

**COLORADO DENTAL ASSOCIATION
BENEFIT PLAN, INC.
HIGH DEDUCTIBLE HEALTH PLAN (HDHP)
(\$2,500 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 a 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

This 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 is and 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 your own account. A hard copy is available upon request at no charge.

High Deductible Health Plan

A qualified High Deductible Health Plan (HDHP) with a Health Savings Account provides comprehensive coverage for high cost medical events and a tax-advantaged way to help build savings for future medical expenses. The Plan gives you greater control over how health care benefits are used. A HDHP satisfies certain statutory requirements with respect to minimum deductibles and out-of-pocket expenses for both single and family coverage. These minimum deductibles and limits for out-of-pocket expenses' limit are set forth by the U.S. Department of Treasury and will be indexed for inflation in the future.

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 or Family Unit. Each January 1st, a new deductible amount is required. For family coverage, the deductible must be met as a Family Unit, without regard to which family member incurred the expenses. For single coverage, the Covered Person must meet the individual deductible before any money is paid by the Plan for any Covered Charge. For family coverage, the entire family deductible must be met before any money is paid by the Plan for any Covered Charge. Deductibles 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

HDHP \$2,500	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	\$2,500	\$5,000
Per Family Unit	\$5,000	\$10,000
The Medical Plan deductible accrues concurrently with the Rx Plan deductible.		
COPAYMENTS		
Colonoscopies (routine screening only)	N/A	\$500
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
(Network and Non-Network are separate)		
The Rx Charges from the Prescription Drug Plan accrues toward the Medical Plan Out-of-Pocket Maximum		
Per Covered Person	\$5,000	\$10,000
Per Family Unit	\$10,000	\$20,000
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.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%:		
<ul style="list-style-type: none"> Cost containment penalties Ineligible charges and charges in excess of Plan maximums 		
COVERED CHARGES		
Acupuncture office visits	80% after deductible \$50 per visit and \$600 per Calendar Year maximum	80% after deductible \$50 per visit and \$600 per Calendar Year maximum
Laboratory and x-ray during office visits	80% after deductible	Not Covered
Ambulance Service	80% after deductible	80% after deductible
Diagnostic X-ray and Lab Expenses (including interpretation fees)		
In physician's office	80% after deductible	60% after deductible
Inpatient/Outpatient/ or Freestanding facilities	80% after deductible	60% after deductible

HDHP \$2,500	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Durable Medical Equipment (DME)	80% after deductible \$3,000 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	80% after deductible 60 visit Calendar Year maximum	Not Covered
Hospice Care		
Inpatient Care	80% after deductible	60% after deductible
Home Care	80% after deductible \$100 per day maximum	60% after deductible \$100 per day maximum
Bereavement Counseling	80% after deductible Up to 12 months after death \$1,150 payment maximum	60% 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	80% after deductible Semiprivate room rate	60% after deductible Semiprivate room rate
Intensive Care Unit	80% after deductible Hospital's ICU Charge	60% after deductible Hospital's ICU Charge
Outpatient Hospital / Ambulatory Surgery Center	80% after deductible	60% after deductible
Emergency Room True Emergency	80% after deductible	80% after deductible
Emergency Room Non-Emergency	80% after deductible	60% after deductible
<i>Laboratory and x-rays during emergency visit</i>	80% after deductible	60% after deductible
Infertility Benefits	80% after deductible \$2,000 Lifetime maximum	60% after deductible \$2,000 Lifetime maximum
Initial diagnosis of infertility.		
Mental Disorders, Substance Abuse and Alcoholism Treatment		
Mental Disorder Treatment		
Inpatient	80% after deductible	60% after deductible
Outpatient	80% after deductible	60% after deductible
Substance and Alcohol Abuse Treatment		
Inpatient	80% after deductible	60% after deductible
Outpatient	80% after deductible	60% after deductible

