Colorado Health Benefit Plan Description Form

Standard Security Life Insurance Company of New York

Name of Carrier

IAC Personal Health Plans HDHP PPO Plan (HSA Qualified)

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) Single$_{2b}$ b) Non-Single$_{2c}$	Per covered person – Separate calendar year deductible based on in-network selection: a) If selected In-Network individual calendar year deductible is: $1,800 $2,700 $3,500 $5,250 b) If selected In-Network family calendar year deductible is: $3,600 $5,450 $7,000 $10,500	a) Out-of-Network individual calendar year deductible is: $5,400 $8,100 $10,500 $15,750 b) Out-of Network family calendar year deductible is: $10,800 $16,350 $21,000 $31,500
	The calendar year deductible amounts are subject to annual cost of living adjustments as may be required by tax law to maintain the plan's eligibility as an HSA qualified plan.	

	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?	Per covered person –includes deductible; does not include expenses not covered by the plan. Individual calendar year out-of-pocket maximum is based on selected in-network calendar year deductible amount (in parenthesis) and coinsurance (in brackets) a) If selected **In-Network** individual calendar year out-of-pocket maximum is: ($1,800)[100%] $1,800 ($1,800)[80%] $5,250 ($2,700)[100%] $2,700 ($2,700)[80%] $5,250 ($3,500)[100%] $3,500 ($5,250)[100%] $5,250 b) If selected In-Network family calendar year out-of-pocket maximum is: ($3,600)[100%] $3,600 ($3,600)[80%] $10,500 ($5,450)[100%] $5,450 ($5,450)[80%] $10,500 ($7,000)[100%] $7,000 ($10,000)[100%] $10,500 The out-of-pocket maximum amounts are subject to annual cost of living adjustments as may be required by tax law to maintain the plan's eligibility as an HSA qualified plan. c) Yes	**Out-of-Network** individual calendar year out-of-pocket maximum is: $ 12,000 $ 15,750 $ 14,700 $ 15,750 $ 15,500 $ 16,500 b) Out-of-Network family calendar year out-of-pocket maximum is: $22,000 $31,500 $25,000 $31,500 $28,000 $32,000
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	Lifetime Maximum - $5,000,000; Applicable to both in-network and out-of-network expenses. Calendar Year Maximum per Covered Person - $1,000,000. Applicable to both in-network and out-of-network expenses.	

	IN-NETWORK	OUT-OF-NETWORK
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	a) Subject to selected calendar year deductible, then paid at selected Coinsurance percentage. b) same as above.	a) Subject to selected out-of-network calendar year deductible, then paid at the selected Out-of-Network Coinsurance percentage.

		b) same as above.

9. PREVENTIVE CARE a) Children's services b) Adults' services	a) Subject to the selected coinsurance percentage 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: Benefit is paid at 100% at defined ages. The calendar year deductible is not applicable. Pap Smear: Benefit is paid at 100%. The calendar year deductible is 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 deductible and selected coinsurance. Routine Physical Exams: covered only if the optional Preventive Care Benefit Rider is specified as applicable on the Schedule of Benefits If optional Preventive Care Benefit Rider elected, Child Preventive Care Services, Colorectal Cancer Exams, PSA and Routine Physical Exams are paid at 100% up to the selected calendar year maximum of $250 or $500 per Covered Person. Covered charges in excess of selected calendar year maximum are subject to selected calendar year deductible and selected coinsurance.	a) Subject to the selected Out-of-Network Coinsurance percentage 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, benefit is paid at 100% of usual and reasonable charges. The calendar year deductible is not applicable. Pap Smear: Benefit is paid at 100% of usual and reasonable charges. The calendar year deductible is not applicable. PSA: The out-of-network deductible is not applicable. Colorectal Cancer Exams: Paid upon attaining defined age and subject to selected out-of-network deductible and selected out-of-network coinsurance. 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 and selected out-of-network coinsurance.
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, then paid at selected coinsurance percentage b) Delivery-same as a) above. Inpatient well baby care subject to selected calendar year deductible, then paid at selected coinsurance percentage.	a) Not covered, except for complications of pregnancy (COP). If COP, subject to out-of-network calendar year deductible, then paid at selected Out-of-Network coinsurance percentage of usual and reasonable charges. b) Delivery-same as a) above. Inpatient well baby care subject to out-of-network calendar year deductible, then paid at selected Out-of-Network coinsurance percentage of usual and reasonable charges.

	IN-NETWORK	OUT-OF-NETWORK
11. PRESCRIPTION DRUGS[6] Level of coverage and restrictions on prescriptions	No coverage for outpatient prescriptions unless optional Outpatient Prescription Medication Rider is elected. If elected, benefits are payable subject to selected calendar year deductible and selected coinsurance percentage.	
12. INPATIENT HOSPITAL	Subject to selected calendar year deductible, then paid at selected coinsurance percentage.	Subject to selected out-of-network calendar year deductible, then paid at selected Out-of-Network coinsurance percentage.
13. OUTPATIENT/AMBULATORY SURGERY	Subject to selected calendar year deductible, and selected coinsurance percentage.	Subject to selected out-of-network calendar year deductible, then paid at selected Out-of-Network coinsurance percentage of usual and reasonable charges.
14. DIAGNOSTICS a) Laboratory & x-ray b) MRI, nuclear medicine and other high-tech services	a & b) Subject to selected calendar year deductible, and selected coinsurance percentage.	a & b) Subject to selected out-of-network calendar year deductible, then paid at selected Out-of-Network coinsurance percentage of usual and reasonable charges.
15. EMERGENCY CARE[7,8]	Subject to selected calendar year deductible, and selected coinsurance.	Subject to selected calendar year deductible, and selected coinsurance.
16. AMBULANCE	Subject to selected calendar year deductible, and selected coinsurance percentage.	Same as in-network
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	Subject to selected calendar year deductible, and selected coinsurance percentage.	Subject to selected out-of-network calendar year deductible, then paid at selected Out-of-Network coinsurance percentage of usual and reasonable charges.

