

**Colorado Health Benefit Plan Description Form**  
**Golden Rule Insurance Company**  
**Copay Saver<sup>SM</sup>**

**PART A: TYPE OF COVERAGE**

1. TYPE OF PLAN	Preferred provider plan
2. OUT-OF-NETWORK CARE COVERED? <sup>1</sup>	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.

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
4. DEDUCTIBLE TYPE <sup>2</sup>	Calendar year	Calendar year
4A. ANNUAL DEDUCTIBLE <sup>2a</sup> a) Individual <sup>2b</sup>  b) Family <sup>2c</sup>	a) Select only <u>one</u> of the following optional individual annual deductible amounts: 1. \$1,500    2. \$2,500 3. \$5,000  b) Maximum 2 per calendar year.	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) Not applicable
5. OUT-OF-POCKET ANNUAL MAXIMUM <sup>3</sup> a) Individual b) Family c) Is deductible included in the out-of-pocket maximum?	a) Individual deductible + \$3,000 b) Family deductible + \$3,000 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 an 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?	Yes	Not applicable

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<p>8. MEDICAL OFFICE VISITS<sup>4</sup></p> <p>a) Primary Care Providers</p> <p>b) Specialists</p>	<p>a) and b): Select <u>one</u> of the following:</p> <p>1) \$35 copay, then 100% Maximum of 2 visits per person, per calendar year.</p> <p>2) \$35 copay, then 100% Maximum of 4 visits per person, per calendar year.</p>	<p>Not covered</p>
<p>9. PREVENTIVE CARE</p> <p>a) Children's services (not subject to deductible)</p> <p>b) Adults' services (not subject to deductible)</p> <p>c) Select either Standard or Optional Benefit:</p> <p>1) Standard Benefit Adults' services (subject to deductible)</p> <p>2) Optional Benefit All covered persons: (exempt from deductible and coinsurance)</p>	<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.</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>One pap smear per female covered person, per calendar year.</p> <p>Colorectal screening in accordance with the American Cancer Society Guidelines (ACS).</p> <p>Routine office visits (age 13+): \$35 Copay; urinalysis; blood tests; EKGs; cardiac stress tests; cervical smears and pap smears; screening and vaccinations for HPV.</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%.</p> <p>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.</p> <p>Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25%.</p>



	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
15. EMERGENCY CARE <sup>7,8</sup>	Additional \$500 emergency room deductible (waived if admitted).	Additional \$500 emergency room deductible (waived if admitted)
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	Not covered	Not covered
18. BIOLOGICALLY BASED MENTAL ILLNESS <sup>9</sup>	See Other Mental Health Care.	See Other Mental Health Care.
19. OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	a) Not covered b) Not covered	Not covered
20. ALCOHOL & SUBSTANCE ABUSE	Not covered	Not covered

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	Covered on an inpatient basis. Outpatient expenses 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 on an inpatient basis. Outpatient expenses 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.
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.

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
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. Additional coverage 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.
29. VISION CARE	Available as an optional benefit.	Available as an optional benefit.
30. CHIROPRACTIC CARE	Not covered	Not covered
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, outpatient preadmission and presurgical 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 an additional deductible amount equal to the calendar-year deductible.

## PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PREEXISTING CONDITIONS ARE NOT COVERED <sup>10</sup>	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? <sup>11</sup>	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-N23S-05 Individual	
43. Does this plan have a binding arbitration clause?	No	

## Endnotes

- <sup>1</sup> “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).
- <sup>2</sup> “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”.
- <sup>2a</sup> “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.
- <sup>2b</sup> “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.
- <sup>2c</sup> “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.
- <sup>3</sup> “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.
- <sup>4</sup> Medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically based mental illness.
- <sup>5</sup> 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.
- <sup>6</sup> Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.
- <sup>7</sup> “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.
- <sup>8</sup> 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.
- <sup>9</sup> “Biologically based mental illness” means schizophrenia, schizo-affective disorder, bipolar-affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.
- <sup>10</sup> 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.
- <sup>11</sup> Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.