amounts: 1. $1,500 2. $2,500 3. $5,000 4. $7,500 5. $10,000	a) Same as in-network, except that nonemergency services received out-of-network are subject to an additional deductible amount equal to the calendar-year deductible.
b) Family[2c]	b) Maximum 2 per calendar year.	b) Not applicable
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] a) Individual b) Family c) Is deductible included in the out-of-pocket maximum?	a) Equal to individual deductible b) Equal to family deductible c) Yes	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to an additional deductible amount equal to the calendar-year deductible.
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum	No lifetime maximum
7A. COVERED PROVIDERS	All providers licensed or certified to provide covered benefits.	All providers licensed or certified to provide covered benefits.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes	Not applicable

	IN-NETWORK	OUT-OF-NETWORK
8. MEDICAL OFFICE VISITS[4] a) Primary Care Providers b) Specialists	Covered expense	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to an additional deductible amount equal to the calendar-year deductible.
9. PREVENTIVE CARE a) Children's Services:	a) Evidence-informed preventive care and screenings, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration (not subject to deductible, coinsurance, and copayment).	a) Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to deductible and coinsurance.
b) Adults' Services:	b) Additional preventive care and screenings not included in c) below, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women (not subject to deductible, coinsurance, and copayment).	b) Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to deductible and coinsurance.
c) All Covered Persons:	c) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force (not subject to deductible, coinsurance, and copayment).	c) Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to deductible and coinsurance.
	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 an individual (not subject to deductible, coinsurance, and copayment).	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to deductible and coinsurance.

	IN-NETWORK	OUT-OF-NETWORK
10. MATERNITY a) Prenatal care b) Delivery c) Inpatient Well-baby care[5]	a) and b): Covered expense c) Newborn inpatient hospital stay following birth to maximum of: 1) 48 hours after normal vaginal delivery; or 2) 96 hours after Cesarean section delivery.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to an additional deductible amount equal to the calendar-year deductible.
11. PRESCRIPTION DRUGS[6] Level of coverage and restrictions on prescriptions	Select only <u>one</u> of the following prescription drug benefits: a) Covered Expense b) Optional Benefit: <u>Drug Card Copay</u> per prescription order or refill: Tier 1 - $15* Tier 2 - $35* Tier 3 - $65* Tier 4 - 25% of negotiated rate* Tiers 2-4 require satisfaction of a $200 calendar year prescription drug deductible, per covered person. No annual maximum * Reduction if drug card or member pharmacy is not used.	a) Same as in-network b) Same as in-network except benefit limited to predominant reimbursement rate plus dispensing fee.
12. INPATIENT HOSPITAL	Daily room and board maximum: Most common semi-private room rate. Intensive care unit: Eligible expenses.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to an additional deductible amount equal to the calendar-year deductible.
13. OUTPATIENT/ AMBULATORY SURGERY	Covered expense	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to an additional deductible amount equal to the calendar-year deductible.

	IN-NETWORK	OUT-OF-NETWORK
14. DIAGNOSTICS a) Laboratory & X-ray b) MRI, nuclear medicine, and other high-tech services	Covered expense	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to an additional deductible amount equal to the calendar-year deductible.
15. EMERGENCY CARE[7, 8]	Additional $100 emergency room deductible (waived for injury or if admitted).	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to an additional deductible amount equal to the calendar-year deductible.
16. AMBULANCE	Covered expense	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to an additional deductible amount equal to the calendar-year deductible.
17. URGENT, NONROUTINE, AFTER-HOURS CARE	Covered expense	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to an additional deductible amount equal to the calendar-year deductible.
18. BIOLOGICALLY BASED MENTAL ILLNESS[9]	See Other Mental Health Care.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to an additional deductible amount equal to the calendar-year deductible.
19. OTHER MENTAL HEALTH CARE	Covered the same as any physical illness.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25%, and are subject to an additional deductible amount equal to the calendar-year deductible.

