COLORADO HEALTH PLAN DESCRIPTION FORM

Celtic Insurance Company
CeltiCare Health Plan with "Any Doc" and Select PPO Options

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	ANNUAL DEDUCTIBLE a) Individual b) Family	a) Select between $250 and $10,000 b) Equal to three (3) individual deductibles per calendar year.	Same as In-Network.
5	OUT-OF-POCKET ANNUAL MAXIMUM[2] a) Individual b) Family	a) 0/20% coinsurance of first $5,000 or 30% coinsurance of first $10,000 inn eligible expenses, plus the deductible, excluding any copays. b) Three (3) times the individual maximum per calendar year.	a) Any Doc - 20/40/50% coinsurance of eligible expenses up to $5,000 per occurrence after deductible, excluding any copays. Select - 20/40/50% coinsurance of eligible expenses after deductible, excluding any copays. b) Same as Individual Maximum.
6	LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	$5,000,000	Same as In-Network.
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	ROUTINE MEDICAL OFFICE VISITS	Not covered unless Plus Option is selected. Plus Option – 100% up to $300 per insured per calendar year. Outpatient non-preventive office visits are covered: Select - $10 copay for office visit only. Any Doc - $25 copay for office visit up to $200.	Same as In-Network. Outpatient non-preventive office visits are covered: Deductible does apply. Select - 50/60/80%. Any Doc – Same as In-Network.

		IN-NETWORK	OUT-OF-NETWORK
9	PREVENTIVE CARE a) Children's services b) Adult's services	a) Child Health Supervision Services: 70/80/100%. Deductible does not apply. b) Covered Adult Services: 70/80/100% 1. Annual Mammogram up to $77, no deductible 2. Annual Prostate Cancer Screening up to $65, no deductible 3. Cytologic screenings for women, deductible applies. Option available: Plus Option- 100%up to $300 per insured per calendar year. (Combined for in or out of network)	a) and b): Any Doc –50/60/80%o up to $5,000 of eligible expenses per occurrence plus deductible, 100% thereafter. Select – 50/60/80% of eligible expenses per occurrence plus deductible. Deductible does not apply to Child Health Supervision Services, Mammogram screenings and Prostate Cancer Screening. Option available: Plus Option- 100%up to $300 per insured per calendar year. (Combined for in or out of network)
10	MATERNITY a) Prenatal care b) Delivery & inpatient well baby care	a) Not Covered. b) Delivery is not covered. 70/80/100% hospital stay up to 48 (vaginal) or 96 (cesarean) hours following delivery. Deductible does apply. In and Out-of-Network benefits apply to hospital stay for newborns only.	a) Not Covered. b) Delivery is not covered. Any Doc – 50/60/80% up to $5,000 per occurrence, 100% thereafter for hospital stay up to 48 (vaginal) or 96 (cesarean) hours following delivery. Select – 50/60/80% for hospital stay up to 48 (vaginal) or 96 (cesarean) hours following delivery. Deductible does apply.
11	PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions	70/80/100%. Deductible does apply. Plus Option - $15 copay for generics, $35 copay plus 20% coinsurance for brands and $35 plus 20% coinsurance plus 100% of the cost difference between the brand name drug and the generic substitute for brands with a generic substitute.	Same as In-Network.
12	INPATIENT HOSPITAL	70/80/100%. Deductible does apply.	Any Doc – 50/60/80% up to $5,000 per occurrence, 100% thereafter. Select – 50/60/80% per occurrence. Deductible does apply.
13	OUTPATIENT/AMBULATORY SURGERY	70/80/100%. Deductible does apply.	Any Doc – 50/60/80% up to $5,000 per occurrence, 100% thereafter. Select – 50/60/80% per occurrence. Deductible does apply.
14	LABORATORY & X-RAY	70/80/100%. Deductible does apply. Select- lab & x-ray services delivered as part of an office visit are covered at 100%. Any Doc - lab & x-ray services delivered as part of an office visit are covered at 100% up to $200 per visit.	Any Doc – 50/60/80% up to $5,000 per occurrence, 100% thereafter. Any Doc - lab & x-ray services delivered as part of an office visit – Same as In-Network Select – 50/60/80% per occurrence. Select- lab & x-ray services delivered as part of an office visit – 50/60/80% per occurrence. Deductible does apply.