	IN-NETWORK	OUT-OF-NETWORK
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]	*Inpatient Care*: Subject to selected calendar year deductible, then paid at the selected coinsurance percentage up to the maximum calendar year benefit of 10 days of Inpatient Confinement, up to $2,500 per Calendar Year per Covered Person, and up to the Lifetime Maximum Benefit. *Outpatient Care:* Subject to selected calendar year deductible, then paid at the selected coinsurance percentage up to $25 per visit; up to the maximum calendar year benefit of 50 visits, up to $1,250 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 selected out-of-network calendar year deductible, then paid at the selected out-of-network coinsurance percentage of usual and reasonable charges up to the maximum calendar year benefit 10 days of Inpatient Confinement, up to $2,500 per Calendar Year per Covered Person, and up to the Lifetime Maximum Benefit. *Outpatient Care*: Subject to selected out-of-network calendar year deductible, then paid at the selected out-of-network coinsurance percentage of usual and reasonable charges up to $25 per visit up to the maximum calendar year benefit of 50 visits, up to $1,250 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.

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 selected calendar year deductible, then paid at the selected coinsurance percentage up to $25 per visit up to the maximum calendar year benefit of 50 visits, up to $1,250 per calendar year per Covered Person and up to the Lifetime Maximum Benefit While Covered Under the Policy. (Outpatient benefit limits are in conjunction with #18 and #19 above.) ($10,000 lifetime maximum benefit is combined for inpatient and outpatient mental or nervous disorders and outpatient chemical dependency disorders.) Outpatient Care maximums are in-network or out-	*Inpatient Care*: Not covered. *Outpatient Care*: Subject to selected out-of-network calendar year deductible, then paid at the selected out-of-network coinsurance percentage of usual and reasonable charges up to $25 per visit up to the maximum calendar year benefit of 50 visits, up to $1,250 per calendar year per Covered Person and up to the Lifetime Maximum Benefit While Covered Under the Policy. (Outpatient benefit limits are in conjunction with #18 and #19 above.) ($10,000 lifetime maximum benefit is combined for inpatient and outpatient mental or nervous disorders and outpatient chemical dependency

	of-network.	disorders.) Outpatient Care maximums are in-network or out-of-network.
21. PHYSICAL, OCCUPATIONAL & SPEECH THERAPY	Covered for rehabilitative treatment. Subject to selected calendar year deductible, then paid at the selected coinsurance percentage up to a maximum calendar year benefit of 30 treatments for any one type of therapy per Covered Person, and up to a maximum of 60 combined treatments per calendar year for any combination of therapies per Covered Person.	Covered for rehabilitative treatment. Subject to selected out-of-network calendar year deductible, then paid at the selected out-of-network coinsurance percentage of usual and reasonable charges up to a maximum calendar year benefit of 30 treatments for any one type of therapy per Covered Person, and up to a maximum of 60 combined treatments per calendar year for any combination of therapies per Covered Person.

	IN-NETWORK	**OUT-OF-NETWORK**
22. DURABLE MEDICAL EQUIPMENT	Rental covered up to the purchase price. Subject to selected calendar year deductible, then paid at the selected coinsurance percentage. See policy for types and circumstances of coverage.	Rental covered up to the purchase price. Subject to selected out-of-network calendar year deductible, then paid at the selected out-of-network 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 selected calendar year deductible, then paid at the selected coinsurance percentage	Covered including rental of equipment for the administration of oxygen up to the purchase price of equipment. Subject to selected out-of-network calendar year deductible, then paid at the selected out-of-network coinsurance percentage of usual and reasonable charges.

24. ORGAN TRANSPLANTS	Subject to selected calendar year deductible, then paid at the selected coinsurance percentage up to the lifetime maximum benefit described below: *Center of Excellence*: $1,000,000. 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 selected out-of-network calendar year deductible, then paid at the selected out-of-network coinsurance percentage of usual and reasonable charges up to the $175,000 lifetime maximum benefit

25. HOME HEALTH CARE	Subject to selected calendar year deductible, then paid at the selected coinsurance percentage up to a maximum calendar year benefit of 60 home health care visits per Covered Person	Subject to selected out-of-network calendar year deductible, then paid at the selected out-of-network 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	Subject to selected deductible then paid at the selected coinsurance percentage 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. 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.	Subject to the selected calendar year deductible then paid at the selected out-of-network coinsurance percentage of usual and reasonable 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. 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.

	IN-NETWORK	**OUT-OF-NETWORK**
27. SKILLED NURSING FACILITY CARE	Subject to selected calendar year deductible, then paid at the selected coinsurance percentage up to the maximum calendar year benefit of $100 per day and a maximum of 50 days per Covered Person.	Subject to selected out-of-network calendar year deductible, then paid at the selected out-of-network 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.

30. CHIROPRACTIC CARE	Physician Charges for non-surgical back treatment, including spinal adjustment and manipulation, Subject to selected calendar year deductible, then paid at the selected coinsurance percentage up to the maximum calendar year benefit of $500 per Covered Person Calendar year maximum is in-network or out-of-network.	Physician Charges for non-surgical back treatment, including spinal adjustment and manipulation, Subject to out-of-network calendar year deductible, then paid at the selected out-of-network coinsurance percentage of usual and reasonable charges up to the maximum calendar year benefit of $500 per Covered Person Calendar year maximum is in-network 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

	IN-NETWORK	OUT-OF-NETWORK
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.