[NOTE: This benefit grid has been formatted to more closely conform to the Colorado Comprehensive Health Plan Description Form. However, it does *not* reflect full compliance with that form.]

All Colorado Small Group Health Insurance Companies
Name of Carrier

JANUARY 1, 2006 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER, AND HMO
Name of Plan

PART A: TYPE OF COVERAGE

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN	STANDARD HMO PLAN
1. TYPE OF PLAN	Medical expense policy	Preferred provider plan	Health maintenance organization (HMO)
2. OUT-OF-NETWORK CARE COVERED? [1]	Yes, policy makes no distinction between in- and out-of-network care.	Yes, but patient pays more for out-of-network care.	Only for emergency and urgent care.
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado.	Varies by insurance company.	Varies by HMO.

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the percentage copay listed is what the member will pay.)

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDARD HMO PLAN IN-NETWORK ONLY (Out-of-network care is not covered except as noted.)
		IN-NETWORK	OUT-OF-NETWORK [2]	
4. ANNUAL DEDUCTIBLE *(Deductibles do not apply to benefits with flat dollar copays.)*				
a) Individual	$ 1,500	$ 1,500	$ 3,000	No deductible.
b) Family	$ 4,500	$ 4,500	$ 9,000 (Deductibles are separate from in-network deductibles)	No deductible.

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDARD HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK [2]	IN-NETWORK ONLY (Out-of-network care is not covered except as noted.)
5. OUT-OF-POCKET ANNUAL MAXIMUM [3] *(Includes deductibles and coinsurance. Copays apply for the HMO plan only. All copays for prescription drugs are excluded.)*			(Out-of-pocket amounts are separate from in-network out-of-pocket amounts.)	
a) Individual	$ 2,500	$ 3,000 excluding flat dollar co-pays	$ 6,000	$ 3,000
b) Family	$ 7,500	$ 6,000 excluding flat dollar co-pays	$ 12,000	$ 6,000
5A. COINSURANCE (amount paid by carrier) **or COPAY** (amount paid by insured/member)	80% coinsurance	80% coinsurance	50% coinsurance	Depends on the service, see details below. [4]
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	$1 million	$2 million		No lifetime maximum.
7A. COVERED PROVIDERS	All providers licensed or certified to provide benefits.	List of covered in-network providers varies by insurance company.	All providers licensed or certified to provide benefits.	List of covered providers varies by HMO.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Not applicable. This is not a network plan.	Answer varies by insurance company.	Not applicable.	Answer varies by HMO.
8. ROUTINE MEDICAL OFFICE VISITS [5]				
PCP	80% coinsurance	$25 copay/visit	50% coinsurance	$25 copay/visit
Specialist	80% coinsurance	$40 copay/visit	50% coinsurance	$40 copay/visit
9. PREVENTIVE CARE [6]	For all plans, only specified preventive services are covered.			
a) Children's services (No deductible prior to application of coinsurance.)	80% coinsurance	$25 copay/visit	50% coinsurance	$25 copay/visit
b) Adults' services	80% coinsurance	$25 copay/visit	50% coinsurance	$25 copay/visit

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDARD HMO PLAN IN-NETWORK ONLY (Out-of-network care is not covered except as noted.)
		IN-NETWORK	OUT-OF-NETWORK [2]	
10. MATERNITY [7]	80% coinsurance Deductible and coinsurance apply	80% coinsurance (1 PCP copay then deductible and coinsurance for all other charges)	50% coinsurance	Applicable copays for type of service. [8]
11. PRESCRIPTION DRUGS [9] *(Copays do not apply to out-of-pocket maximums.)*	$10 copay preferred generic; $30 copay preferred brand name $50 copay non-preferred [9a]	$10 copay preferred generic; $30 copay preferred brand name $50 copay non-preferred [9a]	$10 copay preferred generic; $30 copay preferred brand name $50 copay non-preferred [9a]	$10 copay preferred generic; $30 copay preferred brand name $50 copay non-preferred [9a]
12. INPATIENT HOSPITAL	80% coinsurance	80%coinsurance	50% coinsurance	$250/day to a max of $1,000 per admission [10]
13. OUTPATIENT/AMBULATORY SURGERY	80% coinsurance	80% coinsurance	50% coinsurance	$100 copay/visit [10a]
14. DIAGNOSTICS [11]				
a) Laboratory & X-ray	80% coinsurance	80% coinsurance If services are delivered as part of an office visit to the designated primary care provider, no additional copay or coinsurance requirement for lab & x-ray services applies.	50% coinsurance	No copay for physician-ordered services.
b) MRI, Nuclear Medicine and Other High Tech Services	80% coinsurance	80% coinsurance	50% coinsurance	$100 copay
15. EMERGENCY CARE [12, 13]	80% coinsurance	$125 copay then plan pays 80% coinsurance		$125 copay/visit [14] for in- and out-of-network emergency care.
16. AMBULANCE	80% coinsurance	80% coinsurance		$100 copay
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	80% coinsurance	80% coinsurance	50% coinsurance	$75 copay/visit. Out-of-network urgent care covered only if temporarily traveling out of service area.

