COLORADO HEALTH PLAN DESCRIPTION FORM

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	ANNUAL DEDUCTIBLE a) Individual b) Family	a) Determined annually. Choice of $1500, $2600, or $5000 for calendar year 2005. b) Determined annually. Choice of $3000, $5150, or $10,000 for calendar year 2005.	Same as In-Network.
5	OUT-OF-POCKET ANNUAL MAXIMUM[2] a) Individual b) Family	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)	Individual pays: a) 20/40% coinsurance after the deductible. b) 20/40% coinsurance after the deductible
6	LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	$7,000,000	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	80/100%. Limited Coverage. Deductible does apply.	60/80%. Limited Coverage. Deductible does apply..

		IN-NETWORK	OUT-OF-NETWORK
9	PREVENTIVE CARE a) Children's services b) Adult's services	a) Covered from birth to age 13. 80/100% Deductible does not apply. b) Covered Adult Services: 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.	c) Covered from birth to age 13. 60/80% Deductible does not apply. d) Covered Adult Services: 60/80% 4. Annual Mammogram up to $77, no deductible 5. Annual Prostate Cancer Screening up to $65, no deductible Cytologic screenings for women, deductible applies.
10	MATERNITY a) Prenatal care b) Delivery & inpatient well baby care	a) Not Covered. b) Delivery is not covered. 80/100%. Hospital Stay (newborns only) Coverage is provided for a hospital stay up to 48 (vaginal) or 96 (cesarean) hours following delivery. Deductible does apply.	a) Not Covered. b) Delivery is not covered. 60/80%. Hospital Stay (newborns only) Coverage is provided for a 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.
11	PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions	80/100% Deductible does apply.	60/80% Deductible does apply.
12	INPATIENT HOSPITAL	80/100% Deductible does apply.	60/80% Deductible does apply.
13	OUTPATIENT/AMBULATORY SURGERY	80/100% Deductible does apply.	60/80% Deductible does apply.
14	LABORATORY & X-RAY	80/100% Deductible does apply.	60/80% Deductible does apply.
15	EMERGENCY CARE[3]	80/100% after separate Emergency Room Deductible of $250 per visit (waived if admitted) - Deductible does apply.	Same as In-Network.
16	AMBULANCE	80/100% up to $3000, per calendar year for ground or air transportation. Deductible does apply.	60/80% up to $3000, per calendar year for ground or air transportation. Deductible does apply.
17	URGENT, NON-ROUTINE, AFTER HOURS CARE	80/100% Deductible does apply	60/80% Deductible does apply.
18	BIOLOGICALLY-BASED MENTAL ILLNESS[4] CARE	Not Covered.	Not Covered.
19	OTHER MENTAL HEALTH CARE a) Inpatient care Outpatient care	a) 80/100% up to $2,500 per insured, per calendar year. Deductible does apply. b) 80/100% up to $1,000 per insured, per calendar year. Deductible does apply. Lifetime maximum of $10,000 per insured for inpatient and outpatient combined.	a) 60/80% up to $2,500 per insured, per calendar year. Deductible does apply. b) 60/80% up to $1,000 per insured, per calendar year. Deductible does apply. Lifetime maximum of $10,000 per insured for inpatient and outpatient combined.

		IN-NETWORK	OUT-OF-NETWORK
20	ALCOHOL & SUBSTANCE ABUSE	Not Covered.	Not Covered.
21	PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	80/100% Deductible does apply	60/80% Deductible does apply.
22	DURABLE MEDICAL EQUIPMENT	80/100% Deductible does apply See policy for types and circumstances of coverage.	60/80% Deductible does apply. See policy for types and circumstances of coverage
23	OXYGEN	80/100% Deductible does apply	60/80% 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	80/100% up to 60 visits per calendar year, one visit per day. Deductible does apply.	60/80% up to 60 visits per calendar year, one visit per day. Deductible does apply.
26	HOSPICE CARE	80/100% up to a $5,000 lifetime maximum per insured. Deductible does apply.	60/80% up to a $5,000 lifetime maximum per insured. Deductible does apply.
27	SKILLED NURSING FACILITY CARE	80/100% up to 12 days of confinement per calendar year. Deductible does apply.	60/80% up to 12 days of confinement per calendar year. Deductible does apply.
28	DENTAL CARE	Not Covered.	Not Covered.
29	VISION CARE	80/100%. Limited coverage. Routine eye exam. Deductible does apply.	60/80%. Limited coverage. Routine eye exam Deductible does apply.
30	CHIROPRACTIC CARE	80/100% up to $500 per insured per calendar year. Deductible does apply.	60/80% up to $500 per insured per calendar year. 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. 80/100% up to 30 visits for outpatient rehabilitation therapy per calendar year. Deductible does apply.	60/80% up to 30 days of confinement in a rehabilitation facility per calendar year. 60/80% up to 30 visits for outpatient rehabilitation therapy per calendar year. Deductible does apply.

PART C: LIMITATIONS AND EXCLUSIONS

32	PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.[5]	12 consecutive months for all pre-existing conditions. Any period of time that a covered person was covered under previous qualifying coverage will be applied to this 12 month period, if such qualifying coverage was continuous to a date not more than 90 days prior to the policy effective date.
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.