	IN-NETWORK	OUT-OF-NETWORK
20. ALCOHOL & SUBSTANCE ABUSE	Covered the same as any physical illness.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to an additional deductible amount equal to the calendar-year deductible.
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	Physical therapy is a covered expense. Outpatient occupational therapy is covered following treatment of traumatic hand injuries. Other outpatient occupational therapy and speech therapy are covered only under Home Health Care Expense Benefits or Hospice Care Expense Benefits.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to an additional deductible amount equal to the calendar-year deductible.
22. DURABLE MEDICAL EQUIPMENT	I.V. stand and I.V. tubing, infusion pump or cassette, portable commode, patient lift, bili lights, and suction machine or suction catheters.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to an additional deductible amount equal to the calendar-year deductible.
23. OXYGEN	Covered expense	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to an additional deductible amount equal to the calendar-year deductible.
24. ORGAN TRANSPLANTS	Specifically listed transplants covered, subject to policy limitations.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to an additional deductible amount equal to the calendar-year deductible.
25. HOME HEALTH CARE	Home health aide service limited to 7 visits/week up to 60 visits per calendar year. Private duty registered nurse services limited to 1,000 hours lifetime maximum per covered person, at maximum $75 per visit.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to an additional deductible amount equal to the calendar-year deductible.

	IN-NETWORK	OUT-OF-NETWORK
26. HOSPICE CARE	Occupational and speech-language therapy; medical, palliative and support care; procedures necessary for pain control and acute and chronic symptom management; counseling for the terminally ill person and his or her immediate family; bereavement counseling limited to $1,150 in the 12-month period after death; drugs and biologicals; transportation; nutritional counseling. Limited to one continuous period of up to 180 days, per covered person.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to an additional deductible amount equal to the calendar-year deductible.
27. SKILLED NURSING FACILITY CARE	Must begin within 14 days of a hospital stay of at least 3 days and be for active treatment of same illness or injury. Limited to 60 days per year, per covered person.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to an additional deductible amount equal to the calendar-year deductible.
28. DENTAL CARE	Damage to natural teeth by injury occurring after the covered person's effective date, if expenses incurred within 6 months after injury.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to an additional deductible amount equal to the calendar-year deductible.
29. VISION CARE	Limited to medically necessary treatment of an illness or injury. Additional coverage is available as an optional benefit.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to an additional deductible amount equal to the calendar-year deductible.
30. CHIROPRACTIC CARE	Covered expense	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to an additional deductible amount equal to the calendar-year deductible.
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	Surgical treatment of temporomandibular joint disorders excluding tooth extraction (limited to $10,000 per covered person), hemodialysis, diabetes management, cleft lip/palate, second surgical opinions.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to an additional deductible amount equal to the calendar-year deductible.

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PREEXISTING CONDITIONS ARE NOT COVERED[10]	For covered persons ages 19 years and older, 12 months for all preexisting conditions unless the covered person is a HIPAA-eligible individual as defined under federal and state law, in which case there are no preexisting condition exclusions.
33. EXCLUSIONARY RIDERS. Can an individual's specific, preexisting condition be entirely excluded from the policy?	Yes
34. HOW DOES THE POLICY DEFINE A "PREEXISTING CONDITION"?	A preexisting condition is an injury, sickness, or pregnancy for which a person incurred charges, received medical treatment, consulted a health-care professional, or took prescription drugs within the last 12 months immediately preceding the effective date of coverage.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier or agent. Review the list to see if a service or treatment you may need is excluded from the policy.

PART D: USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	No
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	No	No
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes
39. What is the main customer service number?	(800) 657-8205	
40. Whom do I write/call if I have a complaint or want to file a grievance?[11]	Golden Rule Customer Service 712 Eleventh Street Lawrenceville, Illinois 62439 (800) 657-8205	
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance ICARE Section Suite 850, 1560 Broadway Denver, Colorado 80202	
42. To assist in filing a grievance, indicate the form number of this policy, whether it is individual, small group, or large group; and if it is a short-term policy.	Policy form MTI00001-05 Individual	
43. Does this plan have a binding arbitration clause?	No	

Endnotes

[1] "Network" refers to a specified group of physicians, hospitals, medical clinics and other health-care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

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

[2a] "Deductible" means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year or benefit year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible should be noted in rows 8 through 31.