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN IN-NETWORK	STANDARD PREFERRED PROVIDER PLAN OUT-OF-NETWORK [2]	STANDARD HMO PLAN IN-NETWORK ONLY (Out-of-network care is not covered except as noted.)
18. BIOLOGICALLY BASED MENTAL ILLNESS [15] CARE	For all plans, coverage is no less extensive than the coverage for any other physical illness under that plan.			
19. OTHER MENTAL HEALTH CARE [17]				
a) Inpatient care [16]	50% coinsurance Maximum 45 inpatient or 90 partial days/year	50% coinsurance Maximum 45 inpatient or 90 partial days/year		50% copay Maximum 45 inpatient or 90 partial days/year
b) Outpatient care	50% coinsurance Plan/insurer pays maximum $1,500/year	50% coinsurance Plan/insurer pays maximum $1,500/year		50% copay Plans pay maximum 20 visits or $1,500/year
20. ALCOHOL AND SUBSTANCE ABUSE	Acute detox: maximum 5 days per episode and 2 episodes per lifetime, 50% coinsurance.[18]	Acute detox: maximum 5 days per episode and 2 episodes per lifetime, 50% coinsurance.[18]		Diagnosis, medical treatment & referral services. 50% copay.[19]
21. PHYSICAL, OCCUPATIONAL & SPEECH THERAPY [20]	80% coinsurance **(Limited to 25 total visits/year)**	80% coinsurance **(Limited to 25 total visits/year combined in and out-network)**	50% coinsurance **(Limited to 25 total visits/year combined in and out-network)**	$25 copay **(Limited to 25 total visits/year)**
22. DURABLE MEDICAL EQUIPMENT [21]	80% coinsurance $2,000/year maximum	80% coinsurance	50% coinsurance	20% copay $2,000/year maximum
		$2,000/year maximum (In-network deductible applies to network providers and the out-of-network deductible applies to non-network providers. However, the maximum benefit is combined for in-network and out-of-network benefits.)		
23. OXYGEN	(Included under durable medical equipment)	(Included under durable medical equipment)		(Included under durable medical equipment)
24. ORGAN TRANSPLANTS [22]	Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.			

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDARD HMO PLAN IN-NETWORK ONLY (Out-of-network care is not covered except as noted.)
		IN-NETWORK	OUT-OF-NETWORK [2]	
(ORGAN TRANSPLANTS continued)	80% coinsurance	80% coinsurance	50% coinsurance	Coverage is no less extensive than the coverage for any other physical illness.
25. HOME HEALTH CARE	80% coinsurance	80% coinsurance	50% coinsurance	No copay (100% covered)
26. HOSPICE CARE [22a]	80% coinsurance per diem	80% coinsurance per diem	50% coinsurance per diem	No copay (100% covered)
27. SKILLED NURSING FACILITY CARE[23]	80% coinsurance (Not to exceed 100 days/year)	80% coinsurance (Not to exceed 100 days/year)	50% coinsurance (Not to exceed 100 days/year)	$50 copay/day (Not to exceed 100 days/year)
28. DENTAL CARE	For all plans, not covered except for dental care needed as a result of an accident.			
29. VISION CARE	No coverage	No coverage	No coverage	No coverage
30. CHIROPRACTIC CARE	No [See 31(1)]	No [See 31(1)]	No [See 31(1)]	No [See 31(1)]
31. SIGNIFICANT ADDITIONAL SERVICES (List up to 5)				
(1) Spinal manipulation	80% coinsurance	80% coinsurance	50% coinsurance	$25 copay

PART C: LIMITATIONS AND EXCLUSIONS

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDARD HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK	
32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED [24, 25]	Business Groups of One: 12 months for all pre-existing conditions Business Groups of 2 – 50: 6 months for all pre-existing conditions			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.	No.	No.	No.

