
MTN Health Insurance, LLC

303-594-1939

To apply for this policy or for more information please go to:

<http://mtnhealthinsurance.com>

Colorado Health Benefit Plan Description Form

Time Insurance Company

SaveRight Traditional

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Medical Expense Policy
2. OUT-OF-NETWORK CARE COVERED? ¹	Yes; policy makes no distinction between in-network and 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
4. Deductible Type ²	Calendar Year
4a. ANNUAL DEDUCTIBLE ^{2a} a.) Individual ^{2b} b.) Family ^{2c}	a.) \$2,300, \$3,000 or \$5,100 b.) \$4,600, \$6,000 or \$10,200
5. OUT-OF-POCKET ANNUAL MAXIMUM ³ a.) Individual b.) Family c.) Is deductible included in the out-of-pocket maximum?	a.) Deductible plus coinsurance b.) 2 times the deductible plus 2 times coinsurance (aggregate) c.) Yes. Coinsurance options available are 50%, 75%, 100% (not all coinsurance options are available with all deductible options). Copayments or access fees do not apply to out-of-pocket maximums.
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	\$2 million PRESCRIPTION DRUG MAXIMUM: \$2,000 per covered person per year or customer can purchase the option to have prescription coverage subject only to the lifetime maximum. OUTPATIENT SERVICES MAXIMUM: \$15,000 or \$25,000 options available. <u>All</u> outpatient services are subject to this maximum. The maximum lifetime benefit for surgical and nonsurgical treatment for Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services is \$1,000 per covered person. Benefits for sterilization are limited to maximum lifetime benefit of \$500 per covered person after a 12-month waiting period.

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7A. COVERED PROVIDERS	All providers licensed or certified to provide covered benefits.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Not applicable.
8. MEDICAL OFFICE VISITS ⁴ a.) Primary Care Providers b.) Specialists	Office visits with Primary Care Providers and Specialists are subject to deductible; coinsurance, outpatient services maximum and out-of-pocket maximum.
9. PREVENTIVE CARE 12-month waiting period for the \$500 wellness benefit. This 12-month wait does not apply to child wellness, routine mammograms, PAP tests or PSA tests. a.) Children's Services b.) Adults' Services	<p>Subject to deductible; coinsurance, outpatient services maximum and out-of-pocket maximum. After deductible, pays up to \$500 per calendar year.</p> <p>a.) Deductible waived; coinsurance, outpatient services maximum and out-of-pocket maximum applies; the \$500 Preventive Care Services maximum does not apply to child wellness charges.</p> <p>0-12 years: Immunizations recommended by the American Academy of Pediatrics, including chicken pox vaccination. 0-12 months: 5 well child visits / 1 PKU 13-35 months: 2 well child visits 3-12 years: 3 well child visits</p> <p>b) The Preventive Care Services maximum benefit is \$500 per person per year - subject to deductible, coinsurance, outpatient services maximum and out-of-pocket maximum. This maximum does not apply to routine mammograms, PAP tests and PSA tests. The plan deductible is waived for routine mammograms, PAP tests and PSA tests. Routine mammography coverage guidelines:</p> <ul style="list-style-type: none"> * One screening mammogram for women who are 35-39 years of age. * Screening mammogram not less than once every two years for women 40 years of age and under 50 years of age. * At least one screening mammogram a year for women with risk factors to breast cancer as determined by her physician. * One screening mammogram a year for women who are 50 years of age or older. * PSA tests must consist at a minimum of a prostate-specific antigen blood test and a digital rectal exam. * At least one PSA screening a year for men 40-45 with increased risk of developing prostate cancer as determined by his physician. * One PSA screening per year for men who are 50 or older.
10. MATERNITY a.) Prenatal Care b.) Delivery & inpatient well baby care ⁵ 90-day waiting period for conception to occur See policy for complications of pregnancy coverage	Maternity Benefit options are available with a \$1,000, \$2,500, \$5,000 and \$10,000 maternity deductible.
11. PRESCRIPTION DRUGS ⁶	Applied to annual plan deductible. Calendar year maximum benefit of