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

[2c] "Family" is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified policy and it may be an aggregated amount (e.g., "$3,000 per family") or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family"). "Non-single" is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any covered expenses are paid.

[3] "Out-of-pocket maximum" means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy. Expenses that are applied toward the out-of-pocket maximum should be noted in rows 8 through 31.

[4] Medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically based mental illness.

[5] Well-baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together; there are not separate copayments.

[6] Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

[7] "Emergency care" means all services delivered in an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably, would have believed that an emergency medical condition or life or limb threatening emergency existed.

[8] Nonemergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for nonemergency after-hours care, then urgent care copayments apply.

[9] "Biologically based mental illness" means schizophrenia, schizo-affective disorder, bipolar-affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

[10] Waiver of preexisting condition exclusions. State law requires carriers to waive some or all of the preexisting condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

[11] Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

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COLORADO HEALTH BENEFIT PLAN DESCRIPTION FORM

2010 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER, AND HMO

PART A: TYPE OF COVERAGE

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN	STANDARD HMO PLAN
1. TYPE OF PLAN	Medical expense policy	Preferred provider plan (PPO)	Health maintenance organization (HMO)
2. OUT-OF-NETWORK CARE COVERED? [1]	Yes, policy makes no distinction between in- and out-of-network care.	Yes, but patient pays more for out-of-network care.	Only for emergency and urgent care.
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado.	Varies by carrier.	Varies by HMO.

PART B: SUMMARY OF BENEFITS

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

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDARD HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK [2]	IN-NETWORK ONLY (Out-of-network care is not covered except as noted.)
4. Deductible Type [3]	Calendar Year or Benefit Year	Calendar Year or Benefit Year	Calendar Year or Benefit Year	No deductible
4a. ANNUAL DEDUCTIBLE [3a] *(Deductibles do not apply to benefits with flat dollar copays.)*			*(Deductibles are separate from in-network deductibles)*	
a) Individual [3b]	$ 2,000	$ 1,500	$ 3,000	No deductible.
b) Family [3c] (Aggregate deductibles.)	$ 6,000	$ 4,500	$ 9,000	No deductible.

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDARD HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK [2]	IN-NETWORK ONLY (Out-of-network care is not covered except as noted.)
5. OUT-OF-POCKET ANNUAL MAXIMUM [4] *(Includes deductibles and coinsurance. Copays apply for the HMO plan only. All copays for prescription drugs are excluded.)*		*(Excludes flat dollar copays.)*	*(Out-of-pocket amounts are separate from in-network out-of-pocket amounts.)*	
a) Individual	$ 5,000	$ 4,500	$ 9,000	$ 4,000
b) Family	$15,000	$ 9,000	$18,000	$ 8,000
c) Is deductible included in the out-of-pocket maximum?	Yes	Yes	Yes	N/A
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	$2 million	$5 million		No lifetime maximum.
7A. COVERED PROVIDERS	All providers licensed or certified to provide benefits.	List of covered in-network providers varies by carrier.	All providers licensed or certified to provide benefits.	List of covered providers varies by HMO.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Not applicable. This is not a network plan.	Answer varies by carrier.	Not applicable.	Answer varies by HMO.
8. MEDICAL OFFICE VISITS [5]	*(Deductible applies)*		*(Deductible applies)*	
Primary Care Providers	20% coinsurance	$30 copay/visit	50% coinsurance	$30 copay/visit
Specialist	20% coinsurance	$50 copay/visit	50% coinsurance	$50 copay/visit
9. PREVENTIVE CARE	For all plans, only specified preventive services are covered.			
a) Children's services (No deductible prior to application of coinsurance.)	20% coinsurance	$30 copay/visit	50% coinsurance	$30 copay/visit
b) Adults' services	20% coinsurance *(Deductible applies)*	$30 copay/visit	50% coinsurance *(Deductible applies)*	$30 copay/visit