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDARD HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK	
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	A pre-existing 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 pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.			Not applicable. Plan does not exclude coverage for pre-existing conditions.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Standard exclusions, including benefits covered by employers liability laws; care that is not medically necessary; cosmetic care; custodial care; dental care except for accidents and anesthesia for dependent children as required by law; educational training problems; experimental and investigational procedures; eye glasses and contact lenses; hearing aides and fitting; learning disorders; marital or social counseling; nursing home care except as specifically otherwise covered under this plan; sexual dysfunction, infertility treatment and counseling except as specifically otherwise covered under the policy requirements of this plan; TMJ; treatment for work-related illnesses and injuries except for those individuals who are not required to maintain or be covered by workers' compensation insurance as defined by workers' compensation laws [26]; transplants except for those listed above; charges related to the surgical treatment of obesity; and war.			

1 "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that the plan may require the insured/member to use in order to get any coverage at all under the plan, or that the plan may encourage the insured/member to use because it may pay more of the bill if their network providers are used (i.e., go in-network) than if they aren't used (i.e., go out-of-network).

2 Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply ***ONLY IF*** plan has network providers for the covered benefit and insured goes out of the network. Otherwise, in-network-levels apply.

3 "Out-of-pocket maximum" refers to the maximum amount the insured/member will have to pay for allowable covered expenses under a health plan, which includes the deductible, coinsurance and copayments, as specified. Copays for prescription drugs, however, are not applied to the deductible or out-of-pocket maximum. Under the standard plans, copays for other than prescription drugs are applied to the out-of-pocket maximum on HMO plans only.

4 However, notwithstanding the copay amounts listed in this Standard HMO Plan, under no circumstances, with the exception of the prescription drug benefit, shall the copay amount paid by the insured exceed 50% of charges for any single service.

5 Routine medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically based mental illnesses.

6 See Attachment 1 for list of covered preventive services. Immunization schedule will be published in a bulletin that will be updated yearly.

7 Well-baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. Well-baby charges incurred during the hospital stay are covered under the mother's deductible.

8 The hospital copay applies to mother and well baby together; there are not separate copays.

9 Includes expendable medical supplies for the treatment of diabetes. Carriers are allowed to provide a mail order benefit or discount rate in the manner they do for their most frequently sold non-basic, non-standard group health plan in Colorado. Additionally, as noted above in footnote 3, prescription drug benefits are not subject to the deductible and the copays are not applied to the out-of-pocket maximums.

9a Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

10 Inpatient care includes all physician, surgical, and other services delivered during a hospital stay.

10a Copay includes all physician, facility services and supplies delivered during the visit.

11 Includes low dose mammography screening not otherwise covered under the list of preventive care services, as mandated by Colorado law, §10-16-104(4), C.R.S.

12 "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 than an emergency medical condition or life or limb threatening emergency existed.

13 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 coinsurance and copays apply.

14 Emergency copay is waived if patient is admitted to hospital since hospital copay would apply.

15 "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. Outpatient psychotherapy visits for biologically based mental illnesses are covered at the same level as routine medical office visits.

16 The day cost of residential care must be less than or equal to the cost of a partial day of hospitalization. Each two days of residential or partial hospital care counts as one day of inpatient care.

17 Pursuant to §10-16-105(1), C.R.S., the following small employers may exclude mental health coverage from their plans: any small employer who has not provided group sickness and accident insurance to employees after July 1, 1989, and any small employer who has provided group sickness and accident from a person or entity licensed pursuant to §10-3-903.5, C.R.S., that did not include mental health coverage after July 1, 1989. However, carriers allowing for such an exclusion must follow all the relevant provisions of §10-16-105(2), C.R.S., relating to such an exclusion.

18 Carriers shall also offer alcoholism coverage pursuant to §10-16-104(9), C.R.S., as may be amended.

19 HMOs shall comply with the alcohol and drug abuse benefit for federally qualified HMOs pursuant to 42 C.F.R., Section 417.101 (a)(5).

20 Coverage for medically necessary therapeutic treatment only - benefits will not be paid for maintenance therapy after maximum medical improvement achieved, except as required by law for children under 5 years of age.

21 Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen, reusable equipment for the treatment of diabetes, and prostheses. Although the cost of prosthetic devices applies to the annual DME cap, benefits for prosthetic devices for arms or legs (or any part thereof) themselves are not subject to this limitation. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by §10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered up to the benefit cap; and repair and replacement needed due to misuse/abuse by the insured is ***not*** covered.

