

**COLORADO DENTAL ASSOCIATION
BENEFIT PLAN, INC.**

**(\$5,000 Deductible)
SCHEDULE OF BENEFITS**

EFFECTIVE JANUARY 1, 2010

Verification of Eligibility (303) 770-5710 or (800) 232-2588

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Note: If Precertification is NOT received, benefit payment will be reduced by 50% up to \$500 maximum penalty per occurrence. The following services must be precertified or reimbursement from the Plan may be reduced or denied:

- **Inpatient Hospitalizations**
- **Inpatient Cardiac rehabilitation therapy**
- **Inpatient Hospice Care**
- **Outpatient surgical procedures not performed in the physician's office**
- **Skilled Nursing Facility stays**
- **Transplants**
- **Dental services**

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours or less for a cesarean delivery.

Please see the Cost Management section in this booklet for details.

The Plan is a plan which contains multiple Network Provider Organizations.

LOCATION	NAME	PHONE #	WEB SITE
Colorado	ASO Select Network	(800) 232-2588	www.rmhp.org
Residing out of Colorado	PHCS Network	(800) 922-4362	www.multiplan.com
Traveling out of Colorado	PHCS Healthy Directions	(800) 678-7427	www.multiplan.com

The Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive a higher payment from the Plan than when a Non-Network Provider is used. It is the Covered Person's choice as to which Provider to use and in some instances, treatments will **not** be covered if a Non-Network Provider is chosen.

Under the following circumstances, the higher In-Network payment will be made for certain Non-Network services:

If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the PPO service area.

If a Covered Person has a Medical Emergency requiring immediate care.

If a Covered Person is traveling outside of the United States area and has no choice of a network provider.

Provider directories are available through Healthx at www.cnichs.com. Once there click on "For CNIC Members" and sign up to create you on account. A hard copy is available upon request at no charge.

Deductibles/Copayments payable by Plan Participants

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one (1) deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required. However, Covered Charges incurred in, and applied toward the deductible in October, November and December will be applied to the deductible in the next Calendar Year as well as the current Calendar Year. Deductibles do not accrue toward the 100% maximum out-of-pocket payment.

A copayment is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments. Copayments do not accrue toward the 100% maximum out-of-pocket payment.

MEDICAL BENEFITS SCHEDULE

\$5,000 DEDUCTIBLE	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM LIFETIME BENEFIT AMOUNT	\$2,000,000	
<p>Note: The maximums listed below are the total for Participating and Non-Participating expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Participating and Non-Participating providers.</p>		
DEDUCTIBLE, PER CALENDAR YEAR		
(Network and Non-Network are separate)		
Per Covered Person	\$5,000	\$10,000
Per Family Unit	\$15,000	\$30,000
COPAYMENTS		
Physician office visits	\$30	N/A
Chiropractic visits	\$15	N/A
Colonoscopies (routine screening only)	N/A	\$500
Urgent Care	\$60	N/A
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
(Network and Non-Network are separate)		
Per Covered Person	\$10,000	\$20,000
Per Family Unit	\$20,000	\$40,000
<p>The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.</p>		
<p>The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%:</p> <ul style="list-style-type: none"> Copayments Deductible(s) Cost containment penalties Ineligible charges and charges in excess of Plan maximums 		
COVERED CHARGES		
Acupuncture office visits	100% \$50 per visit and \$600 Calendar Year maximum	100% \$50 per visit and \$600 Calendar Year maximum
Laboratory and x-ray services during office visits	70% after deductible	Not Covered
Ambulance Service	70% after deductible	70% after deductible