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDARD HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK [2]	IN-NETWORK ONLY (Out-of-network care is not covered except as noted.)
c) Colorectal screening services [5a, 5b]	100% *(Deductible does not apply.)*	$30 copay/visit for office visits $250 copay for outpatient/ambulatory surgery procedures (Deductible does not apply.)		$30 copay/visit for office visits $250 copay for outpatient/ambulatory surgery procedures
d) Mandated preventive services [6]	100% coverage (Deductible does not apply.)	$30 copay/visit (Deductible does not apply.)		$30 copay/visit
10. MATERNITY [6]	20% coinsurance	20% coinsurance	50% coinsurance	Applicable copays for type of service. [7]
a) Prenatal care	Deductible and coinsurance apply.	(Applicable copays, deductible and coinsurance apply to each type of service.)	Deductible and coinsurance apply.	
b) Delivery & inpatient well-baby care	Deductible and coinsurance apply.		Deductible and coinsurance apply.	
11. PRESCRIPTION DRUGS [8, 9]	$10 copay preferred generic	$10 copay preferred generic	$10 copay preferred generic	$10 copay preferred generic
Level of coverage & restrictions on prescriptions.	$40 copay preferred brand name	$40 copay preferred brand name	$40 copay preferred brand name	$40 copay preferred brand name
(Copays do not apply to out-of-pocket maximums.)	$60 copay non-preferred	$60 copay non-preferred	$60 copay non-preferred	$60 copay non-preferred
12. INPATIENT HOSPITAL	20% coinsurance *(Deductible applies)*	20% coinsurance *(Deductible applies)*	50% coinsurance *(Deductible applies)*	$500/day to a max of $2,000 per admission [10]
13. OUTPATIENT/AMBULATORY SURGERY	20% coinsurance *(Deductible applies)*	20% coinsurance *(Deductible applies)*	50% coinsurance *(Deductible applies)*	$250 copay/visit [10a]
14. DIAGNOSTICS [11]				
a) Laboratory & X-ray	20% coinsurance *(Deductible applies)*	20% coinsurance *(Deductible applies)*	50% coinsurance *(Deductible applies)*	No copay for physician-ordered services.
b) MRI, Nuclear Medicine and Other High Tech Services [11a]	20% coinsurance *(Deductible applies)*	20% coinsurance *(Deductible applies)*	50% coinsurance *(Deductible applies)*	$150 copay
15. EMERGENCY CARE [12, 13]	20% coinsurance *(Deductible applies)*	$150 copay then plan pays 80% coinsurance *(No deductible)*		$150 copay/visit [14] for in- and out-of-network emergency care.
16. AMBULANCE	20% coinsurance *(Deductible applies)*	20% coinsurance *(After satisfaction of in-network deductible)*		20% copay

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDARD HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK [2]	IN-NETWORK ONLY (Out-of-network care is not covered except as noted.)
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	20% coinsurance *(Deductible applies)*	$75 copay/visit	50% coinsurance *(Deductible applies)*	$75 copay/visit Out-of-network urgent care covered only if temporarily traveling out of service area.
18. BIOLOGICALLY BASED MENTAL ILLNESS [15] CARE	For all plans, coverage is no less extensive than the coverage for any other physical illness under that plan.			
19. OTHER MENTAL HEALTH CARE[16]	*(Deductible applies)*	*(Deductible applies)*		
a) Inpatient care [17]	50% coinsurance Maximum 45 inpatient or 90 partial days/year	50% coinsurance Maximum 45 inpatient or 90 partial days/year		50% copay Maximum 45 inpatient or 90 partial days/year
b) Outpatient care	50% coinsurance Plan/carrier pays maximum $1,500/year	50% coinsurance Plan/carrier pays maximum $1,500/year		50% copay Plan pays maximum 20 visits or $1,500/year
20. ALCOHOL AND SUBSTANCE ABUSE	Acute detox: maximum 5 days per episode and 2 episodes per lifetime, 50% coinsurance.[18] *(Deductible applies)*	Acute detox: maximum 5 days per episode and 2 episodes per lifetime, 50% coinsurance.[18] *(Deductible applies)*		Diagnosis, medical treatment & referral services. 50% copay.[19]
21. PHYSICAL, OCCUPATIONAL & SPEECH THERAPY [20]	20% coinsurance *(Deductible applies)* **(Limited to 25 visits per therapy per year)**	20% coinsurance *(Deductible applies)*	50% coinsurance *(Deductible applies)*	$30 copay **(Limited to 25 visits per therapy per year)**
		(Limited to 25 visits per therapy per year combined in-network and out-network)		
22. DURABLE MEDICAL EQUIPMENT [21]	20% coinsurance *(Deductible applies)* $ 2,500/year maximum	20% coinsurance *(Deductible applies)*	50% coinsurance *(Deductible applies)*	20% copay $2,500/year maximum
		$2,500/year maximum (In-network deductible applies to network providers and the out-of-network deductible applies to out-of-network providers. However, the maximum benefit is combined for in-network and out-of-network benefits.)		
23. OXYGEN	(Included under durable medical equipment)	(Included under durable medical equipment)		(Included under durable medical equipment)