		IN-NETWORK	OUT-OF-NETWORK
15	EMERGENCY CARE[3]	70/80/100% after separate Emergency Room Deductible of $50 per visit (waived if admitted). Deductible does apply.	Same as In-Network.
16	AMBULANCE	70/80/100% up to $3,000, ground or air transportation per calendar year. Deductible does apply.	Any Doc and Select – 50/60/80% up to $3,000, ground or air transportation per calendar year. Deductible does apply.
17	URGENT, NON-ROUTINE, AFTER HOURS CARE	70/80/100%. Deductible does apply.	Any Doc – 50/60/80% up to $5,000 per occurrence, 100% thereafter. Select – 50/60/80% per occurrence. Deductible does apply.
18	BIOLOGICALLY-BASED MENTAL ILLNESS[4] CARE	Not Covered.	Not Covered.
19	OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	a) 70/80/100% up to $2,500 per person, per calendar year. Deductible does apply. b) 70/80/100% up to $1,000 per person, per calendar year. Deductible does apply. Lifetime maximum of $10,000 per person for inpatient and outpatient combined.	a) 50/60/80% up to $2,500 per person, per calendar year. Deductible does apply. b) 50/60/80% up to $1,000 per person, per calendar year. Deductible does apply. Lifetime maximum of $10,000 per person for inpatient and outpatient combined.
20	ALCOHOL & SUBSTANCE ABUSE	Not Covered.	Not Covered.
21	PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	70/80/100%. Deductible does apply.	Any Doc – 50/60/80% up to $5,000 per occurrence, 100% thereafter. Select – 50/60/80% per occurrence. Deductible does apply.
22	DURABLE MEDICAL EQUIPMENT	70/80/100%. Deductible does apply. See policy for types and circumstances of coverage.	Any Doc – 50/60/80% up to $5,000 per occurrence, 100% thereafter. Select – 50/60/80% per occurrence. Deductible does apply. See policy for types and circumstances of coverage.
23	OXYGEN	70/80/100%. Deductible does apply.	Any Doc – 50/60/80% up to $5,000 per occurrence, 100% thereafter. Select – 50/60/80% per occurrence. Deductible does apply.
24	ORGAN TRANSPLANTS	Maximum of 2 transplant procedures per lifetime. Negotiated rate for transplants in the transplant network.	Maximum of 2 transplant procedures per lifetime limited to $100,000 per procedure.
25	HOME HEALTH CARE	70/80/100% up to 60 visits per year, one visit per day. Deductible does apply.	Any Doc – 50/60/80% $5,000 per occurrence, 100% thereafter, up to 60 visits per year. Select – 50/60/80% up to 60 visits per year. Deductible does apply.
26	HOSPICE CARE	70/80/100% up to a $5,000 lifetime maximum per person. Deductible does apply.	Any Doc – 50/60/80% up to a $5,000 lifetime maximum per person. Select –50/ 60/80% up to a $5,000 lifetime maximum per person. Deductible does apply.

		IN-NETWORK	OUT-OF-NETWORK
27	SKILLED NURSING FACILITY CARE	70/80/100% up to 12 days of confinement per year. Deductible does apply.	Any Doc – 50/60/80% up to $5,000 per occurrence, 100% thereafter, up to 12 days of confinement per year. Select – 50/60/80% up to 12 days of confinement per year. Deductible does apply.
28	DENTAL CARE	Not Covered.	Not Covered.
29	VISION CARE	Not Covered except under Plus Option. Plus Option - Routine eye exam up to $50 per calendar year.	Same as In-Network.
30	CHIROPRACTIC CARE	70/80/100% up to $500 per individual per calendar year. Deductible does apply.	Any Doc – 50/60/80% up to $500 per person per calendar year. Select –50/ 60/80% up to $500 per person per calendar year. Deductible does apply.
31	SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	70/80/100% up to 30 days of confinement in a rehabilitation facility per year. 70/80/100% up to 30 visits for outpatient rehabilitation therapy per year. Deductible does apply.	Any Doc – 50/60/80% up to $5,000 per occurrence, 100% thereafter, up to 30 days of confinement in a rehabilitation facility per year. Select – 50/60/80% up to 30 days of confinement in a rehabilitation facility per year. Deductible does apply.

PART C: LIMITATIONS AND EXCLUSIONS

32	PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.[5]	12 months for all pre-existing conditions unless the covered person is a HIPAA-eligible individual 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, Suite 700 Chicago, IL 60606	

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 #I5-543-00150-CO – Individual.
43	Does the plan have a binding arbitration clause?	Yes.

PART E: COST

44	What is the cost of this plan?	Contact your agent or Celtic to find out the premium for this plan. In some cases, plan costs are included with this form.

PART F: PHYSICIAN PAYMENT METHODS, AND PLAN EXPENDITURES FOR HEALTH EXPENSES, ADMINISTRATION AND PROFIT

Any person interested in applying for coverage, or who is covered by, or who purchased coverage under this plan may request answers to the questions listed below. The request may be made orally or in writing to the agent marketing the plan or directly to the insurance company and shall be answered within five (5) working days of the receipt of the request.

- What are the three most frequently used methods of payment for primary care physicians?
- What are the three most frequently used methods of payment for physician specialists?
- What other financial incentives determine physician payment?
- What percentage of total Colorado premiums are spent on health care expenses as distinct from administration and profit?

[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] Out-of-pocket maximum. 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.

[3] "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.

[4] "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

[5] 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.

[6] Grievances. Insurance regulation 4-2-17 establishes carrier grievance procedures and appeals process requirements. A copy of the regulation is available from the Colorado Division of Insurance.