

Colorado Health Benefit Plan Description Form
Colorado Choice Health Plans d/b/a San Luis Valley HMO
STATE OF COLORADO – JULY 1, 2008

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Health Maintenance Organization (HMO)
2. OUT-OF-NETWORK CARE COVERED? ¹	Only for emergency and urgent care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available only in the following areas: the counties of Alamosa, Conejos, Costilla, Mineral, Rio Grande and Saguache

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 specialist, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

	IN-NETWORK ONLY (Out-of-network care is not covered except as noted)
4. Deductible type ²	Benefit Year
4. ANNUAL DEDUCTIBLE ^{2a} a) Individual ^{2b} b) Family ^{2c}	a) \$250.00 b) \$750.00
5. OUT-OF-POCKET ANNUAL MAXIMUM ³ a) Individual b) Family c) Is deductible included in the out-of-pocket max?	a) \$1,000 excluding copays b) \$3,000 excluding copays c) No Additional items not subject to Out-of-Pocket Maximum as noted herein.
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	\$2,000,000 Lifetime Maximum
7A. COVERED PROVIDERS	Approx. 2,500 physicians and specialty providers and 20 hospitals in Colorado. See provider directory for complete list of current providers
7B. WITH RESPECT TO NETWORK PLANS, ARE ALL THE PROVIDERS LISTED IN 7A ACCESSIBLE TO ME THROUGH MY PRIMARY CARE PHYSICIAN?	Yes.
8. ROUTINE MEDICAL OFFICE VISITS ⁴ a) Primary Care Physician b) Specialists	a) \$30 per visit copay. b) \$50 per visit copay. (Subject to deductible)
9. PREVENTIVE CARE a) Children's services b) Adults' services	a) \$30 per visit copay-Primary care Physician; \$50 per visit copay-Specialist. b) \$30 per visit copay-Primary care Physician; \$50 per visit copay-Specialist. Not subject to deductible
10. MATERNITY a) Prenatal care b) Delivery & inpatient well baby care ⁵	Coverage is no less extensive than the coverage provided for any other physical illness. Subject to deductible. a) \$30 per visit copay-Primary care Physician; \$50 per visit copay-Specialist. b) \$250 copay per day; up to a maximum of 4 days per admission copay. Applies to maximum out-of-pocket.

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11. PRESCRIPTION DRUGS ⁶ Level of coverage and restrictions on prescriptions	After a \$100 common prescription deductible: \$10 copay for formulary generic; \$25 copay for formulary brand name ; \$50 copay for non-formulary brand name and non-formulary generic. Prescriptions are filled at the lesser of a 30-day supply or 100 unit dose. Two copays required for 90-day supply of maintenance drugs through mail order. 20% copay for injectables and specific listed high cost oral medications. For drugs on our approved list, excluded drugs and injectables subject to the 20% copay contact Customer Service. Not subject to out of pocket maximum.
12. INPATIENT HOSPITAL	\$250 copay per day; up to a maximum of 4 days per admission copay. Subject to deductible. Applies to maximum-out-of-pocket.
13. OUTPATIENT/AMBULATORY SURGERY (INVASIVE PROCEDURES CONSIDERED SURGERY)	\$200 copay per procedure/surgery. Subject to deductible. Applies to maximum-out-of-pocket.
14. LABORATORY & X-RAY a) Laboratory & X-ray b) MRI, nuclear medicine, and other high-tech services	a) Inpatient - Included in per admission copay. Outpatient - \$20 copay +10% b) Inpatient - Included in per admission copay. Outpatient - \$75 copay + 20% Subject to deductible.
15. EMERGENCY CARE ^{7,8}	\$100 per visit copay (waived if admitted). Out-of-network follow-up treatment for out of service area medical emergencies is not covered. Subject to deductible
16. AMBULANCE	20% copay per trip. Not waived if admitted, not included in Out-of-Pocket maximum. Subject to deductible.
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	\$50 per visit copay at Participating Urgent Care Facility. Out-of-network urgent care covered only if traveling or temporarily absent from the service area. Out-of-network follow-up treatment for out-of-service area urgent care services is not covered. Subject to deductible.
18. BIOLOGICALLY-BASED MENTAL ILLNESS ⁹ CARE	Coverage is no less extensive than the coverage provided for any other physical illness. Subject to deductible.
19. OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	a) 50% copay. Inpatient care covered up to 45 full days or 90 half days per contract year. Does not apply to out-of-pocket maximum. b) \$30 per visit copay up to 20 visits per contract year. Maximum Plan Benefit is \$1,000 per contract year. Subject to deductible.
20. ALCOHOL & SUBSTANCE ABUSE a) Inpatient Care b) Outpatient Care	a) 50% copay. Coverage is limited to medically necessary detoxifications as determined by the Plan Medical Director. Limited to one treatment per contract year, two per lifetime. Does not apply to out-of-pocket maximum. b) \$30 per visit copay. Limited to 20 visits per year. Limited to medically necessary treatment as determined by the Plan Medical Director. Maximum Plan Benefit is \$1,000 per contract year. Subject to deductible.
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	Inpatient - \$250 copay per day; up to a maximum of 4 days per admission copay. (Limited to 30 days per injury or illness). Outpatient - \$30 per visit copay, up to 30 treatments per contract year. See policy for types and circumstances of coverage. Subject to deductible.

