

**COLORADO HEALTH PLAN DESCRIPTION FORM (Effective 9/23/2010)**

**Celtic Insurance Company**  
**Celtic Basic Fully Steered PPO Plan**

**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	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.

		IN-NETWORK	OUT-OF-NETWORK
4	Deductible Type <sup>2</sup>	a) Calendar Year.	a) Calendar Year.
4a.	ANNUAL DEDUCTIBLE <sup>2a</sup> a) Individual <sup>2b</sup> b) Family <sup>2c</sup>	a) Select between \$1,500, \$2,500, \$3,500, \$5,000 and \$7,500. b) Equal to three (3) individual deductibles per calendar year.	a) \$1,500 in addition to the In-network deductible selected. b) Equal to three (3) individual out-of-network deductibles per calendar year.
5	OUT-OF-POCKET ANNUAL MAXIMUM <sup>3</sup> a) Individual b) Family c) Is deductible included in the out-of-pocket maximum	a) 3,500 to 10,500 per calendar year. b) Three (3) times the individual maximum per calendar year. c) Yes.	a) 40/50% coinsurance of eligible expenses after out of network deductible. b) 40/50% coinsurance of eligible expenses after out of network deductible. c) Yes.
6	LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No Maximum.	No Maximum.
7A	COVERED PROVIDERS	Private Healthcare Systems Inc. See provider directory for complete list of current providers.	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 <sup>4</sup>	2 visits: \$30 office visit copay (annual deductible does not apply). Non-preventive labs & x-ray-(annual deductible does apply) 70/80%. 3 <sup>rd</sup> and subsequent visits, including Non-preventive labs & x-ray-70/80% (annual deductible does apply)	50/60%. Annual out-of-network deductible does apply.

		IN-NETWORK	OUT-OF-NETWORK
9	<p>PREVENTIVE CARE</p> <p>a) Children's services</p> <p>b) Adult's services</p>	<p>Includes but not limited to: (Annual deductible does not apply)</p> <p>a) Child Health Supervision Services: 80/100% Annual deductible does not apply.</p> <p>b) Covered Adult Services: 100%. Annual Mammogram, Annual Prostate Cancer, Cytology &amp; Colorectal Cancer Screening.</p>	<p>Includes but not limited to (Annual deductibles do not apply):</p> <p>a) Child Health Supervision Services: 60/80% Annual deductible does not apply.</p> <p>b) Covered Adult Services: 80%. Annual Mammogram, Annual Prostate Cancer, Cytology &amp; Colorectal Cancer Screening.</p>
10	<p>MATERNITY</p> <p>a) Prenatal care</p> <p>b) Delivery &amp; inpatient well baby care<sup>5</sup></p>	<p>a) 70/80%. Annual deductible does apply.</p> <p>b) 70/80%. Hospital stays -up to 48 (vaginal) or 96 (cesarean) hours following delivery. Annual deductible does apply.</p> <p>Children born to dependents do not meet the definition of a dependent and are not eligible under the plan.</p>	<p>a) 50/60%. Annual deductible does apply.</p> <p>b) 50/60%. Hospital stays -up to 48 (vaginal) or 96 (cesarean) hours following delivery. Annual deductibles do apply.</p> <p>Children born to dependents do not meet the definition of a dependent and are not eligible under the plan.</p>
11	<p>PRESCRIPTION DRUGS<sup>6</sup></p> <p>Level of coverage and restrictions on prescriptions</p>	<p>Prescription Drug Card Benefit:</p> <p>Separate Annual Deductible: \$1000</p> <p>Generic: \$25 copay</p> <p>Preferred Brand: 35% coinsurance</p> <p>Non-Preferred Brand &amp; Specialty: 50% coinsurance</p> <p>Brands with a generic substitute: \$25 plus 100% of the cost difference between the brand name drug and the generic substitute</p> <p>Prescription Drug Option available with a separate lower annual deductible of \$500 and the same copays as listed above</p>	<p>Outpatient prescription drugs must be purchased through a participating pharmacy. Coverage is not provided for prescription drugs purchased at non-participating pharmacies.</p>
12	INPATIENT HOSPITAL	Separate \$500 deductible for each admission. Annual Deductible does apply. 70/80%.	Separate \$500 deductible for each admission. Annual out-of-network deductible does apply. 50/60% per occurrence.
13	OUTPATIENT/AMBULATORY SURGERY	Separate \$250 deductible for each occurrence. Annual Deductible does apply. 70/80%.	Separate \$250 deductible for each occurrence. Annual out-of-network deductible does apply. 50/60% per occurrence.
14	LABORATORY & X-RAY	70/80%. Annual Deductible does apply.	50/60% per occurrence. Annual out-of-network deductible applies.
15	EMERGENCY CARE <sup>7</sup>	Separate Emergency Room Deductible of \$250 per visit (waived if admitted). Annual Deductible does apply. 70/80%.	Separate Emergency Room Deductible of \$250 per visit (waived if admitted). Annual out-of-network deductible does apply. 70/80%.
16	AMBULANCE	70/80%. Up to \$3,000, ground or air transportation per calendar year. Annual Deductible does apply.	50/60%. Up to \$3,000, ground or air transportation per calendar year. Annual Deductible applies.
17	URGENT, NON-ROUTINE, AFTER HOURS CARE	70/80%. Annual Deductible does apply.	50/60%. Annual out-of-network deductible does apply.

