

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

**(OUTLOOK PPO PLAN)
SCHEDULE OF BENEFITS**

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.multipplan.com
Traveling out of Colorado	PHCS Healthy Directions	(800) 678-7427	www.multipplan.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

OUTLOOK PPO PLAN	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>		
<p>DEDUCTIBLE, PER CALENDAR YEAR (Network and Non-Network are Combined)</p>		
Per Covered Person	\$1,500	
Per Family Unit	\$3,000	
<p>COPAYMENTS</p>		
Physician office visits	\$35	N/A
Specialist office visits	\$35	N/A
Diagnostic Lab	\$25	N/A
Diagnostic X-ray	\$50	N/A
Urgent Care	\$50	N/A
Vision Care	\$35	N/A
Colonoscopies (routine screening only)	N/A	\$500
Emergency Room	\$250	\$250
<p>The Emergency room copayment is waived if the patient is admitted to the Hospital on an emergency basis. The utilization review administrator, CNIC Health Solutions, Inc., must be notified at (303) 770-5710 or (800) 426-7453 within 48 hours of the admission, even if the patient is discharged within 48 hours of the admission.</p>		
<p>MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR (Network and Non-Network are separate)</p>		
Per Covered Person	\$3,000	\$7,000
Per Family Unit	\$6,000	\$14,000
<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 Cost containment penalties Deductible(s) Ineligible charges and charges in excess of Plan maximums 		

OUTLOOK PPO PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
COVERED CHARGES		
Ambulance Service	70% after deductible	70% after deductible
Diagnostics		
Laboratory	100% after \$25 copayment	50% after deductible
X-ray	100% after \$50 copayment	50% after deductible
MRI, nuclear medicine and other high tech services	70% after deductible	50% after deductible
Dental Care		
Routine Care	Not Covered	Not Covered
Non-Routine Care	70% after deductible	50% after deductible
Includes: repair to sound and natural teeth due to accidental injury.		
Durable Medical Equipment (DME)	70% after deductible \$2,500 per Calendar Year maximum	Not Covered
Durable Medical Equipment (Obtained from a pharmacy)	70% Deductible waived; up to \$150 maximum copayment	Not Covered
Includes: disposable medical supplies. Maximum limits are combined with DMS, Repairs, Oxygen, Orthotics and Prosthetics. Diabetic and injectable supplies are NOT subject to the annual limit maximum.		
Disposable Medical Supplies (DMS)	70% after deductible \$2,500 per Calendar Year maximum	50% after deductible
Durable Medical Supplies (Obtained from a pharmacy)	70% Deductible waived; up to \$150 maximum copayment	Not Covered
Includes: disposable medical supplies. Maximum limits are combined with DME, Repairs, Oxygen, Orthotics and Prosthetics. Diabetic and injectable supplies are NOT subject to the annual limit maximum.		
Home Health Care	70% after deductible	50% after deductible
Limited to a maximum of 60 combined visits per Calendar Year		
Hospice Care		
Inpatient Care	70% after deductible	50% after deductible
Respite Care is limited to periods of 5 days or less.		
Hospital Services		
Inpatient	70% after deductible Semiprivate room rate	50% after deductible Semiprivate room rate
Intensive Care Unit	70% after deductible	50% after deductible
Outpatient/ Ambulatory Surgery	70% after deductible	50% after deductible
Emergency Room	70% after \$250 copayment	70% after \$250 copayment

OUTLOOK PPO PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
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
Organ Transplants		
Inpatient care	70% after deductible	Not Covered
Outpatient care	70% after deductible	Not Covered
Orthotics and Prosthetics	70% after deductible \$2,500 Calendar Year maximum	Not Covered*
Note: limits are combined with DME, DMS, Repairs, and Oxygen This Benefit is only covered for Diabetes. *Arm, leg, breast prosthetics and mastectomy bras <u>will be covered</u> as required by Law and are not subject to the annual limit maximum.		
Oxygen	70% after deductible \$2,500 Calendar Year maximum	Not Covered
Note: limits are combined with DME, DMS, Repairs, Orthotics and Prosthetics.		
Physical, Speech and Occupational Therapies		
Inpatient care	70% after deductible	50% after deductible
Limited to a combined Maximum of 60 days per episode, per medical condition		
Outpatient care	100% after \$35 copayment	50% after deductible
Limited to a combined Maximum of 20 visits per therapy, per Calendar Year.		
Medical office visits		
Physician office visits	100% after \$35 copayment	50% after deductible
Specialist office visits	100% after \$35 copayment	50% after deductible
Physician surgical and medical services	70% after deductible	50% after deductible
Pregnancy		
Prenatal Care (routine)	70% after deductible	50% after deductible
Delivery and inpatient well baby care	70% after deductible	50% after deductible
Note: Non-routine Prenatal care will have the applicable copayment/coinsurance for the type of service.		
Preventive Care		
Routine Well Adult Care	100%	Not Covered
Includes: Gynecological exam, routine physical examination, laboratory tests, x-rays, and hearing tests.		
Adult Immunizations and flu shots (excluding travel)	100%	50% after deductible
Cervical cancer vaccines	100%	100%

OUTLOOK PPO PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
PAP Smear	100%	100%
Mammogram	100%	100% (up to \$115 maximum)
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.		
Colonoscopies (routine screening only)	100%	100% after \$500 copay
Routine Prostate Screening	100%	100% (up to \$65 maximum)
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%
Skilled Nursing Facility	70% after deductible Semiprivate room rate	50% after deductible Semiprivate room rate
Limited to a combined maximum of 60 days per Calendar Year.		
Urgent Care Facility/Extended Hour/Walk-in Facility (not ER of hospital)		
Emergency or illness care	100% after \$50 copayment	50% after deductible
Vision Care		
Annual Routine Vision Screening	100% after \$35 copayment	Not Covered
Non-Routine Vision Screening	70% after deductible	50% after deductible
Note: Non-routine Vision care (due to injury or disease of the eye) will have the applicable copayment/coinsurance for the type of service.		
All Other Eligible Expenses	70% after deductible	50% after deductible

PRESCRIPTION DRUG BENEFIT

Retail Pharmacy Option (WellDyneRx – 31 day supply)

Tier I - Generic drugs

Copayment.....	\$15
Percentage payable	100%

Tier II - Formulary Brand Name drugs

Copayment.....	\$40
Percentage payable	100%

Tier III - Non-Formulary Brand Name drugs

Copayment.....	\$55
Percentage payable	100%

Tier IV - Self-administered Injectables and drugs purchased from a specialty pharmacy

Copayment.....	30%
Percentage payable	70% up to \$250 maximum copay for a 31-day supply

Mail Order Prescription Drug Option (WellDyneRx – 90 day supply)

Tier I - Generic drugs

Copayment.....	\$37.50
Percentage payable	100%

Tier II - Formulary Brand Name drugs

Copayment.....	\$100
Percentage payable	100%

Tier III - Non-Formulary Brand Name drugs

Copayment.....	\$137.50
Percentage payable	100%

Tier IV - Self-administered Injectables and drugs purchased from a specialty pharmacy

Copayment.....	20%
Percentage payable	80% up to \$375 maximum copay for a 90-day supply

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.