

Colorado Health Benefit Plan Description Form
Golden Rule Insurance Company

Name of Carrier

Short Term Major Medical Expense Policy

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 and 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	Per Illness or Injury	Per Illness or Injury
4A. ANNUAL DEDUCTIBLE ^{2a} a) Individual ^{2b} b) Family ^{2c}	a) and b) select only <u>one</u> of the following optional individual annual deductible amounts: 1. \$250 2. \$500 3. \$1,000 4. \$1,500	Same as in-network.
5. OUT-OF-POCKET ANNUAL MAXIMUM ³ a) Individual b) Family	a) \$1,000 plus deductible b) \$1,000 plus deductible c) No	Same as in-network.
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	\$1,000,000 per covered person	\$1,000,000 per covered person
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
<p>8. MEDICAL OFFICE VISITS⁴</p> <p>a) Primary Care Physicians</p> <p>b) Specialists</p>	<p>a) 80% after deductible has been met.</p> <p>b) 80% after deductible has been met.</p>	<p>Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% before application of any applicable deductible amounts and coinsurance provisions.</p>
<p>9. PREVENTIVE CARE</p> <p>a) Children's Services:</p> <p>b) Adult's Services:</p>	<p>a) 80% for children under age 13 (not subject to deductible).</p> <p>b) One routine mammography examination for each female covered person during the policy term; 80% after deductible has been met. One colorectal cancer screening during the policy term for each covered person age 50 or older; or age 30 or older who is considered a high risk because the insured or the insured's immediate family has a history of colorectal cancer; 80% after deductible has been met. One cervical smear or pap smear for each female covered person during the policy term; 80% after deductible has been met. One prostate cancer screening during the policy term, upon the recommendation of a licensed physician, for each male covered person age 40 or older; 80% after deductible has been met.</p>	<p>Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% before application of any applicable deductible amounts and coinsurance provisions.</p>
<p>10. MATERNITY</p> <p>a) Prenatal Care:</p> <p>b) Delivery and inpatient well-baby care⁵</p>	<p>a) Not covered</p> <p>b) Delivery not covered. Newborn inpatient hospital stay following birth to maximum of 48 hours after normal vaginal delivery or 96 hours after cesarean section delivery.</p>	<p>Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% before application of any applicable deductible amounts and coinsurance provisions.</p>
<p>11. PRESCRIPTION DRUGS⁶</p> <p>Level of coverage and restrictions on prescriptions</p>	<p>80% after deductible has been met.</p>	<p>Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% before application of any applicable deductible amounts and coinsurance provisions.</p>

	IN-NETWORK	OUT-OF-NETWORK
12. INPATIENT HOSPITAL	Daily hospital room and board maximum: 80% of most common semi-private room rate after deductible has been met. ICU: 80% of reasonable and customary after deductible has been met.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% before application of any applicable deductible amounts and coinsurance provisions.
13. OUTPATIENT/ AMBULATORY SURGERY	80% after deductible has been met.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% before application of any applicable deductible amounts and coinsurance provisions.
14. DIAGNOSTICS a) Laboratory & X-ray b) MRI, nuclear medicine, and other high-tech services	a) 80% (not subject to deductible) b) 80% (some services not subject to deductible)	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% before application of any applicable deductible amounts and coinsurance provisions.
15. EMERGENCY CARE ^{7, 8}	80% after deductible has been met. However, for illnesses, emergency room charges are not covered unless the person is directly admitted to the hospital for further treatment of the illness.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% before application of any applicable deductible amounts and coinsurance provisions.
16. AMBULANCE	80% after deductible has been met.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% before application of any applicable deductible amounts and coinsurance provisions.
17. URGENT, NONROUTINE, AFTER HOURS CARE	80% after deductible has been met.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% before application of any applicable deductible amounts and coinsurance provisions.
18. BIOLOGICALLY BASED MENTAL ILLNESS ⁹	Same as other mental health care.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% before application of any applicable deductible amounts and coinsurance provisions.