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDARD HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK [2]	IN-NETWORK ONLY (Out-of-network care is not covered except as noted.)
24. ORGAN TRANSPLANTS [22]	Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, other single and multi-organ transplants, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.			
	20% coinsurance *(Deductible applies)*	20% coinsurance *(Deductible applies)*	50% coinsurance *(Deductible applies)*	Coverage is no less extensive than the coverage for any other physical illness.
25. HOME HEALTH CARE [22a]	20% coinsurance *(Deductible applies)*	20% coinsurance *(Deductible applies)*	50% coinsurance *(Deductible applies)*	No copay (100% covered)
26. HOSPICE CARE [23]	20% coinsurance per diem *(Deductible applies)*	20% coinsurance per diem *(Deductible applies)*	50% coinsurance per diem *(Deductible applies)*	No copay (100% covered)
27. SKILLED NURSING FACILITY CARE [24]	20% coinsurance *(Deductible applies)* (Not to exceed 100 days/year)	20% coinsurance *(Deductible applies)* (Not to exceed 100 days/year)	50% coinsurance *(Deductible applies)* (Not to exceed 100 days/year)	20% copay/day (Not to exceed 100 days/year)
28. DENTAL CARE	For all plans, not covered except for dental care needed as a result of an accident. [24a]			
29. VISION CARE	Excluded	Excluded	Excluded	Excluded
30. CHIROPRACTIC CARE	No [See 31(a)]	No [See 31(a)]	No [See 31(a)]	No [See 31(a)]
31. SIGNIFICANT ADDITIONAL SERVICES (List up to 5)				
a) Spinal manipulation	20% coinsurance *(Deductible applies)*	20% coinsurance *(Deductible applies)*	50% coinsurance *(Deductible applies)*	$30 copay
b) Hearing Aids [24b]	Benefit level determined by place of service	Benefit level determined by place of service	Benefit level determined by place of service	Benefit level determined by place of service

PART C: LIMITATIONS AND EXCLUSIONS

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDARD HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK	
32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED [25]	Business Groups of One: Up to 12 months for all pre-existing conditions Business Groups of 2 – 50: Up to 6 months for all pre-existing conditions			Not applicable; plan does not impose limitation periods for pre-existing conditions.

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDARD HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK	
33. EXCLUSIONARY RIDERS Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No	No	No	No
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last 6 months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.			Not applicable. Plan does not exclude coverage for pre-existing conditions.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Standard exclusions, including benefits covered by employers liability laws; care that is not medically necessary; cosmetic care; custodial care; dental care except for accidents[24a] and anesthesia for dependent children as required by law; educational training problems; experimental and investigational procedures; eye glasses and contact lenses; hearing aids[25a] and fitting; learning disorders; marital or social counseling; nursing home care except as specifically otherwise covered under this plan; sexual dysfunction, infertility treatment and counseling except as specifically otherwise covered under the policy requirements of this plan; TMJ; treatment for work-related illnesses and injuries except for those individuals who are not required to maintain or be covered by workers' compensation insurance as defined by workers' compensation laws [26]; transplants except for those listed above; charges related to the surgical treatment of obesity; and war.			

