Colorado Health Benefit Plan Description Form

Standard Security life Insurance Company of New York

Name of Carrier

IAC Personal Health Plans Copay PPO 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.

	IN-NETWORK	**OUT-OF-NETWORK**
4.DEDUCTIBLE TYPE[2]	Calendar year deductible per covered person	Calendar year deductible per covered person
4a. ANNUAL DEDUCTIBLE$_{2a}$ a) Individual$_{2b}$ b) Family$_{2c}$	Per covered person – Separate calendar year deductible based on in-network selection: a) If selected **In-network individual** calendar year deductible is: $500 $1,000 b) satisfied when 3 covered persons each satisfy their individual calendar year deductible. In-network and out-of-network deductibles accumulate separately except when the out-of-network calendar year deductible maximum is satisfied then the in-network deductible maximum will be deemed satisfied.	a) **Out-of-network individual** calendar year deductible is: $1,500 $3,000

	IN-NETWORK	OUT-OF-NETWORK
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] a) Individual b) Family c) Is deductible included in the out-of-pocket maximum?	a) Per covered person based on selected individual out-of-pocket maximum – does not include deductible, copays (excluding Inpatient Confinement and Surgical Services Copay) and outpatient mental, nervous or chemical dependency disorders or expenses not covered. Medical Services and Outpatient Surgical Services and Supplies $0 Inpatient Confinement and Surgical Services $4,000 or $8,000 Medical Services and Outpatient Surgical Services and Supplies $10,000 Inpatient Confinement and Surgical Services $12,000 or $24,000 b) Satisfied when 3 covered persons each satisfy their individual calendar year out-of-pocket maximum. c) No In-network and out-of-network out-of-pocket maximums accumulate separately, except when the out-of-network calendar year out-of-pocket maximum is satisfied then the in-network out-of-pocket maximum will be deemed satisfied.	
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	Lifetime Maximum: $5,000,000; Calendar Year Maximum per Covered Person: $1,000,000. Applicable to both in-network and out-of-network expenses.	
7. A. COVERED PROVIDERS	PHCS, First Health Network, Cofinity. See provider directory for complete list of current providers.	All providers licensed or certified to provide covered benefits.
7. B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes	Not Applicable
8. MEDICAL OFFICE VISITS[4] a) Primary Care Specialists b) Specialists	Subject to selected calendar year deductible then $40 copay per physician office visit, then plan pays 100% of the balance of office visit charge; b) same as a) above	a) Subject to the out-of-network calendar year deductible, then $70 copay per physician office visit then paid at 70% percentage of usual and reasonable charges. b) Same as a) above.

	IN-NETWORK	OUT-OF-NETWORK
9. PREVENTIVE CARE a) Children's services b) Adults' services	a) Paid at 100% for eligible charges for specified services at defined age intervals covered from birth through age 12. The calendar year deductible is not applicable. b) Mammogram: Paid at 100% at defined ages. The calendar year deductible and copays are not applicable. Pap Smear: Paid at 100%. The calendar year deductible and copays are not applicable. PSA: Paid upon attaining defined age. The calendar year deductible is not applicable. Colorectal Cancer Exams: Paid upon attaining defined age and subject to selected calendar year deductible, coinsurance and any applicable copay. Routine Physical Exams: covered only if the optional Preventive Care Benefit Rider is specified as applicable on the Schedule of Benefits If the optional Preventive Care Benefit Rider elected, Child Preventive Care Services, Colorectal Cancer Exams, PSA and Routine Physical Exams are paid at 100% up to selected maximum of $250 or $500 per Covered Person. Covered charges in excess of selected maximum subject to selected calendar year deductible, coinsurance and applicable copay.	a) Paid at 70% of usual and reasonable charges, for eligible charges for specified services at defined age intervals covered from birth through age 12. The calendar year deductible is not applicable. b) Mammogram: at defined ages, paid at 100% of usual and reasonable charges. The calendar year deductible and copays are not applicable. Pap Smear: Paid at 100% of usual and reasonable charges. The calendar year deductible and copays are not applicable. PSA: Paid upon attaining defined age. The out-of-network calendar year deductible is not applicable. Colorectal Cancer Exams: Paid upon attaining defined age and subject to selected out-of-network calendar year deductible, 70% coinsurance and any applicable copay. Routine Physical Exams: covered only if the optional Preventive Care Benefit Rider is specified as applicable on the Schedule of Benefits; subject to selected out-of-network calendar year deductible, 70% coinsurance and any applicable copay.
10. MATERNITY a) Prenatal care b) Delivery & inpatient well baby care [5]	a) Not covered, except for complications of pregnancy (COP). If COP, subject to selected calendar year deductible and applicable copay. b) Delivery-same as a) above. Inpatient well baby care subject to selected calendar year deductible then $500 copay per day.	a) Not covered, except for complications of pregnancy (COP). If COP, subject to the selected out-of-network calendar year deductible, $750 per day copay, then paid at 70% coinsurance of usual and reasonable charges. b) Delivery-same as a) above. Inpatient well baby care subject to the selected out-of-network calendar year deductible, $750 copay per day then paid at 70% coinsurance percentage of usual and reasonable charges.