\$5,000 DEDUCTIBLE	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Diagnostic X-ray and Lab Expenses (including interpretation fees)		
In physician's office	70% after deductible	50% after deductible
Inpatient/Outpatient/ or Freestanding facilities	70% after deductible	50% after deductible
Durable Medical Equipment (DME)	70% after deductible \$3,000 per Calendar Year maximum	Not Covered
Note: DME and Oxygen limits are combined.		
Note: Prosthetic devices for arms and legs are NOT subject to, or limited by, the maximum payment of \$3,000. However a claim for such a device will reduce the \$3,000 maximum payment for other Durable Medical Equipment and Oxygen services.		
Home Health Care	70% after deductible 60 visit Calendar Year maximum	Not Covered
Hospice Care		
Inpatient Care	70% after deductible	50% after deductible
Home Care	70% after deductible \$100 per day maximum	50% after deductible \$100 per day maximum
Bereavement Counseling	70% after deductible Up to 12 months after death \$1,150 payment maximum	50% after deductible Up to 12 months after death \$1,150 payment maximum
Respite Care is covered on an inpatient basis, limited to periods of five (5) days or less, up to two (2) admissions per member's lifetime.		
Hospital Services		
Room and Board	70% after deductible Semiprivate room rate	50% after deductible Semiprivate room rate
Intensive Care Unit	70% after deductible Hospital's ICU Charge	50% after deductible Hospital's ICU Charge
Outpatient Hospital / Ambulatory Surgery Center	70% after deductible	50% after deductible
Emergency Room	70% after deductible	70% after deductible
<i>Laboratory and x-rays during emergency visit</i>	70% after deductible	50% after deductible
Infertility Benefits	70% after deductible \$2,000 Lifetime maximum	50% after deductible \$2,000 Lifetime maximum
Initial diagnosis of infertility.		
Inpatient Prescription Drugs	70% after deductible	50% after deductible
Mental Disorders, Substance Abuse and Alcoholism Treatment		
Mental Disorder Treatment		
Inpatient	70% after deductible	50% after deductible
Outpatient	70% after deductible	50% after deductible
Substance and Alcohol Abuse Treatment		
Inpatient	70% after deductible	50% after deductible
Outpatient	70% after deductible	50% after deductible

\$5,000 DEDUCTIBLE	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Morbid Obesity		
Bariatric Surgery	70% after deductible \$7,500 Lifetime maximum*	50% after deductible \$1,500 Lifetime maximum**
* Services must be performed at a designated Center for Excellence for Bariatric Surgery. ** \$1,500 is the Lifetime maximum for surgery due to complications from surgery performed at a Non-Network facility.		
Occupational Therapy		
Inpatient	70% after deductible 30 non-acute inpatient day Calendar Year maximum	50% after deductible 30 non-acute inpatient day Calendar Year maximum
Outpatient	70% after deductible 20 visit Calendar Year maximum	50% after deductible 20 visit Calendar Year maximum
Organ Transplants	70% after deductible \$1,000,000 per transplant maximum, per person	Not Covered
Donor Limit	\$25,000 per transplant maximum, per person	Not Covered
Transportation, lodging, and meals. (\$100 per day allowed)	\$10,000 per transplant maximum, per person	Not Covered
Oxygen	70% after deductible \$3,000 Calendar Year maximum	Not Covered
Note: Oxygen and DME limits are combined.		
Note: Prosthetic devices for arms and legs are NOT subject to, or limited by, the maximum payment of \$3,000. However a claim for such a device will reduce the \$3,000 maximum payment for other Durable Medical Equipment and Oxygen services.		
Physical Therapy		
Inpatient	70% after deductible 30 non-acute inpatient day Calendar Year maximum	50% after deductible 30 non-acute inpatient day Calendar Year maximum
Outpatient	70% after deductible 20 visit Calendar Year maximum	50% after deductible 20 visit Calendar Year maximum
Physician Services		
Inpatient hospital visit	70% after deductible	50% after deductible
Physician office visit	100% after copayment	50% after deductible
All other services during office visit including lab, x-ray and surgery in office	70% after deductible	50% after deductible
Surgery in office	70% after deductible	50% after deductible
Physician emergency room visits - emergency	70% after deductible	70% after deductible

