TO THE CONSUMER: This Health Plan Description Form contains information specific to the particular product in which you have expressed an interest. Please be sure that the options you have selected have been correctly circled.

Colorado Health Plan Description Form

Golden Rule Insurance Company
Plan 100®

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. AREA 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 only one of the following optional individual annual deductible amounts: 1. $1,000 2. $1,500 3. $2,500 4. $5,000 b) Maximum 2 per calendar year.	Same as in-network, except that nonemergency services received out-of-network are subject to an additional deductible amount equal to the calendar-year deductible.
5. OUT-OF-POCKET ANNUAL MAXIMUM[2] a) Individual b) Family	a) Equal to individual deductible b) Equal to family deductible	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25%, and are subject to additional deductible amount equal to the calendar-year deductible.
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	$3,000,000 per covered person	$3,000,000 per covered person
7A. COVERED PROVIDERS	All providers licensed or certified to provide covered benefits.	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	Covered expense	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25%, and are subject to additional deductible amount equal to the calendar-year deductible.
9. PREVENTIVE CARE a) Children's services (not subject to deductible)	a) Child health supervision services (including a history, complete physical exam, developmental assessment, appropriate immunizations and laboratory tests in accordance with the recommendations of the American Academy of Pediatrics) limited to the following: 1 home visit for a newborn released from the hospital within 48 hours after delivery; Birth -- 12 months, 5 visits, 1 PKU; 13-24 months, 2 visits; 3 years-6 years, 3 visits; 7 years-12 years, 3 visits.	a) Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25%, and are subject to additional deductible amount equal to the calendar-year deductible.
b) Adults' services (not subject to deductible)	b) Mammograms according to the following schedule: Age 35-39, one mammogram, inclusive; Age 40 > 50 one mammogram biannually; Age 50+, one mammogram per year. Prostate cancer screening according to the following schedule: Age 40 > 50 annual screening for high risk individuals; Age 50+, one screening annually; Maximum benefit: $65.	b) Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25%.
c) Adults' services (subject to deductible)	c) $150 per covered adult, per calendar year for routine physicals -- benefit available after coverage in force 12 months.	c) $150 per covered adult, per calendar year for routine physicals -- benefit available after coverage in force for 12 months and subject to out-of-network deductible and coinsurance.

10. MATERNITY a) Prenatal care b) Delivery & inpatient well-baby care	a) and b) select only one of the following maternity benefits: Not covered (optional benefits rejected). Optional Benefit A: $1,250 if child is delivered during first year of coverage or $2,500 if child is delivered during and after second year of coverage. Optional Benefit B: $2,000 if child is delivered during first year of coverage or $4,000 if child is delivered during and after second year of coverage. Newborn inpatient hospital stay following birth to maximum of: 1) 48 hours after normal vaginal delivery; or 2) 96 hours after cesarean section delivery.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25%, and are subject to additional deductible amount equal to the calendar-year deductible.
11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions	Select only <u>one</u> of the following optional prescription drug benefits: a) Covered expenses b) PCS Card Copays Per perscription order to refill: Generic Drug Copay $20 Name Brand Drug Copay $50 after a $250 calendar year, per person deductible (benefit reduction if drug card or member pharmacy is not used).	a) Same as in-network b) Same as in-network except benefit limited to ingredient cost plus dispensing fee.
12. INPATIENT HOSPITAL	Daily room and board maximum: Most common semi-private room rate. Intensive care unit: First 60 days of confinement for one illness or injury at reasonable and customary charges with remainder of confinement at most common semi-private room rate.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25%, and are subject to additional deductible amount equal to the calendar-year deductible.

13. OUTPATIENT/ AMBULATORY SURGERY	Covered expense	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25%, and are subject to additional deductible amount equal to the calendar-year deductible.
14. LABORATORY & X RAY	Covered expense	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25%, and are subject to additional deductible amount equal to the calendar-year deductible.
15. EMERGENCY CARE[3]	Additional $100 emergency room deductible (waived for injury or if admitted).	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25%, and are subject to additional deductible amount equal to the calendar-year deductible.
16. AMBULANCE	Covered expense	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25%, and are subject to additional deductible amount equal to the calendar-year deductible.
17. URGENT, NONROUTINE, AFTER-HOURS CARE	Covered expense	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25%, and are subject to additional deductible amount equal to the calendar-year deductible.
18. BIOLOGICALLY BASED MENTAL ILLNESS[4]	Coverage is no less extensive than the coverage provided for any other physical illness.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25%, and are subject to additional deductible amount equal to the calendar-year deductible.
19. OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	a) Limited to 45 days inpatient confinement or 90 days partial hospitalization per covered person, per calendar year. b) Limited to $1,000 per covered person, per calendar year, and subject to 50%	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25%, and are subject to additional deductible amount equal to the calendar-year deductible.