	IN-NETWORK	OUT-OF-NETWORK
19. OTHER MENTAL HEALTH CARE a) Inpatient care: b) Outpatient care:	a) 80% after deductible has been met. b) 80% after deductible has been met, limited to \$50 per visit. Combined inpatient and outpatient lifetime maximum limit paid by the plan is \$3,000 per covered person.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% before application of any applicable deductible amounts and coinsurance provisions.
20. ALCOHOL & SUBSTANCE ABUSE	Included in other mental health care.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% before application of any applicable deductible amounts and coinsurance provisions.
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	Physical: 80% after deductible has been met. Occupational and Speech: Covered only under home health care or hospice care benefits, at 80% after deductible has been met.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% before application of any applicable deductible amounts and coinsurance provisions.
22. DURABLE MEDICAL EQUIPMENT	80% after deductible has been met. See policy for types and circumstances of coverage.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% before application of any applicable deductible amounts and coinsurance provisions.
23. OXYGEN	80% after deductible has been met.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% before application of any applicable deductible amounts and coinsurance provisions.
24. ORGAN TRANSPLANTS	80% after deductible has been met.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% before application of any applicable deductible amounts and coinsurance provisions.
25. HOME HEALTH CARE	80% after deductible has been met if provided in lieu of medically necessary inpatient care. Plan covers up to 7 visits per week up to a maximum of 365 visits. After that, plan covers 60 visits per person, per calendar year.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% before application of any applicable deductible amounts and coinsurance provisions.

	IN-NETWORK	OUT-OF-NETWORK
26. HOSPICE CARE	<p>80% after deductible has been met.</p> <p>For routine home care, plan covers \$100 per day for up to a maximum benefit limit of \$9,100.</p> <p>Plan covers bereavement support services up to \$1,150.</p>	<p>Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% before application of any applicable deductible amounts and coinsurance provisions.</p>
27. SKILLED NURSING FACILITY CARE	<p>80% after deductible has been met. Must begin within 14 days of a hospital stay of at least 3 days and be for active treatment of same illness or injury. Daily limit: 50% of most common semi-private room rate for prior hospital confinement. Maximum: 60 days in a benefit period for each covered person.</p>	<p>Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% before application of any applicable deductible amounts and coinsurance provisions.</p>
28. DENTAL CARE	<p>80% after deductible has been met, only for injury that damages natural teeth, if expenses incurred within 6 months after injury.</p>	<p>Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% before application of any applicable deductible amounts and coinsurance provisions.</p>
29. VISION CARE	<p>Limited to medically necessary treatment of an illness or injury.</p>	<p>Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% before application of any applicable deductible amounts and coinsurance provisions.</p>
30. CHIROPRACTIC CARE	<p>80% after deductible has been met, limited to a maximum of 6 visits in any 3-month period at maximum of \$50 visit.</p>	<p>Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% before application of any applicable deductible amounts and coinsurance provisions.</p>
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	<p>Surgical treatment of temporomandibular joint disorders, hemodialysis, diagnostic testing, diabetes, and reconstructive surgery following a covered surgery or to correct a birth defect in a child covered since birth.</p> <p>Second surgical opinions.</p>	<p>Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25% before application of any applicable deductible amounts and coinsurance provisions.</p>

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PREEXISTING CONDITIONS ARE NOT COVERED ¹⁰	This individual short-term health benefit plan does not cover preexisting conditions.
33. EXCLUSIONARY RIDERS. Can an individual's specific, preexisting condition be entirely excluded from the policy?	Yes
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	Preexisting conditions are not covered.
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

36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	No
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	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 GRI-H-5.7-05; Individual Short Term
43. Does this plan have a binding arbitration clause?	No, 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 you will have to pay for allowable covered expenses under an HSA-qualified health plan when you are the only individual covered by the plan.
- ^{2c} “Family” is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified policy and it may be an aggregated amount (e.g., “\$3,000 per family”) or specified as the number of individual deductibles that must be met (e.g., “3 deductibles per family”). “Non-single” is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any covered expenses are paid.
- ³ “Out-of-pocket maximum” means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the 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.