\$5,000 DEDUCTIBLE	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Physician emergency room visits - non-emergency	70% after deductible	50% after deductible
Allergy testing	70% after deductible	50% after deductible
Allergy serum and injections	70% after deductible	50% after deductible
Preadmission Testing	70% after deductible	50% after deductible
Pregnancy		
Prenatal Care office visits	100% after copayment (Copayment charge for initial office visit only)	50% after deductible
Laboratory or x-rays	70% after deductible	50% after deductible
Delivery and Inpatient well baby care	70% after deductible	50% after deductible
The dependent child of a Covered Employee or Spouse will be covered for pregnancy; however the newborn will not be covered.		
Preventive Care		
Routine Well Adult Care	100%	Not Covered
Includes: Gynecological exam, routine physical examination, laboratory tests, x-rays, hearing tests, and immunization/flu shots (excluding travel immunizations).		
Mammogram	100%	100%
Mammogram screenings provided for women age 35 and older. For women between the ages of 50 and 65 years, a screening mammogram is covered annually.		
Cervical cancer vaccines	100%	100%
PAP Smear	100%	100%
Colonoscopies (routine screening only)	100%	100% after \$500 copay
Prostate Screening	100%	100%
Prostate screenings provided for men age 40 and older. For men between the ages of 40 but less than 50 years, a screening is covered annually if the member's physician has identified prostate cancer risk factors are present. For men 50 years of age and older, a prostate cancer screening is covered annually.		
Routine Well Child Care	100%	Not Covered
Includes: office visits, routine physical examination, laboratory tests, x-rays and hearing tests through age 12.		
Child Immunizations and flu shots	100%	100%
Prosthetics	70% after deductible	50% after deductible
Note: Prosthetic devices for arms and legs are NOT subject to, or limited by, the maximum payment of \$3,000. However a claim for such a device will reduce the \$3,000 maximum payment for other Durable Medical Equipment and Oxygen services.		
Rehabilitation Facility	70% after deductible 30 day Calendar Year maximum	50% after deductible 30 day Calendar Year maximum

\$5,000 DEDUCTIBLE	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Skilled Nursing Facility	70% after deductible Semiprivate room rate 60 day Calendar Year maximum	50% after deductible Semiprivate room rate 60 day Calendar Year maximum
Speech Therapy		
Inpatient	70% after deductible 30 non-acute inpatient day Calendar Year maximum	50% after deductible 30 non-acute inpatient day Calendar Year maximum
Outpatient	70% after deductible 20 visit Calendar Year maximum	50% after deductible 20 visit Calendar Year maximum
Spinal Manipulation / Chiropractic Care	100% after copayment 12 visit Calendar Year maximum	Not Covered
Laboratory and X-rays during office visit	70% after deductible	Not Covered
Urgent Care Facility/Extended Hour/Walk-in Facility (not ER of hospital)		
Emergency or illness care	100% after copayment	50% after deductible
Laboratory and x-rays during visits	70% after deductible	50% after deductible
Wig After Chemotherapy	70% after deductible (Only 1 st wig following cancer treatment)	50% after deductible (Only 1 st wig following cancer treatment)
Well newborn hospital care	70% after deductible	50% after deductible
All other Eligible Expenses	70% after deductible	50% after deductible

PRESCRIPTION DRUG BENEFIT – WellDyneRx

Individual Deductible per Calendar Year..... \$1,000

Family Deductible per Calendar Year \$3,000

Retail Pharmacy Option – 30 day supply

Prescription payment after deductible

Copayment 30%

Plan Percentage payable 70%

Mail Order Prescription Drug Option – 90 day supply

Prescription payment after deductible

Copayment 30%

Plan Percentage payable 70%

Over the Counter (OTC) medications (with a prescription)

Copayment \$3

Plan Percentage payable 100%

If the Covered Person chooses a Formulary Brand or Non-Formulary Brand drug instead of a Generic drug, he/she will be responsible for the Formulary Brand or Non-Formulary Brand copayment plus the difference in cost between the Formulary Brand or Non-Formulary Brand drug and Generic drug.

If there is no Generic drug available or the Physician indicates DAW (dispense as written) on the prescription or prescribes Formulary Brand or Non-Formulary Brand over Generic, the appropriate copayment as outlined above will apply.

NOTE: Prescription drugs and supplies received from a non-network pharmacy are not covered under this Plan.

Additional information on Prescription Drug can be found in the Prescription Drug Benefits section of this document.

VISION CARE BENEFITS

Charges will be covered for services performed by a licensed ophthalmologist or optometrist.

Vision Examination	Network	Non-Network
Once every 12 months	\$15 copayment	Up to \$35 reimbursement