	IN-NETWORK	OUT-OF-NETWORK
11. PRESCRIPTION DRUGS[6] Level of coverage and restrictions on prescriptions	**Not covered unless optional Outpatient Prescription Drug Coverage elected . If elected**: ***Rx Plan 3*** Prescription medication calendar year deductible not applicable. Each generic medication: $30 copay; 100% of balance of cost. Each formulary brand drug: Not Covered Each non-formulary brand drug: Not Covered Specialty medications: Not Covered ***OR*** ***Rx Plan 4*** Prescription medication calendar year deductible not applicable. Each generic medication: $30 copay; 100% of balance of cost. Each formulary brand drug: subject to the applicable calendar year deductible and coinsurance. Each non-formulary brand drug: subject to the applicable calendar year deductible and coinsurance. Specialty medications: subject to the applicable calendar year deductible and coinsurance. ***OR*** ***Rx Plan 5*** Prescription medication calendar year deductible not applicable for generic medication; $500 per covered person for formulary brand, non-formulary brand drug and specialty medications. Outpatient Prescription medication calendar year deductible family maximum is satisfied when 3 covered person have each satisfied their outpatient prescription medication calendar year deductible. Each generic medication: $30 copay; 100% of balance of cost.. Each formulary brand drug: $50 copay; 100% of balance of cost. Each non-formulary brand drug: $75 copay; 100% of balance of cost. Specialty medications: $100 copay; 100% of balance of cost. ***OR*** ***Rx Plan 6*** Prescription medication calendar year deductible not applicable for generic medication; $1,000 per covered person for formulary brand, non-formulary brand drug and specialty medications. Outpatient Prescription medication calendar year deductible family maximum is satisfied when 3 covered person have each satisfied their outpatient prescription medication calendar year deductible. Each generic medication: $30 copay; 100% of balance of cost.. Each formulary brand drug: $50 copay; 100% of balance of cost. Each non-formulary brand drug: $75 copay; 100% of balance of cost. Specialty medications: $100 copay; 100% of balance of cost.	

12. INPATIENT HOSPITAL	Subject to the selected calendar year deductible, then $500 per day copay.	Subject to the selected out-of-network calendar year deductible, then $750 per day copay, then paid at 70% coinsurance percentage of usual and reasonable charges.

13. OUTPATIENT/AMBULATORY SURGERY	Subject to the selected calendar year deductible, then $200 copay per visit.	Subject to the selected out-of-network calendar year deductible, then $400 copay per visit then

		paid at 70% coinsurance percentage of usual and reasonable charges.
14. DIAGNOSTICS a) Laboratory & x-ray b) MRI, nuclear medicine and other high-tech services	a) Subject to the selected calendar year deductible, then $40 copay per visit b) Same as a) above.	a) Subject to the selected out-of-network calendar year deductible, then $70 copay per visit, then paid at 70% coinsurance percentage. b) Same as a) above.

	IN-NETWORK	**OUT-OF-NETWORK**
15. EMERGENCY CARE[7,8]	Covered Charges subject to applicable calendar year deductible, copay then coinsurance. Emergency Room subject to applicable calendar year deductible then $200 copay per occurrence then coinsurance. Emergency room copay is not applicable if Hospital confined as an Inpatient immediately following the emergency room visit.	Covered Charges subject to applicable calendar year deductible, copay then coinsurance. Emergency Room subject to applicable calendar year deductible then $400 copay per occurrence then coinsurance. Emergency room copay is not applicable if Hospital confined as an Inpatient immediately following the emergency room visit.
16. AMBULANCE	Subject to the selected calendar year deductible, then $200 copay per occurrence.	Same as in-network
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	Subject to the selected calendar year deductible and applicable copay.	Subject to the selected out-of-network calendar year deductible applicable copay then paid at 70% coinsurance of usual and reasonable charges.