22 Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.

22a Although the number of days for this benefit is not limited, ancillary services, such as bereavement, shall be limited consistent with Colorado Regulation 4-2-8.

23 Coverage for medically necessary skilled nursing facility care only. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.

24 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 the insured/member recently may have had. The carrier or plan sponsor (e.g., employer) should provide details.

25 The plan shall waive any time period applicable to a pre-existing condition limitation period for the period of time an individual was covered by creditable coverage, if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. Any waiting period before the effective date of the new coverage applied by the employer or the carrier shall not be considered a lapse of coverage and shall count toward satisfying any applicable pre-existing condition limitation.

26 Except that, if a workers' compensation policy is in place (although not required by state labor law), the workers' compensation policy, not this plan, is responsible for medical benefits for work-related illnesses and injuries. Also, if this plan is a federally qualified HMO plan, proof of workers' compensation coverage, if such coverage is required by law, may be required as a condition of coverage *if* such proof is required on the HMO's other small employer plans.

Attachment 1

Covered Preventive Services [1]	
All Persons	1 smoking cessation education program benefit under physician supervision or as authorized by plan per lifetime, not to exceed $150 payment by insurer.
	Chicken pox vaccination for all persons who have not had chicken pox.
All Children	Immunizations. Immunization deficient children are not bound by “recommended ages”.
Age 0-12 months	1 newborn home visit during first week of life if newborn released from hospital less than 48 hours after delivery.
	5 well-child visits [2]
	1 PKU
Age 13-35 months	2 well-child visits
Age 3-6	3 well-child visits
Age 7-12	3 well-child visits
Age 13-18	1 age appropriate health maintenance visit [3] every year
	1 Td
	Females: screening pap smears not to exceed 1 per year
	1 hepatitis B vaccination if not given previously

1 Not all preventive services and screenings are specifically listed, but the list is considered to include all services and screenings deemed to be preventive by the Federal Department of the Treasury for HSA (health savings account) compliant plans.

2 "Well-child visit" means a visit to a primary care provider that includes the following elements: age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age appropriate behaviors, etc.), and growth and development assessment. For older children, this also includes safety and health education counseling.

3 “Age appropriate health maintenance visit” means an exam which includes the following components: age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, discuss dietary issues, review health promotion activities of the patient, etc.), and exercise and nutrition counseling (including folate counseling for women of child bearing age).

Age 19-39	1 Td every ten years
	1 age appropriate health maintenance visit every three years
	1 fasting lipid panel
	Females ages 35-39: 1 baseline screening mammogram and clinical breast exam **(*Not covered under the Basic Limited Mandate Health Benefit Plans and the Basic HSA Limited Mandate Health Benefit Plans.*)**
	Females: screening pap smears not to exceed 1 per year
Age 40-64	1 Td every ten years
	1 fasting lipid panel every five years
	Either annual fecal occult blood testing or 2 colorectal visualizations between ages 50 and 75
	1 age appropriate health maintenance visit every 24 months
	Females ages 40-49: 1 screening mammogram and clinical breast exam every 2 years (annually, if high risk) **(*Not covered under the Basic Limited Mandate Health Benefit Plans and the Basic HSA Limited Mandate Health Benefit Plans.*)**
	Females ages 50-64: 1 screening mammogram and clinical breast exam every 12 months **(*Not covered under the Basic Limited Mandate Health Benefit Plans and the Basic HSA Limited Mandate Health Benefit Plans.*)**
	Females: screening pap smears not to exceed 1 per year
	Males: Prostate screening as specified in state law **(*Not covered under the Basic Limited Mandate Health Benefit Plans and the Basic HSA Limited Mandate Health Benefit Plans.*)**
Age 65 and older	1 influenza immunization every year
	1 pneumococcal vaccine at or after age 65
	Females: screening pap smears not to exceed 1 per year
	1 Td every ten years
	1 age appropriate health maintenance visit every year
	Females age 65 to 74: 1 screening mammogram and clinical breast exam every 12 months
	Either annual fecal occult blood testing or 2 colorectal visualizations between ages 50 and 75
	Males: Prostate screening as specified in state law **(*Not covered under the Basic Limited Mandate Health Benefit Plans and the Basic HSA Limited Mandate Health Benefit Plans.*)**