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Level of coverage and restrictions on prescriptions.	\$2,000 per covered person with the option to buy up to the lifetime maximum benefit. If use of brand when a generic is available, insured pays the difference between the brand contracted rate and the generic contracted rate.
12. INPATIENT HOSPITAL	Deductible; coinsurance and out-of-pocket maximum.
13. OUTPATIENT/AMBULATORY SURGERY	Outpatient/Ambulatory Surgery are any services, supplies or treatment received at a Hospital or other licensed medical facility for a stay of less than 24 hours on other than an Inpatient basis; subject to deductible; coinsurance; outpatient services maximum; subject to out-of-pocket maximum.
14. DIAGNOSTICS a.) Laboratory & x-ray b.) MRI, nuclear medicine, and other high-tech services	Deductible; coinsurance, outpatient services maximum and out-of-pocket maximum.
15. EMERGENCY CARE ^{7 8}	\$75 access fee; then deductible; coinsurance, outpatient services maximum and out-of-pocket maximum. \$75 access fee will be waived if admitted inpatient. Emergency care charges are subject to the Outpatient Services Maximum if claims are billed by the provider as outpatient.
16. AMBULANCE	Deductible; coinsurance and out-of-pocket maximum; \$1,000 per trip, limited to one trip per person each year
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	Deductible; coinsurance, outpatient services maximum and out-of-pocket maximum.
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE ⁹	Plan does not offer coverage for Biologically Based Mental Illness Care
19. OTHER MENTAL HEALTH CARE a.) Inpatient Care b.) Outpatient Care	Plan does not offer coverage for behavioral health
20. ALCOHOL & SUBSTANCE ABUSE	Plan does not offer coverage for Alcohol and Substance Abuse
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY a.) Inpatient: b.) Outpatient:	Deductible; coinsurance, outpatient services maximum (if outpatient) and out-of-pocket maximum. a.) Deductible; coinsurance and out-of-pocket maximum. \$100 maximum per day, limited to 50 Inpatient days per calendar year. b.) Deductible; coinsurance, outpatient services maximum and out-of-pocket maximum; \$50 per visit, 2-visit limit per person per year. Does not include vertebrae, disc, spine, back and neck. Refer to #30 CHIROPRACTIC CARE
22. DURABLE MEDICAL EQUIPMENT	Deductible; coinsurance, outpatient services maximum and out-of-pocket maximum. See policy for types and circumstances of coverage
23. OXYGEN	Deductible; coinsurance, outpatient services maximum and out-of-pocket maximum.
24. ORGAN TRANSPLANTS	<ul style="list-style-type: none"> • Deductible; coinsurance • Transplant benefits include all related expenses from 14 days before transplant until 365 days after transplant. The maximum benefit for potential donor and donor expenses is \$10,000 for each transplant and is applied to the transplant benefit.

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	<ul style="list-style-type: none"> • All transplant related claims continue to apply to the Calendar Year and Lifetime Maximum Benefit. • Covered Charges are limited to the following: Solid Organ Transplants, heart, lung, combined heart/lung, combined kidney/pancreas, liver (Candidates for liver transplantation must have abstained from alcohol for one year immediately prior to transplantation.), and marrow reconstitution or support.
25. HOME HEALTH CARE	Deductible; coinsurance, outpatient services maximum and out-of-pocket maximum; up to 60 visits per calendar year. Services up to 4 hours are considered 1 visit.
26. HOSPICE CARE	Deductible; coinsurance and out-of-pocket maximum. Hospice care includes bereavement counseling by a licensed clinical social worker for Covered Dependents during the twelve month period after the Insured's death, up to a maximum benefit of \$1,150. Benefits for bereavement counseling are subject to the Outpatient Calendar Year Maximum.
27. SKILLED NURSING FACILITY CARE	Deductible; coinsurance and out-of-pocket maximum; up to 30 days per calendar year.
28. DENTAL CARE	Deductible, coinsurance, outpatient services maximum and out-of-pocket maximum. Benefits include the following: Injury resulting from accidental blow to the mouth causing trauma to sound teeth, the gums or supporting structures of the teeth; dental treatment for cleft lip and cleft palate of a covered newborn to include: oral and facial surgery, surgical management and follow-up care by plastic surgeons and oral surgeons; prosthetic treatment such as obturators, speech appliances and feeding appliances; orthodontic and prosthodontic treatment; rehabilitative speech therapy; otolaryngology treatment; and audiological assessments and treatment; anesthesia and hospital or facility charges for a dependent child.
29. VISION CARE	No coverage
30. CHIROPRACTIC CARE	No coverage
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	Telehealth Services Therapies for Congenital Defects and Birth Abnormalities

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 the Federal and State law, in which case there are no pre-existing condition exclusions. If non- HIPAA, credit will be given for prior coverage.
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	Yes, unless the individual is a HIPAA-eligible individual as defined under Federal and State law.
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	A pre-existing condition is an injury, sickness or pregnancy for which a person incurred charges, received medical treatment, consulted a health care professional, or took 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

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	need is excluded from the policy (request Form #29254).
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Part D: USING THE PLAN

	BENEFIT LEVELS
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No - This is not a gatekeeper plan
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	Yes
39. What is the main customer service number?	800-553-7654
40. Whom do I write/call if I have a complaint or want to file a grievance? ¹¹	Assurant Health P.O. Box 3089 Milwaukee, WI 53201 800-553-7654
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 Number: 253 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 (ie., 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 that 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 the number of individual deductibles that must be met (e.g., “3

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	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.

“Colorado law requires carriers to make available a Colorado Health Benefit Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan or who has selected the plan as a finalist from which the ultimate selection will be made. The carrier also must provide the form, upon oral or written request, within three (3) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier.”