

Colorado Health Benefit Plan Description Form
Golden Rule Insurance Company
Copay SelectSM

PART A: TYPE OF COVERAGE

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| 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 |
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| 4. DEDUCTIBLE TYPE ² | Calendar year | Calendar year |
| 4A. ANNUAL DEDUCTIBLE ^{2a} a) Individual ^{2b} b) Family ^{2c} | a) Select only <u>one</u> of the following optional individual annual deductible amounts: 1. \$500 2. \$1,000 3. \$1,500 4. \$2,500 5. \$5,000 b) Maximum 2 per calendar year. | 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. |
| 5. OUT-OF-POCKET ANNUAL MAXIMUM ³ a) Individual b) Family c) Is deductible included in the out-of-pocket maximum? | a) Individual deductible + \$2,000 b) Family deductible + \$2,000 per covered person c) Yes | Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to additional deductible amount equal to the calendar-year deductible. |
| 6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE | Select <u>one</u> of the following lifetime maximum amounts: 1. \$3,000,000 per covered person 2. \$5,000,000 per covered person | Same as in-network. |
| 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? | Not applicable | Not applicable |

| | IN-NETWORK | OUT-OF-NETWORK |
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| 7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician? | Not applicable | Not applicable |
| 8. MEDICAL OFFICE VISITS⁴ a) Primary Care Physicians b) Specialists | \$35 copay not subject to deductible and coinsurance. | Subject to out-of-network deductible and coinsurance |
| 9. PREVENTIVE CARE a) Children's Services (not subject to deductible) b) Children's Services (subject to deductible) c) Adults' Services (not subject to deductible) d) Adults' Services (subject to deductible) | <p>Child Health Supervision Services (including a history, complete physical exam, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests in accordance with the recommendations of the American Academy of Pediatrics) limited to the following:</p> <p>1 home visit for a newborn released from the hospital within 48 hours after delivery; Birth-12 months: 5 visits, 1 PKU; 13-36 months: 2 visits; 3-6 years: 3 visits; 7-12 years: 3 visits.</p> <p>13-18 years: \$300 per calendar year for routine physical exams; \$300 per calendar year for immunizations.</p> <p>One routine mammography examination each calendar year. Limited to the lesser of the actual amount charged or the maximum payment required by Colorado law.</p> <p>One digital rectal examination and one prostate specific antigen test each calendar year for male covered persons; Maximum benefit: \$65.</p> <p>Routine physicals – \$35 copay. Maximum covered expenses (including copays) per covered person, per calendar year – \$300.</p> <p>One pap smear or cervical smear per female covered person, per calendar year.</p> <p>Colorectal cancer screening in accordance with the American Cancer Society Guidelines (ACS).</p> | <p>Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25%.</p> <p>Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to additional deductible amount equal to the calendar year deductible, if applicable.</p> <p>Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25%.</p> <p>Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to additional deductible amount equal to the calendar year deductible, if applicable.</p> |

| | IN-NETWORK | OUT-OF-NETWORK |
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| <p>14. DIAGNOSTICS</p> <p>a) Laboratory & X-ray</p> <p>b) MRI, nuclear medicine, and other high-tech services</p> | Covered expense | Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to 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 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 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 additional deductible amount equal to the calendar-year deductible. |
| 18. BIOLOGICALLY BASED MENTAL ILLNESS ⁹ | Coverage is no less extensive than the coverage provided for any other physical illness. | Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to additional deductible amount equal to the calendar-year deductible. |
| <p>19. OTHER MENTAL HEALTH CARE</p> <p>a) Inpatient care</p> <p>b) Outpatient care</p> | <p>a) Limited to 45 days inpatient confinement or 90 days partial hospitalization per covered person, per calendar year.</p> <p>b) Limited to \$1,000 per covered person, per calendar year and subject to 50% coinsurance.</p> | Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to additional deductible amount equal to the calendar-year deductible. |

| | IN-NETWORK | OUT-OF-NETWORK |
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| 20. ALCOHOL & SUBSTANCE ABUSE | Inpatient care covered the same as any illness. Professional fees of a medical practitioner for outpatient care limited to \$50 per visit. Inpatient and outpatient care limited to combined \$3,000 lifetime maximum per covered person. | Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to 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 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 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 additional deductible amount equal to the calendar-year deductible. |
| 24. ORGAN TRANSPLANTS | Covered expense | Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to additional deductible amount equal to the calendar-year deductible. |
| 25. HOME HEALTH CARE | Home health aide service limited to 7 visits/week to a maximum of 365 visits/lifetime. 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 additional deductible amount equal to the calendar-year deductible. |

| | IN-NETWORK | OUT-OF-NETWORK |
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| 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 \$250. Inpatient: 90 days/lifetime. Outpatient: \$1,500/lifetime. | Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to 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 30 days per year, per covered person. Maximum benefit is \$15,000 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 additional deductible amount equal to the calendar-year deductible. |
| 28. DENTAL CARE | Damage to natural teeth by injury incurred 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 additional deductible amount equal to the calendar-year deductible. |
| 29. VISION CARE | Limited to medically necessary treatment of an illness or injury. | Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to additional deductible amount equal to the calendar-year deductible. |
| 30. CHIROPRACTIC CARE | Limited to \$2,000 per covered person, per calendar year. | Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to 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, diagnostic testing, diabetes management. Second surgical opinions. | Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% and are subject to additional deductible amount equal to the calendar-year deductible. |

PART C: LIMITATIONS AND EXCLUSIONS

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| 32. PERIOD DURING WHICH PREEXISTING CONDITIONS ARE NOT COVERED ¹⁰ | 6 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 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 preexisting condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy. |
| 35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY? | Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier or agent. Review them to see if a service or treatment you may need is excluded from the policy. |

PART D: USING THE PLAN

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| 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 number P-006.4 Large group only | |
| 43. Does this plan have a binding arbitration clause? | Yes, to the extent allowed by Colorado law. | |

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.