Colorado Health Benefit Plan Description Form

World Insurance Company

ExpressMed Premier Major Medical Plan

ExpressMed Premier Coinsurance Options *(check appropriate box)*

☐ 100% ☐ 80% to $15,000 ☐ 50% to $15,000

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. AREAS 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. Coinsurance options reflect the amount you will pay.

	In-Network	**Out-of-Network**
4. Deductible Type[2]	Calendar Year	Calendar Year
4a. ANNUAL CALENDAR YEAR DEDUCTIBLE[2a] a) Individual[2b]	*(check appropriate box)* a) ☐$500 ☐$2,500 ☐$10,000 ☐$1,000 ☐$3,500 ☐$25,000 ☐$1,500 ☐$5,000 ☐$2,000 ☐$7,500	2 times the In-Network annual calendar year deductible – accumulates separately from the In-Network calendar year deductible.
b) Family[2c]	b) Maximum of 3 individual In-Network deductibles per calendar year.	b) Maximum of 3 individual Out-of-Network deductibles per calendar year.
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] *(check appropriate box)* ☐ **ExpressMed Premier - 100** a) Individual	a) $0; You pay 0% of the covered expenses plus all deductibles and copays/access fees.	a) $2,000; You pay 20% of the first $10,000 of covered expenses plus all deductibles and copays/access fees, plus charges in excess of usual and customary amounts.
b) Family	b) You pay the deductible (with a maximum of 3 individual In-Network deductibles per calendar year), plus any copays/access fees, if applicable; and coinsurance accumulates per person	b) You pay the deductible (with a maximum of 3 individual Out-of-Network deductibles per calendar year) plus any copays/access fees, and charges in excess of usual and customary amount and coinsurance accumulates per person
c) Is deductible included in the Out-of-Pocket maximum?	c) No.	c) No.

	In-Network	Out-of-Network
☐ **ExpressMed Premier - 80** a) Individual	a) $3,000; You pay 20% of the first $15,000 of covered expenses plus all deductibles and copays/access fees.	a) $12,000; You pay 40% of the first $30,000 of covered expenses plus all deductibles and copays/access fees, plus charges in excess of usual and customary amounts.
b) Family	b) You pay the deductible (with a maximum of 3 individual In-Network deductibles per calendar year), plus any copays/access fees, if applicable; and coinsurance accumulates per person	b) You pay the deductible (with a maximum of 3 individual Out-of-Network deductibles per calendar year) plus any copays/access fees, and charges in excess of usual and customary amount and coinsurance accumulates per person
c) Is deductible included in the Out-of-Pocket maximum?	c) No.	c) No.
☐ **ExpressMed Premier - 50** a) Individual	a) $7,500; You pay 50% of the first $15,000 of covered expenses plus all deductibles and copays/access fees.	a) $15,000; You pay 50% of the first $30,000 of covered expenses plus all deductibles and copays/access fees, plus charges in excess of usual and customary amounts.
b) Family	b) You pay the deductible (with a maximum of 3 individual In-Network deductibles per calendar year), plus any copays/access fees, if applicable; and coinsurance accumulates per person	b) You pay the deductible (with a maximum of 3 individual Out-of-Network deductibles per calendar year) plus any copays/access fees, and charges in excess of usual and customary amount and coinsurance accumulates per person
c) Is deductible included in the Out-of-Pocket maximum?	c) No.	c) No.
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	$3 million per covered person with option to decrease to $1 million..	
7a. COVERED PROVIDERS	Great-West Healthcare Open Access (Other providers are available in a few areas. See provider directory for complete list.)	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.
8. MEDICAL OFFICE VISITS[4] a) Primary Care Providers b) Specialists	a) and b) Subject to $50 copay per visit.	
9. PREVENTIVE CARE a) Children's services b) Adults' services	a) Covered as outlined in Colorado law. b) Subject to deductible and coinsurance as checked under #4 and #5 up to $250 per year after 6 month wait. (See #31 for optional Wellness Benefit.)	
10. MATERNITY a) Prenatal care b) Delivery & inpatient well-baby care	a) Not covered. b) Not covered except for complications of pregnancy. Inpatient well-baby care covered as outlined in Colorado law. (See #31 for optional Maternity Benefit coverage.)	
11. PRESCRIPTION DRUGS[6] Level of coverage and restrictions on prescriptions	Outpatient: Generic - $15 copay. Brand name (formulary and nonformulary) after $500 deductible, $30 copay (formulary) and $45 copay (nonformulary). Inpatient: Subject to deductible and coinsurance as checked under #4 and #5. (See #31 for optional benefit.)	
12. INPATIENT HOSPITAL	Covered subject to deductible and coinsurance as checked under #4 and #5.	
13. OUTPATIENT/AMBULATORY SURGERY	Covered subject to deductible and coinsurance as checked under #4 and #5.	

