

Colorado Health Plan Description Form

Guarantee Trust Life Insurance Company

Name of Carrier

TrustCare Popular Individual Preferred Provider Plan

Name of 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. Coinsurance and copayment options reflect the amount the covered person will pay.

	BENEFIT LEVELS	
	<i>In Network</i>	<i>Out of Network</i>
4. ANNUAL DEDUCTIBLE ² a) Individual b) Family	a) Separate deductibles of \$1000, \$1500, \$2500, \$3500, \$5000 b) Maximum 3 individual calendar year deductibles	
5. OUT-OF-POCKET ANNUAL MAXIMUM ³ a) Individual b) Family c) Is deductible included in the out-of-pocket maximum?	a) Per insured – based on selected coinsurance plan. Does not include calendar year deductible, copays, service deductibles or non-covered expenses. PPO/NonPPO out-of-pocket maximums accumulate separately. <i>If PPO/NonPPO coinsurance plan selected is:</i> 80/20%*-\$5,000; 60/40%*-\$10,000 80/20%*-\$10,000; 60/40%*-\$20,000 50/50%*-\$10,000; 50/50%*-\$20,000 *Covered person’s coinsurance b) Sum of individual out-of-pocket maximum c) No	<i>Individual Out-of-pocket In/Out of Network is:</i> \$1,000 PPO/\$4,000 NonPPO \$2,000 PPO/\$8,000 NonPPO \$5,000 PPO/\$10,000 NonPPO

	<i>In Network</i>	<i>Out of Network</i>
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	\$5,000,000 per insured; applies to both in and out-of-network expenses	
7. a) COVERED PROVIDERS	a) Sloans Lake Managed Care, Sloans Lake Preferred, First Health Network and Private Health Care Systems (see provider directory for complete list of <u>current providers</u>)	a) All providers licensed or certified to provide covered benefits
7. b) With respect to network plans, are the providers listed in 7a accessible to me through my primary care physician?	b) Yes	b) Not applicable
8. ROUTINE MEDICAL OFFICE VISITS ⁴ a) Primary Care Specialists b) Specialists	a) Subject to \$45 Physician Office Visit Copay After copay, balance of physician office visit charge paid at 100%. All other covered expenses during the office visit subject to selected calendar year deductible and coinsurance plan. b) Same as a) above.	a) Subject to \$45 Physician Office Visit Copay; after copay balance of physician office visit charge and all other covered expenses during office visit are subject to selected calendar year deductible and NonPPO coinsurance. b) Same as a) above.
9. PREVENTIVE CARE a) Children's services b) Adults' services	a) Eligible charges for specified services at defined age intervals covered from birth through age 12. Covered expenses subject to \$45 Physician Office Visit Copay and selected Coinsurance plan. Calendar year deductible does not apply. b) Mammograms: 100% covered at defined age intervals. c) Routine Physical Exam for primary insured and covered spouse: covered after 90 days up to \$150 maximum benefit, including lab tests (blood/urine) associated with the same routine physical exam, per each 2 year Benefit Period. Subject to selected coinsurance plan.	a) Eligible charges for specified services at defined age intervals covered from birth through age 12. Covered expenses subject to \$45 Physician Office Visit Copay and NonPPO coinsurance plan. Calendar Year deductible does not apply. b) Mammograms: 100% covered at defined age intervals. c) Routine Physical Exam for primary insured and covered spouse: covered after 90 days up to \$150 maximum benefit including lab tests (blood/urine) associated with the same physical exam) per each 2 year benefit period. Subject to selected NonPPO coinsurance plan.
10. MATERNITY a) Prenatal care b) Delivery & inpatient well baby care ⁵	a) Not covered unless a complication of pregnancy (COP). If COP, subject to selected calendar year deductible and coinsurance plan, plus a \$200 Service Deductible, if applicable, and/or \$45 Physician Office Visit Copay. b) Delivery–same as a) above. Inpatient Well Baby Care–subject to selected calendar year deductible and coinsurance plan, plus \$200 Inpatient Hospital Service Deductible.	a) Not covered unless a complication of pregnancy (COP). If COP, subject to selected calendar year deductible and coinsurance plan, plus a \$200 Service Deductible, if applicable, and/or \$45 Physician Office Visit Copay. b) Delivery–same as a) above. Inpatient Well Baby Care–subject to selected calendar year deductible and NonPPO coinsurance plan, plus \$200 Inpatient Hospital Service Deductible.
11. PRESCRIPTION DRUGS ⁶ Level of coverage and restrictions on prescriptions	Subject to a separate \$500 or \$1,000 Rx deductible per person per calendar year and to the following drug copays per prescription: \$15 generic, \$30 formulary, \$40 brand name copayment per prescription	