20. ALCOHOL & SUBSTANCE ABUSE	Inpatient care covered the same as any illness. Professional fees of a medical practitioner for outpatient care limited to $50 per visit. Inpatient and out-patient care limited to combined $3,000 lifetime maximum per	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25%, and are subject to additional deductible amount equal to the calendar-year deductible.
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	Covered expense. All covered in relation to Home Health Care or Hospice Care; physical therapy also covered on outpatient basis.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25%, and are subject to additional deductible amount equal to the calendar-year deductible.
22. DURABLE MEDICAL EQUIPMENT	I.V. stand and I.V. tubing, infusion pump or cassette, portable commode, patient lift, bili-lights, and suction machine or suction catheters.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25%, and are subject to additional deductible amount equal to the calendar-year deductible.
23. OXYGEN	Covered expense	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25%, and are subject to additional deductible amount equal to the calendar-year deductible.
24. ORGAN TRANSPLANTS	Covered expense	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25%, and are subject to additional deductible amount equal to the calendar-year deductible.
25. HOME HEALTH CARE	Home health aide service limited to 7 visits/week to a maximum of 365 visits/lifetime. Private duty registered nurse services limited to 1,000 hours lifetime maximum per covered person, at maximum $75 per visit.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25%, and are subject to additional deductible amount equal to the calendar-year deductible.

26. HOSPICE CARE	Occupational and speech-language therapy; medical, palliative and support care; procedures necessary for pain control and acute and chronic symptom management; counseling for the terminally ill person and his or her immediate family; bereavement counseling limited to $250. Inpatient: 90 days/lifetime Outpatient: $1,500/lifetime.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25%, and are subject to additional deductible amount equal to the calendar-year deductible.
27. SKILLED NURSING FACILITY CARE	Must begin within 14 days of a hospital stay of at least 3 days and be for active treatment of same illness or injury. Limited to 30 days per year, per covered person. Maximum benefit is $15,000 per year, per covered person.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25%, and are subject to additional deductible amount equal to the calendar-year deductible.
28. DENTAL CARE	Damage to natural teeth by injury incurred after the covered person's effective date, if expenses incurred within 6 months after injury.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25%, and are subject to additional deductible amount equal to the calendar-year deductible.
29. VISION CARE	Limited to medically necessary treatment of an illness or injury.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25%, and are subject to additional deductible amount equal to the calendar-year deductible.
30. CHIROPRACTIC CARE	Limited to $2,000 per covered person, per calendar year.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25%, and are subject to additional deductible amount equal to the calendar-year deductible.
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	Surgical treatment of temporomandibular joint disorders (limited to $10,000 per covered person), hemodialysis, diagnostic testing, diabetes management.	Same as in-network, except that nonemergency services received out-of-network reduce covered expenses by 25%, and are subject to additional deductible amount equal to the calendar-year deductible.

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PREEXISTING CONDITIONS ARE NOT COVERED[5]	6 months for all preexisting conditions unless the covered person is a HIPAA-eligible individual as defined under federal and state law, in which case there are no preexisting condition exclusions.
33. EXCLUSIONARY RIDERS. Can an individual's specific, preexisting condition be entirely excluded from the policy?	Yes, unless the individual is a HIPAA-eligible individual as defined under federal and state law.
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	A preexisting condition is a condition for which medical advice, diagnosis, care or treatment was recommended or received within the last 6 months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that preexisting condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.
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

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)?	No	No
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?	(618) 943-5064	
40. Whom do I write/call if I have a complaint or want to file a grievance?[6]	Golden Rule Customer Service 712 Eleventh Street Lawrenceville, Illinois 62439 (618) 943-5064	
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 Suite 850, 1560 Broadway 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.	Policy number P-006.4 Large group only	

PART E: COST

43. What is the cost of this plan?	Contact your agent or this insurance company 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?

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[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 may pay 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 illness" means schizophrenia, schizo-affective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

[5] 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 for details.

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