	In-Network	Out-of-Network
14. DIAGNOSTICS a) Laboratory & X-ray performed at a Physician's Office b) Outpatient MRI, nuclear medicine, and other high-tech services (i.e. CAT Scans and PET Scans	a) 100% of Covered Expenses in excess of a $50 copay per test/exam —limited to $200 per test/exam; then subject to deductible and coinsurance as checked under #4 and #5. b) Subject to deductible and coinsurance as checked under #4 and #5.	
15. EMERGENCY CARE[7,8]	Covered person pays a $150 access fee; then subject to deductible and coinsurance as checked under #4 and #5.	
16. AMBULANCE	Ambulance Service is covered subject to deductible and coinsurance as checked in #4 and #5. Air Ambulance Service is limited to $30,000 per covered person per calendar year.	
17. URGENT, NON-ROUTINE AFTER-HOURS CARE	Covered subject to deductible and coinsurance as checked under #4 and #5. (Review #15 above if treated in an Emergency Room).	
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]	Not covered.	
19. OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	a) and b) Not covered.	
20. ALCOHOL & SUBSTANCE ABUSE	Not covered.	
21. PHYSICAL, OCCUPATIONAL & SPEECH THERAPY	Covered $50 per visit; up to $5,000 per calendar year for all therapies.	
22. DURABLE MEDICAL EQUIPMENT	Rental covered up to purchase price of equipment, subject to deductible and coinsurance as checked under #4 and #5.	
23. OXYGEN	Covered subject to deductible and coinsurance as checked under #4 and #5.	
24. ORGAN TRANSPLANTS	If performed at a designated transplant facility, covered subject to deductible and coinsurance as checked under #4 and #5. Limited as follows: $1,000,000 per organ maximum, subject to the lifetime maximum or benefit maximum of the plan, as shown in #6.	If not performed at a designated transplant facility, limited to $100,000 lifetime.
25. HOME HEALTH CARE	Covered subject to deductible and coinsurance as checked under #4 and #5; up to 60 visits per calendar year.	
26. HOSPICE CARE	Limited coverage; up to $100 per day outpatient or $200 per day inpatient, subject to deductible and coinsurance as checked under #4 and #5, and $30,000 per benefit period.	
27. SKILLED NURSING FACILITY CARE	Covered subject to deductible and coinsurance as checked under #4 and #5, maximum of 60 days per calendar year.	
28. DENTAL CARE	Not covered, except treatment required as a result of covered injury to sound natural teeth.	
29. VISION CARE	Not covered.	
30. CHIROPRACTIC CARE	Limited coverage. Covered up to $50/visit and $500/year maximum.	
31. SIGNIFICANT ADDITIONAL COVERED SERVICES — OPTIONAL *(check if applicable)*		
a) Wellness Services Benefits b) Maternity Expense Benefits c) Outpatient Prescription Drugs	a) ☐ 100% of the first $300 of Wellness Covered Expenses per calendar year after 6 month wait. b) ☐ After the maternity waiting period and the maternity deductible amount, pays the maternity benefit percentage of maternity covered expenses. Complications of pregnancy payable as any other illness. c) ☐ $15 copay for generic drugs; No coverage for brand name drugs.	
32. PERIOD DURING WHICH PREEXISTING CONDITIONS ARE NOT COVERED[10]	12 consecutive months. After 12 months, benefits are payable unless specifically excluded from coverage. Any period of time that a covered person was covered under a qualifying creditable coverage, will be applied to this 12-month period.	

	In-Network	Out-of-Network
PART C: LIMITATIONS AND 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 was given or treatment was recommended by a physician within a 12-month period prior to the Issue Date of coverage for that covered person, or for which prescription medication was taken within a 12-month period prior to the Issue Date for that covered person.	
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review the list 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)?	Yes.	
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?	800-786-7557	
40. Whom do I write/call if I have a complaint or want to file a grievance?[11]	Customer Service, World Insurance Company, P.O. Box 3160, Omaha, NE 68103.	
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, 1560 Broadway, Suite 850, 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.	A4800W-CO. Individual.	
43. Does the 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 pays 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 "Pre 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 boxes 8 through 30.

[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, copayments or access fees, depending on the contract for that plan. The specific deductibles, copayments or access fees included in the out-of-pocket maximum should be noted in boxes 8 through 30.

[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] Non-Emergency 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 non-emergency after-hours care, then urgent care copayments or access fees apply.

[9] Biologically based mental illnesses 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.