

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

Celtic Insurance Company CelticSaver HSA PPO with 80% or 100% High Deductible Health 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 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 ²	Calendar Year.	Calendar Year.
4a.	ANNUAL DEDUCTIBLE ^{2a} a) Individual [Single] ^{2b} b) Family [Non-single] ^{2c}	a) Determined annually. Choice of \$1500, \$2600, or \$5000 for current calendar year. b) Determined annually. Choice of \$3000, \$5150, or \$10,000 for current calendar year .	Same as In-Network.
5	OUT-OF-POCKET ANNUAL MAXIMUM ³ a) Individual b) Family c) Is deductible included in the out-of-pocket maximum	a) Determined annually, depending on the deductible and coinsurance chosen (Between \$1,500 & \$5,100) b) Determined annually, depending on the deductible and coinsurance chosen (Between \$3,000 & \$10,200) c) Yes.	a) 20/40% coinsurance of eligible expenses after the deductible. b) 20/40% coinsurance of eligible expenses after the 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 ⁴	80/100%. Annual deductible does apply.	60/80%. Annual deductible does apply.

		IN-NETWORK	OUT-OF-NETWORK
9	PREVENTIVE CARE a) Children's services b) Adult's services	Includes but not limited to: (Annual deductible does not apply) a) Child Health Supervision Services: 80/100%. b) Covered Adult Services: 80/100%. Annual Mammogram, Annual Prostate Cancer, Cytology & Colorectal Cancer Screening.	Includes but not limited to: (Annual deductible does not apply) a) Child Health Supervision Services: 60/80%. b) Covered Adult Services: 60/80%. Annual Mammogram, Annual Prostate Cancer, Cytology & Colorectal Cancer Screening.
10	MATERNITY a) Prenatal care b) Delivery & inpatient well baby care ⁵	a) 80/100%. Annual deductible does apply. b) 80/100%. Hospital stays -up to 48 (vaginal) or 96 (cesarean) hours following delivery. Annual deductible does apply. Children born to dependents do not meet the definition of a dependent and are not eligible under the plan.	a) 60/80%. Annual deductible does apply. b) 60/80%. Hospital stays -up to 48 (vaginal) or 96 (cesarean) hours following delivery. Annual deductible does apply. Children born to dependents do not meet the definition of a dependent and are not eligible under the plan.
11	PRESCRIPTION DRUGS ⁶ Level of coverage and restrictions on prescriptions	80/100%. Annual deductible does apply.	60/80%. Annual deductible does apply.
12	INPATIENT HOSPITAL	80/100%. Annual deductible does apply.	60/80%. Annual deductible does apply.
13	OUTPATIENT/AMBULATORY SURGERY	80/100%. Annual deductible does apply.	60/80%. Annual deductible does apply.
14	LABORATORY & X-RAY	80/100%. Annual deductible does apply.	60/80%. Annual deductible does apply.
15	EMERGENCY CARE ⁷	80/100% after separate Emergency Room Deductible of \$250 per visit (waived if admitted). Annual deductible does apply.	Same as In-Network.
16	AMBULANCE	80/100% up to \$5000, per calendar year for ground or air transportation. Annual deductible does apply.	60/80% up to \$5000, per calendar year for ground or air transportation. Annual deductible does apply.
17	URGENT, NON-ROUTINE, AFTER HOURS CARE	80/100%. Annual deductible does apply	60/80%. Annual deductible does apply.
18	BIOLOGICALLY-BASED MENTAL ILLNESS CARE ⁸	Not Covered.	Not Covered.
19	OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	a) 80/100%. Annual deductible does apply. b) 80/100%. Annual deductible does apply.	a) 60%/80%. Annual deductible does apply. b) 60%/80%. Annual deductible does apply.
20	ALCOHOL & SUBSTANCE ABUSE	Not Covered.	Not Covered.
21	PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	80/100%. Annual deductible does apply.	60/80%. Annual deductible does apply.
22	DURABLE MEDICAL EQUIPMENT	80/100%. Annual deductible does apply. See policy for types and circumstances of coverage.	60/80%. Annual deductible does apply. See policy for types and circumstances of coverage.

		IN-NETWORK	OUT-OF-NETWORK
23	OXYGEN	80/100%. Annual deductible does apply	60/80%. Annual deductible does apply.
24	ORGAN TRANSPLANTS	80/100%. Annual deductible does apply.	60/80%. Annual deductible does apply.
25	HOME HEALTH CARE	80/100% up to 60 visits per calendar year, one visit per day. Annual deductible does apply.	60/80% up to 60 visits per calendar year, one visit per day. Annual deductible does apply.
26	HOSPICE CARE	80/100%. 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).	80/100%. 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	80/100% up to 12 days of confinement per calendar year. Annual deductible does apply.	60/80% up to 12 days of confinement per calendar year. Annual deductible does apply.
28	DENTAL CARE	Not Covered.	Not Covered.
29	VISION CARE	Not Covered except for: Routine eye exam as part of the Preventive Care Benefit. Annual deductible does not apply.	Not Covered except for: Routine eye exam as part of the Preventive Care Benefit. Annual deductible does not apply.
30	CHIROPRACTIC CARE	80/100% up to \$500 per insured per calendar year. Annual deductible does apply.	60/80% up to \$500 per insured per calendar year. Annual deductible does apply.
31	SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	80/100% up to 30 days of confinement in a rehabilitation facility per calendar year. Annual deductible does apply. 80/100% up to 30 visits for outpatient rehabilitation therapy per calendar year. Annual deductible does apply.	60/80% up to 30 days of confinement in a rehabilitation facility per calendar year. Annual deductible does apply. 60/80% up to 30 visits for outpatient rehabilitation therapy per calendar year. Annual deductible does apply.

PART C: LIMITATIONS AND EXCLUSIONS

32	PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED. ⁹	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?	Exclusions vary by 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? ⁶	Celtic Insurance Company, Attn: Appeal Officer 233 South Wacker Drive, Ste. 700, Chicago, IL 60606	
41	Whom do I contact if I am not satisfied with the resolution of my complaint or grievance? ¹⁰	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 #15-555-00229-CO – Individual.	
43	Does the plan have a binding arbitration clause?	Yes.	

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 “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.

^{2b} “Single” means the deductible amount you will have to pay for allowable covered expenses under an HAS-qualified plan when you are the only individual covered by the plan.

^{2c} “Non-single” is the deductible amount that must be met by one or more family members covered by an HAS-qualified plan before any covered expenses are paid.

³ 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.

⁴ Medical office visits include physician, mid-level practitioner, and specialist visits.

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

⁶ Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

⁷ “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.

⁸ “Biologically based mental illnesses” means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

⁹ 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.

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