PART D: USING THE PLAN

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDARD HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK	
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	Yes	No	Yes
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	No	Yes	No	Yes
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	Yes	No	Yes	No
39. What is the main customer service number?	800-657-8205			
40. Whom do I write/call if I have a complaint or want to file a grievance? [27]	Golden Rule Insurance Company, 7440 Woodland Dr, Indianapolis, IN 46278 FAX 317-715-7648			

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDARD HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK	
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Contact:	Colorado Division of Insurance Consumer Affairs Section 1560 Broadway, Suite 850 Denver, CO 80202 Phone: 303-894-7490 Toll-free (in state): 800-930-3745 Email: Insurance@dora.state.co.us Fax: 303-894-7455		
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	This is a small group plan. MTI00001-05			
43. Does the plan have a binding arbitration clause?	Answer varies by carrier.			

1 "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that the plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

2 Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply ***ONLY IF*** plan has network providers for the covered benefit and insured goes out of the network. Otherwise, in-network-levels apply.

3 "Deductible Type" indicates whether the deductible period is "Calendar Year" (January 1 through December 31) or "Benefit Year" (i.e., based on a benefit year beginning on the policy's anniversary date).

3a "Deductible" means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year or benefit year) before the carrier will cover those expenses. The specific expenses that are subject to deductible should be noted in boxes 8 through 31.

3b "Individual" means the deductible amount you and each individual covered will have to pay for allowable covered expenses before the carrier will cover those expenses.

3c "Family" is the maximum deductible amount that is required to be met for all family members covered on a aggregate basis.

4 "Out-of-pocket maximum" refers to the maximum amount you will have to pay for allowable covered expenses under a health plan, which includes the deductible, coinsurance and copayments, as specified. Copays for prescription drugs, however, are not applied to the out-of-pocket maximum. The copays for other than prescription drugs are applied to the out-of-pocket maximum on the HMO plan only.

5 "Medical office visits" include physician, mid-level practitioner, and specialist visits, including the provision of injections of injectable drugs and outpatient psychotherapy visits for biologically based mental illnesses.

5a As of January 1, 2010 includes all preventive services as mandated by §10-16-104(18), C.R.S. in accordance with "A" and "B: recommendations of the U.S. Preventive Services Task Force, or any successor organization, sponsored by the Agency for Healthcare Research and Quality, the health services research arm of the federal Department of Health and Human Services. See Attachment 1 of Colorado Insurance Regulation 4-6-5 for the list of covered preventive services. Immunizations for children up to age 13 shall be provided in accordance with Colorado Insurance Bulletin B-4.24. For the standard HMO plan, services are covered only if they are rendered by a provider who is designated by and affiliated with the HMO.

5b Benefits provided for asymptomatic, average risk adults who are 50 to 75 years of age and all covered persons who are at high risk for colorectal cancer, including covered persons who have a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by the provider.

6 Well-baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. Well-baby charges incurred during the hospital stay are covered under the mother's deductible.

7 The hospital copay applies to mother and well baby together; there are not separate copays.

8 Includes expendable medical supplies for the treatment of diabetes and medically necessary medical foods for inherited enzymatice discorders as required by §10-16-104(1)(c)(III), C.R.S. Carriers are allowed to provide a mail order benefit or discount rate in the manner they do for their most frequently sold group health plan in Colorado. Coverage levels for injectable drugs are based on the place of service (office: included under the office visit copay; pharmacy: covered at appropriate copay based on drug type).

9 Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred. Additionally, as noted above in footnote 4, prescription drug benefits are not subject to the deductible and the copays are not applied to the out-of-pocket maximums.

10 Inpatient care includes all physician, surgical, and other services delivered during a hospital stay.

10a Copay includes all physician, facility services and supplies delivered during the visit.