		IN-NETWORK	OUT-OF-NETWORK
18	BIOLOGICALLY-BASED MENTAL ILLNESS CARE <sup>8</sup>	Not Covered.	Not Covered.
19	OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	Not Covered	Not Covered.
20	ALCOHOL & SUBSTANCE ABUSE	Not Covered.	Not Covered.
21	PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	70/80%. Annual Deductible does apply.	50/60% per occurrence. Annual out-of-network deductible does apply.
22	DURABLE MEDICAL EQUIPMENT	70/80%. Annual Deductible does apply. See policy for types and circumstances of coverage.	50/60% per occurrence. Annual out-of-network deductible does apply. See policy for types and circumstances of coverage.
23	OXYGEN	70/80%. Annual Deductible does apply.	50/60% per occurrence. Annual out-of-network deductible applies.
24	ORGAN TRANSPLANTS	80/100%. Annual deductible applies.	60/80%. Annual out-of-network deductible applies.
25	HOME HEALTH CARE	70/80% up to 60 visits per year, one visit per day. Annual Deductible does apply.	50/60% up to 60 visits per year, one visit per day. Annual out-of-network deductible does apply.
26	HOSPICE CARE	70/80%. Annual deductible does apply. Nursing/social/counseling services up to a per diem benefit of \$100 per day limited to \$9,100 per episode of care (3 months).	50/60%. Annual deductible does apply. Nursing/social/counseling services up to a per diem benefit of \$100 per day limited to \$9,100 per episode of care (3 months).
27	SKILLED NURSING FACILITY CARE	70/80% up to 12 days of confinement per year. Annual Deductible does apply.	50/60% up to 12 days of confinement per year. Annual out-of-network deductible applies.
28	DENTAL CARE	Not Covered.	Not Covered.
29	VISION CARE	Not Covered.	Not Covered.
30	CHIROPRACTIC CARE	Not Covered.	Not Covered.
31	SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5) 1) Rehabilitation Therapy  2) General Anesthesia for Dependent Children.	1) 70/80% up to 30 days of confinement in a rehabilitation facility per year. 70/80% up to 60 visits for outpatient rehabilitation therapy related to home health care per year. Annual Deductible does apply. 2) 70/80%. Annual Deductible does apply.	1) 50/60% up to 30 days of confinement in a rehabilitation facility per year. 50/60% up to 60 visits for outpatient rehabilitation therapy related to home health care per year. Annual out-of-network deductible does apply. 2) 50/60%. Annual out-of-network deductible does apply.

### PART C: LIMITATIONS AND EXCLUSIONS

32	PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED. <sup>9</sup>	12 months for all pre-existing conditions unless the covered person is a HIPAA-eligible individual or a dependent child as defined under federal and state law, in which case there are no pre-existing condition exclusions.
33	EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	Yes.
34	HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	A pre-existing 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 12 months immediately preceding the effective date of coverage.
35	WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	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**

		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)?	Yes.	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?	Celtic Insurance Company: 1-800-477-7870.	
40	Whom do I write/call if I have a complaint or want to file a grievance? <sup>10</sup>	Celtic Insurance Company, Attn: Appeal Officer 233 South Wacker Drive, Suite 700, Chicago, IL 60606-6393	
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, CO 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 #15-544-00159-CO - Individual.	
43	Does the plan have a binding arbitration clause?	Yes.	

<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 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).

<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.

<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.

<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”)

<sup>3</sup> Out-of-pocket maximum means the maximum amount that 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.

<sup>4</sup> Medical office visits include physician, mid-level paractitioner, and specialist visits.

<sup>5</sup> Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening.

<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 services delivered by an emergency care facility which 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> “Biologically based mental illnesses” means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

<sup>9</sup> 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.

<sup>10</sup> Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.