HDHP \$2,500	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Morbid Obesity		
Bariatric Surgery	80% after deductible \$7,500 Lifetime maximum*	50% after deductible \$1,500 Lifetime maximum**
<p>* Services must be performed at a designated Center for Excellence for Bariatric Surgery.</p> <p>** \$1,500 is the Lifetime maximum for surgery due to complications from surgery performed at a Non-Network facility.</p>		
Occupational Therapy		
Inpatient	80% after deductible 30 non-acute inpatient day Calendar Year maximum	60% after deductible 30 non-acute inpatient day Calendar Year maximum
Outpatient	80% after deductible 20 visit Calendar Year maximum	60% after deductible 20 visit Calendar Year maximum
Organ Transplants	80% after deductible \$1,000,000 per transplant maximum	Not Covered
Donor Limit	\$25,000 per transplant maximum	Not Covered
Transportation, lodging, and meals (\$100 per day allowed)	\$10,000 per transplant maximum	Not Covered
Oxygen	80% 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	80% after deductible 30 non-acute inpatient days Calendar Year maximum	60% after deductible 30 non-acute inpatient days Calendar Year maximum
Outpatient	80% after deductible 20 visit Calendar Year maximum	60% after deductible 20 visit Calendar Year maximum
Physician Services		
Inpatient hospital visits	80% after deductible	60% after deductible
Office visits	80% after deductible	60% after deductible
Surgery	80% after deductible	60% after deductible
Physician emergency room visits-emergency	80% after deductible	80% after deductible

HDHP \$2,500	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Physician emergency room visits-non-emergency	80% after deductible	60% after deductible
Allergy testing	80% after deductible	60% after deductible
Allergy serum and injections	80% after deductible	60% after deductible
Preadmission Testing	80% after deductible	60% after deductible
Pregnancy	As any other illness	As any other illness
The dependent child of a Covered Employee or Spouse will be covered for pregnancy; however the newborn will not be covered.		
Prescription Drugs	80% after deductible	
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).		
Cervical cancer vaccines	100%	100%
PAP Smear	100%	100%
Mammogram	100%	100%
Screenings provided for women age 35 and older. For women between the ages of 50 and 65 years, a screening mammogram is covered annually.		
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: routine physical examination, laboratory tests, x-rays, and hearing tests through age 12.		
Child Immunizations and flu shots	100%	100%
Prosthetics	80% after deductible \$3,000 Calendar Year maximum	60% after deductible \$3,000 Calendar Year maximum
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	80% after deductible 30 day Calendar Year maximum	60% after deductible 30 day Calendar Year maximum
Skilled Nursing Facility	80% after deductible Semiprivate room rate 60 day Calendar Year maximum	60% after deductible Semiprivate room rate 60 day Calendar Year maximum

HDHP \$2,500	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Speech Therapy		
Inpatient	80% after deductible 30 non-acute inpatient day Calendar Year maximum	60% after deductible 30 non-acute inpatient day Calendar Year maximum
Outpatient	80% after deductible 20 visit Calendar Year maximum	60% after deductible 20 visit Calendar Year maximum
Spinal Manipulation / Chiropractic Care	80% after deductible 12 visits Calendar Year maximum	Not Covered
Laboratory and X-rays during office visit	80% after deductible	Not Covered
Urgent Care Facility/Extended Hour/Walk-in Facility (not ER of hospital)		
Emergency or illness care	80% after deductible	60% after deductible
Wig After Chemotherapy	80% after deductible 1st wig following cancer treatment	60% after deductible 1st wig following cancer treatment
Well newborn hospital care	80% after deductible	60% after deductible
All other Eligible Expenses	80% after deductible	60% after deductible

PRESCRIPTION DRUG BENEFIT – WellDyneRx

Retail Pharmacy Option – 30 day supply

Mail Order Prescription Drug Option – 90 day supply

Prescription Drug Charges accrue toward the out-of-pocket maximum.

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

Plan Percentage payable 100% after deductible

NOTE: The Plan considers Anti-histamines, Proton pump inhibitors and Anti-inflammatories as Over-the-Counter (OTC) medications.

VISION CARE BENEFITS

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

Vision Examination
Once every 12 months

Network
\$15 copayment

Non-Network
Up to \$35 reimbursement