	For drugs on our approved list, contact a Customer Service Representative at Express Scripts at 800-234-7345.	
	<i>In Network</i>	<i>Out of Network</i>
12. INPATIENT HOSPITAL	Subject to selected calendar year deductible and coinsurance plan plus \$200 Inpatient Hospital Service Deductible per each confinement.	Subject to selected calendar year deductible and NonPPO coinsurance plan plus \$200 Inpatient Hospital Service Deductible per each confinement.
13. OUTPATIENT/ AMBULATORY SURGERY	Subject to selected calendar year deductible and coinsurance plan plus \$200 Outpatient Ambulatory Surgical Facility Service Deductible.	Subject to selected calendar year deductible and NonPPO coinsurance plan plus \$200 Outpatient Ambulatory Surgical Facility Service Deductible.
14. DIAGNOSTICS a) Laboratory & X-ray b) MRI, nuclear medicine and other high-tech services	<p>a) If performed in a PPO doctor's office – subject to \$45 Physician Office Visit Copay plus selected calendar year deductible and coinsurance plan. If performed in a separate testing facility – subject to selected calendar year deductible and coinsurance plan selected.</p> <p>b) Outpatient MRI, CAT Scan, Nuclear Imaging Tests subject to a \$200 Service Deductible per test, plus selected calendar year deductible and coinsurance plan.</p>	<p>a) If performed in a NonPPO doctor's office – subject to \$45 Physician Office Visit Copay plus selected calendar year deductible and NonPPO coinsurance plan. If performed in a separate testing facility – subject to selected calendar year deductible and NonPPO coinsurance plan.</p> <p>b) Outpatient MRI, CAT Scan, Nuclear Imaging Tests subject to a \$200 Service Deductible per test, plus selected calendar year deductible and NonPPO coinsurance plan.</p>
15. EMERGENCY CARE ^{7,8}	Subject to selected calendar year deductible and coinsurance plan, plus \$45 Physician Office Visit Copay, if treated in the doctor's office, or plus \$100 Hospital Emergency Room Service Deductible per occurrence, if treated in the Emergency Room (Service Deductible waived if admitted as an inpatient immediately following emergency room visit)	
16. AMBULANCE	Subject to selected calendar year deductible and coinsurance plan up to a maximum benefit of \$1,000 per each ground or water occurrence; and \$5,000 per each air occurrence.	Subject to selected calendar year deductible and NonPPO coinsurance plan up to a maximum benefit of \$1,000 per each ground or water occurrence; and \$5,000 per each air occurrence.
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	Subject to selected calendar year deductible and coinsurance plan, plus \$45 Physician Office Visit Copay, if treated in the doctor's office, or plus \$100 Hospital Emergency Room Service Deductible per occurrence, if treated in the Emergency Room (Service Deductible waived if admitted as an inpatient immediately following emergency room visit).	Subject to selected calendar year deductible and NonPPO coinsurance plan, plus \$45 Physician Office Visit Copay, if treated in the doctor's office, or plus \$100 Hospital Emergency Room Service Deductible per occurrence, if treated in the Emergency Room (Service Deductible waived if admitted as an inpatient immediately following emergency room visit).

	<i>In Network</i>	<i>Out of Network</i>
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE ⁹	<p>a) <i>Inpatient</i> treatment subject to selected calendar year deductible and coinsurance plan, plus \$200 Inpatient Hospital Service Deductible per each confinement, up to a maximum benefit per calendar year of 55 days of active treatment or \$2,000, whichever occurs first.</p> <p>b) <i>Outpatient</i> treatment in an outpatient mental health treatment center subject to selected calendar year deductible and 50% coinsurance up to a maximum benefit of \$20 per visit and 55 visits per calendar year.</p>	<p>a) <i>Inpatient</i> treatment subject to selected calendar year deductible and NonPPO coinsurance plan, plus \$200 Inpatient Hospital Service Deductible per each confinement, up to a maximum benefit per calendar year of 55 days of active treatment or \$2,000, whichever occurs first.</p> <p>b) <i>Outpatient</i> treatment in an outpatient mental health treatment center subject to selected calendar year deductible and 50% coinsurance up to a maximum benefit of \$20 per visit and 55 visits per calendar year.</p>
19. OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	<p>a) Covered on same basis as #18 above.</p> <p>b) Covered on same basis as #18 above.</p>	<p>a) Covered on same basis as #18 above.</p> <p>b) Covered on same basis as #18 above.</p>
20. ALCOHOL & SUBSTANCE ABUSE	<p>a) <i>Inpatient</i> treatment subject to selected calendar year deductible and coinsurance plan, plus \$200 Inpatient Hospital Service Deductible per each confinement, up to a maximum benefit per calendar year of 55 days of active treatment or \$2,000, whichever occurs first. Benefit limits are in conjunction with #18 and #19 above.</p> <p>b) <i>Outpatient</i> treatment not covered.</p>	<p>a) <i>Inpatient</i> treatment subject to selected calendar year deductible and NonPPO coinsurance plan, plus \$200 Inpatient Hospital Service Deductible per each confinement, up to a maximum benefit per calendar year of 55 days of active treatment or \$2,000, whichever occurs first. Benefit limits are in conjunction with #18 and #19 above.</p> <p>b) <i>Outpatient</i> treatment not covered.</p>
21. PHYSICAL, OCCUPATIONAL & SPEECH THERAPY	Physical & Speech: Covered for rehabilitative treatment, subject to selected calendar year deductible and coinsurance plan. Occupational: Not covered.	Physical & Speech: Covered for rehabilitative treatment, subject to selected calendar year deductible and NonPPO coinsurance plan. Occupational: Not covered.
22. DURABLE MEDICAL EQUIPMENT	Rental covered up to purchase price of equipment, subject to selected calendar year deductible and coinsurance plan. See policy for types and circumstances of coverage.	
23. OXYGEN	Covered including rental of equipment for the administration of oxygen up to purchase price of equipment, subject to selected calendar year deductible and coinsurance plan.	
24. ORGAN TRANSPLANTS	Subject to selected calendar year deductible and coinsurance plan, plus \$200 Inpatient Hospital Service Deductible per each confinement.	Subject to selected calendar year deductible and NonPPO coinsurance plan, plus \$200 Inpatient Hospital Service Deductible per each confinement.
25. HOME HEALTH CARE	Subject to selected calendar year deductible and coinsurance plan, up to a maximum benefit of 60 visits per calendar year.	Subject to selected calendar year deductible and NonPPO coinsurance plan, up to a maximum benefit of 60 visits per calendar year.