	IN-NETWORK	**OUT-OF-NETWORK**
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]	*Inpatient Care*: Subject to the selected calendar year deductible, then $500 per day copay up to the maximum calendar year benefit of 5 days of inpatient confinement, up to $1,000 per calendar year per covered person and up to the lifetime maximum benefit. *Outpatient Care:* Subject to the selected calendar year deductible, then $40 copay per visit then paid at 50% coinsurance percentage up to $50 per visit and the combined maximum calendar year benefit of 10 visits, up to $500 per calendar year per covered person and up to the lifetime maximum benefit. ($10,000 lifetime maximum benefit is combined for inpatient and outpatient mental or nervous disorders and outpatient chemical dependency disorders.) Inpatient care and Outpatient Care maximums are in-network or out-of-network.	*Inpatient Care*: Subject to the selected out-of-network calendar year deductible, then $750 per day copay then paid at 70% coinsurance percentage of the usual and reasonable charges, up to the maximum calendar year benefit of 5 days of inpatient confinement, up to $1,000 per calendar year per covered person and up to the lifetime maximum benefit. *Outpatient Care*: Subject to the selected out-of-network calendar year deductible, then $70 copay per visit then paid at 50% coinsurance percentage of the usual and reasonable charges, up to $50 per visit and the combined maximum calendar year benefit of 10 visits, up to $500 per calendar year per covered person and up to the lifetime maximum benefit. ($10,000 lifetime maximum benefit is combined for inpatient and outpatient mental or nervous disorders and outpatient chemical dependency disorders.) Inpatient care and Outpatient care maximums are

		in-network or out-of-network.

	IN-NETWORK	OUT-OF-NETWORK
19. OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	a) Covered on same basis as #18 above. b) Covered on same basis as #18 above.	a) Covered on same basis as #18 above. b) Covered on same basis as #18 above.
20. ALCOHOL & SUBSTANCE ABUSE	*Inpatient Care*: Not covered. *Outpatient Care*: Subject to the selected calendar year deductible, then $40 copay per visit then paid at 50% coinsurance percentage up to $50 per visit and the combined maximum calendar year benefit of 10 visits, up to $500 per calendar year per covered person and up to the lifetime maximum benefit. (Outpatient benefit limits are in conjunction with #18 and #19 above.) ($10,000 lifetime maximum benefit is combined for in-patient and out-patient mental or nervous disorders and outpatient chemical dependency disorders.) Outpatient Care maximums are in-network or out-of-network.	*Inpatient Care*: Not covered. *Outpatient Care*: Subject to the selected out-of-network calendar year deductible, then $70 copay per visit then paid at 50% coinsurance percentage of the usual and reasonable charges, up to $50 per visit and the combined maximum calendar year benefit of 10 visits, up to $500 per calendar year per covered person and up to the lifetime maximum benefit (Outpatient benefit limits are in conjunction with #18 and #19 above.) ($10,000 lifetime maximum benefit is combined for in-patient and out-patient mental or nervous disorders and outpatient chemical dependency disorders.) Outpatient Care maximums are in-network or out-of-network.
21. PHYSICAL, OCCUPATIONAL & SPEECH THERAPY	Covered for rehabilitative treatment. Subject to the selected calendar year deductible, then $40 copay per visit up to a maximum calendar year benefit of 30 treatments for any one type of therapy per Covered Person, and to a maximum of 60 combined treatments per calendar year for any combination of therapies per Covered Person.	Covered for rehabilitative treatment. Subject to the selected out-of-network calendar year deductible, then $70 copay per visit up to a maximum calendar year benefit of 30 treatments for any one type of therapy per Covered Person, to a maximum of 60 combined treatments per calendar year for any combination of therapies per Covered Person.
22. DURABLE MEDICAL EQUIPMENT	Rental covered up to the purchase price. Subject to the selected calendar year deductible, then $40 copay per item See policy for types and circumstances of coverage.	Rental covered up to the purchase price. Subject to the selected out-of-network calendar year deductible, then $70 copay per item, then paid at 70% coinsurance percentage of usual and reasonable charges. See policy for types and circumstances of coverage.
23. OXYGEN	Covered including rental of equipment for the administration of oxygen up to the purchase price of equipment. Subject to the selected calendar year deductible, then $40 copay.	Covered including rental of equipment for the administration of oxygen up to the purchase price of equipment. Subject to the selected out-of-network calendar year deductible, then $70 copay then paid at 70% coinsurance percentage of usual

		and reasonable charges.