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22. DURABLE MEDICAL EQUIPMENT	50% copay of covered charges to total maximum Durable Medical Equipment benefit of \$3000 per contract year. (Diabetes related coverage combined with other DME shall have a combined \$5,000 maximum). See policy for types and circumstances of coverage. Not subject to Out-of-Pocket maximum. Subject to deductible.
23. OXYGEN	50% copay of covered charges. (Part of Durable Medical Equipment coverage.) Subject to deductible.
24. ORGAN TRANSPLANTS	Inpatient - \$250 copay per day; up to a maximum of 4 days per admission copay. See policy for types and circumstances of coverage. Subject to deductible.
25. HOME HEALTH CARE	\$30 copay. Limited to 30 visits per contract year. Subject to deductible.
26. HOSPICE CARE	\$30 copay. Limited to 90 visits per contract year. See policy for circumstances of coverage. Subject to deductible.
27. SKILLED NURSING FACILITY CARE	\$30 copay. Limited to 30 days per contract year. Subject to deductible.
28. DENTAL CARE	Available as a separate dental plan as an optional benefit.
29. VISION CARE	\$30 per visit copay limited to one visit every 24 months. Hardware not covered.
30. CHIROPRACTIC CARE	No chiropractic benefits are available.
31. SIGNIFICANT ADDITIONAL COVERED SERVICES	<p>1. Cancer screening Coverage: (as ordered by your physician) Cancer screening tests are covered as follows (subject to the applicable Health Benefit Plan deductibles, copay/coinsurance, referrals and maximum benefit levels):</p> <p>a) <u>Breast Cancer Screening</u> - Mammograms – single baseline mammogram for women ages 35 to 39 once during a five year period; once every two years for women ages 40 to 50; annually for women over 50; once a year for women with risk factors to breast cancer as determined by her Primary Care Physician.</p> <p>b) <u>Cervical Cancer Screening</u> – Annual pelvic exam and Pap Smear as age appropriate</p> <p>c) <u>Colon Cancer Screening</u> – age 50 and over are covered for two colorectal visualizations between ages 50 and 70.</p> <p>d) <u>Prostate Cancer Screening</u> – men age 50 and over are covered for annual PSA Blood test and digital rectal exam and men 40-49 years of age if at increased risk.</p> <p>Subject to deductible.</p>

PART C: LIMITATIONS AND EXCLUSIONS

	IN-NETWORK
32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED. ¹⁰	Not applicable. Plan does not impose limitation periods for pre-existing conditions.
33. EXCLUSIONARY RIDERS Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No.
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	Not applicable. Plan does not impose limitation periods for pre-existing conditions.

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	IN-NETWORK
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, agent, or plan sponsor (e.g., employer). Review the list to see if a service or treatment you may need is excluded from the policy.

PART D: USING THE PLAN

	IN-NETWORK
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	Yes.
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes.
38. If the provider charges more for a covered service than the plan normally pay, does the enrollee have to pay the difference?	No.
39. What is the main customer service number?	(719)589-3696
40. Whom do I write/call if I have a complaint or want to file a grievance? ¹¹	Complaint & Grievance Coordinator San Luis Valley HMO, Inc. 700 Main Street, Suite 100 Alamosa, CO 81101 (719)589-3696
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, or large group; and if it is a short-term policy.	Policy Form #SOC DOI 7-2008 State of Colorado Employee Group
43. Does the plan have a binding arbitration clause?	Yes, to the extent permitted by law

Endnotes:

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 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 of 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 a benefit year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible should be noted in boxes 8 through 31.
- 2b. "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. "Single" means the deductible amount you will have to pay for allowable covered expenses under an HSA-qualified health plan when you are the only individual covered by the plan.
- 2c. "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"). "Non-Single" is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any covered expenses are paid.
3. "Out-of-pocket maximum" means 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. The specific deductibles or copayments included in the out-of-pocket maximums may vary by policy. Expenses that are applied toward the out-of-pocket maximum should be noted in boxes 8 through 31.
4. Medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically-based mental illness.

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5. Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together; there are not separate copayments.
6. Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.
7. “Emergency care” means all services delivered in an emergency care facility that 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. Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours care, then urgent care copayments apply.
9. “Biologically based mental illnesses” means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.
10. Waiver of pre-existing 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.
11. Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.