	<i>In Network</i>	<i>Out of Network</i>
26. HOSPICE CARE	Subject to selected calendar year deductible and coinsurance plan. The benefit will be not less than \$100 per day per 3-month benefit period, and up to 3 maximum 3-month benefit periods per insured's lifetime.	Subject to selected calendar year deductible and NonPPO coinsurance plan. The benefit will be not less than \$100 per day per 3-month benefit period, and up to 3 maximum 3-month benefit periods per insured's lifetime.
27. SKILLED NURSING FACILITY CARE	Subject to selected calendar year deductible and coinsurance plan.	Subject to selected calendar year deductible and NonPPO coinsurance plan.
28. DENTAL CARE	No coverage, except treatment required as a result of a covered injury to sound natural teeth.	
29. VISION CARE	No coverage.	
30. CHIROPRACTIC CARE	Physician charges for spinal manipulation and other manipulative therapy subject to selected calendar year deductible and coinsurance plan, plus \$45 Physician Office Visit Copay up to a maximum benefit of \$500 per calendar year.	Physician charges for spinal manipulation and other manipulative therapy subject to selected calendar year deductible and NonPPO coinsurance plan, plus \$45 Physician Office Visit Copay up to a maximum benefit of \$500 per calendar year.
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	<p>Mammograms – One baseline ages 35-39; one every two years for ages 40-49, one every year for high risk factors and one every year for ages 50-65. Routine mammograms not subject to any copays, calendar year deductibles, coinsurance or service deductibles.</p> <p>Pap Smears – One screening per calendar year, subject to selected calendar year deductible and coinsurance plan plus \$45 Physician Office Visit Copay.</p> <p>Prostate Exams – Males age 50 and over (40 if high risk). Not subject to any copays, calendar year deductibles, coinsurance or service deductibles.</p>	<p>Mammograms – One baseline ages 35-39; one every two years for ages 40-49, one every year for high risk factors and one every year for ages 50-65. Routine mammograms not subject to any copays, calendar year deductibles, coinsurance or service deductibles.</p> <p>Pap Smears – One screening per calendar year, subject to selected calendar year deductible and NonPPO coinsurance plan plus \$45 Physician Office Visit Copay.</p> <p>Prostate Exams – Males age 50 and over (40 if high risk). Not subject to any copays, calendar year deductibles, coinsurance or service deductibles.</p>

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED ¹⁰	12 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 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 preexisting condition is an illness, injury or pregnancy for which a person incurred charges, received medical advice, treatment, services, diagnostic tests, consultation from a physician or taken 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. A 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

	<i>In Network</i>	<i>Out of Network</i>
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.
	<i>In Network</i>	<i>Out of Network</i>
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?	800-505-3340	
40. Whom do I write/call if I have a complaint or want to file a grievance? ¹¹	Guarantee Trust Life Insurance Company 1275 Milwaukee Avenue, Glenview, IL 60025	
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 GO591-CO, Individual	
43. Does the plan have a binding arbitration clause?	No.	

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 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 “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) 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 may be noted in boxes 8 through 31.
- 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 deductibles 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. Expenses that are applied toward the out-of-pocket maximum may be noted in boxes 8 through 31.
- ⁴ Routine medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically-based mental illness.
- 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 services delivered by 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 illness” means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.
- ¹⁰ 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.
- ¹¹ Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.