	IN-NETWORK	OUT-OF-NETWORK
24. ORGAN TRANSPLANTS	Subject to the selected calendar year deductible, then $500 per day copay up to the lifetime maximum benefit described below: *Center of Excellence*: $1,000,000 lifetime maximum benefit. The lifetime maximum benefit includes an allowance of up to $5,000 per covered transplant service for transportation to and from the site of the transplant for the recipient and companion, and the companion's room and board. In network: $250,000 lifetime maximum benefit.	Subject to the out-of-network calendar year deductible, then $750 per day copay then paid at 70% coinsurance percentage of usual and reasonable charges up to the $175,000 lifetime maximum benefit.
25. HOME HEALTH CARE	Subject to the selected calendar year deductible, then $40 copay per visit up to a maximum calendar year benefit of 60 home health care visits per Covered Person.	Subject to the out-of-network calendar year deductible, then $70 copay per visit then paid at 70% coinsurance percentage of usual and reasonable charges up to a maximum calendar year benefit of 60 home health care visits per Covered Person.
26. HOSPICE CARE	Paid at 100% of covered charges up to the hospice per diem rate of not less than $100 per day, up to a maximum of three benefit periods of 91 days each benefit period up to the Lifetime Maximum Benefit while covered under the policy. Not subject to any copay, deductible or coinsurance. Bereavement support services for the family and primary care-givers of the deceased, for up to12 months following death up to a maximum benefit of $1,150.	Paid at 100% of Covered Charges up to the hospice per diem rate of not less than $100 per day, of usual and reasonable charges up to a maximum of three benefit periods of 91 days each benefit period up to the Lifetime Maximum Benefit while covered under the policy. Not subject to any copay, deductible or coinsurance. Bereavement support services for the family and primary care-givers of the deceased, for up to 12 months following death up to a maximum benefit of $1,150.
27. SKILLED NURSING FACILITY CARE	Subject to the selected calendar year deductible, then $500 copay per day up to the maximum calendar year benefit of $100 per day and a maximum of 50 days per Covered Person.	Subject to the out-of-network calendar year deductible, then $750 copay per day then paid at 70% coinsurance percentage of usual and reasonable charges up to the maximum calendar year benefit of $100 per day and a maximum of 50 days per Covered Person.

28. DENTAL CARE	Not Covered

29. VISION CARE	Not covered..

	IN-NETWORK	OUT-OF-NETWORK
30. CHIROPRACTIC CARE	Physician Charges for non-surgical back treatment, including spinal adjustment and manipulation, subject to the selected calendar year deductible, then $40 copay per visit up to the maximum calendar year benefit of $250 per Covered Person in-network or out-of-network.	Physician Charges for non-surgical back treatment, including spinal adjustment and manipulation, subject to the out-of-network calendar year deductible, then $70 copay per visit then paid at 70% coinsurance percentage of usual and reasonable charges up to the maximum calendar year benefit of $250 per Covered Person in or out-of-network.

31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	**CANCER SCREENING COVERAGES** **MAMMOGRAPHY** Age 35-39: A single baseline mammography Age 40 and older – yearly A mammogram at the age and intervals considered medically necessary as recommended by a physician for any woman who is at risk for breast cancer. The calendar year deductible is not applicable **CERVICAL SMEAR OR PAP SMEAR** One smear for the early detection of cervical cancer and endometrial cancer per calendar year, and as needed upon certification by an attending physician that the test is medically necessary. The calendar year deductible is not applicable. **PROSTATE CANCER** One digital rectal exam and one prostate antigen test (PSA) per calendar year for male insureds age 50 and over and for male insureds age 40 years of age or older who are in high-risk categories according to the most current American Cancer Society prostate cancer screening guidelines. The calendar year deductible is not applicable.

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED [10]	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 covered person incurred charges, received medical treatment, consulted a health care professional or took prescription medications within the twelve (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

	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)?	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?	1-800-518-4510	
40. Whom do I write/call if I have a complaint or want to file a grievance?[11]	Standard Security Life Insurance Company of New York P.O. Box 39119 Phoenix, AZ 85069-9119	
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 SSL IP CO 607; Individual.	
43. Does the plan have a binding arbitration clause?	Yes.	

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 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 or 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 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 a 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 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 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.

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 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.