11 Includes low dose mammography screening as mandated by Colorado law, §10-16-104(18)(b)(III), C.R.S. Diagnostic services do not include therapeutic treatment.

11a Covered procedures are: MRI, Nuclear Medicine, CT, CTA, MRA, and PET scans.

12 "Emergency care" means all services delivered in an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.

13 Non-emergency care delivered in an emergency care facility is covered only if the covered person receiving such care was referred to the emergency care facility by his/her carrier or primary care physician. If emergency care facilities are used by the plan for non-emergency after hours care, then urgent care coinsurance and copays apply.

14 Emergency copay is waived if patient is admitted to hospital since hospital copay would apply.

15 "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. Outpatient psychotherapy visits for biologically based mental illnesses are covered at the same level as medical office visits; however, the copay amount you pay shall not exceed 50% of the charge for any single office visit.

16 Pursuant to §10-16-105(1), C.R.S., the following small employers may exclude mental health coverage from their plans: any small employer who has not provided group sickness and accident insurance to employees after July 1, 1989, and any small employer who has provided group sickness and accident from a person or entity licensed pursuant to §10-3-903.5, C.R.S., that did not include mental health coverage after July 1, 1989. However, carriers allowing for such an exclusion must follow all the relevant provisions of §10-16-105(2), C.R.S., relating to such an exclusion.

17 The day cost of residential care must be less than or equal to the cost of a partial day of hospitalization. Each two days of residential or partial hospital care counts as one day of inpatient care.

18 Carriers shall also offer alcoholism coverage pursuant to §10-16-104(9), C.R.S.

19 Federally-qualified HMOs shall comply with the alcohol and drug abuse benefit for federally qualified HMOs pursuant to 42 C.F.R., Section 417.101(a)(5).

20 Coverage for medically necessary therapeutic treatment only - benefits will not be paid for maintenance therapy after maximum medical improvement achieved, except as required by law for children under 6 years of age. The services covered and the benefits provided for children under 6 years of age must be in accordance with the requirements of §10-16-104, C.R.S., subsections (1.3) and (1.7).

21 Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen and reusable equipment for the treatment of diabetes. The cost of prosthetic devices does not apply to the annual DME cap. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by §10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered up to the benefit cap; and repair and replacement needed due to misuse/abuse by the insured is not covered.

22 Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.

22a Covered services are defined in Colorado Insurance Regulation 4-2-8.

23 Although the number of days for this benefit is not limited, ancillary services, such as bereavement, shall be limited consistent with Colorado Insurance Regulation 4-2-8.

24 Coverage for medically necessary skilled nursing facility care only. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.

24a Dental care related to accidental injury: treatment, supplies and appliances that are needed to restore the mouth, sound natural teeth or jaws to the condition they were in immediately prior to the accident. The first dental services must be performed within 60 days of the accident unless the patient's medical condition prohibits the initial dental care from being provided within that timeframe. Only services provided within 12 months of the accident are covered.

24b Hearing aids for dependent children under the age of 18 are covered in compliance with §10-16-104(19), C.R.S. The coverage includes the initial assessment, fitting adjustments, and the required auditory training. Initial hearing aids and replacement hearing aids are not covered more frequently than every five (5) years; however a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. Hearing aids are not considered to be durable medical equipment. Benefits are provided in the same manner as the same types of services for other covered conditions and are determined by where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided as part of an office visit). Hearing aids are subject to utilization review.

25 "Waiver of pre-existing condition exclusions": State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

25a Only hearing aids for dependent children under the age of 18 are covered in compliance with §10-16-104(19), C.R.S.

26 Except that, if a workers' compensation policy is in place (although not required by state labor law), the workers' compensation policy, not this plan, is responsible for medical benefits for work-related illnesses and injuries. Also, if this plan is a federally qualified HMO plan, proof of workers' compensation coverage, if such coverage is required by law, may be required as a condition of coverage *if* such proof is required on the HMO's other small employer plans.

27 Grievances. Colorado law requires all plans to use consistent grievance procedures. Contact the Colorado Division of Insurance for a copy of those procedures.