2010

BENEFIT HANDBOOK

San Luis Valley
Health Access
Program

CarePoint Benefit Handbook
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IMPORTANT NOTICE

The CarePoint Health Access Program ***is not insurance***, it is a local health access program. CarePoint Health Access Plan reserves the sole right to do any of the following at any time:

(a) terminate the CarePoint program in whole or in part;

(b) change, add or delete any or all of its polices and rules, including but not limited to those pertaining in any way to member or employer eligibility, coverage, exclusions from coverage, termination of coverage, covered and non-covered benefits, claims, billing, benefit levels and maximums, copay, deductibles, subrogation, coordination of benefits, program costs or charges, grievances, protocols, preauthorization, privacy, referrals, assignment of benefits and/or Participating Providers;

(c) change its Participating Providers, including additions and deletions to those participating; and

(d) resolve any conflict between different terms of this Handbook and/or between any of the terms of this Handbook and those of any other CarePoint document or policy. CarePoint will provide advance notice of such terminations or changes when and to the extent such notice is required by law but does not guarantee that any notice not required by law will be given, and does not guarantee that any such termination or change will not be made.

CarePoint Members have access only to CarePoint Participating Providers and only for Covered Services provided in the San Luis Valley.

Welcome!

Welcome to CarePoint, San Luis Valley's own three-share program. Local partnerships with San Luis Valley Regional Medical Center, Conejos County Hospital, Rio Grande Hospital, Valley Wide Health Systems, Colorado Choice Health Plans, participating health care providers, businesses, members and community leaders are contributing to CarePoint's success. These community partnerships have made it possible to offer affordable health care access to community members who, most likely, cannot afford health insurance.

The CarePoint Health Access Plan is unique, and this Handbook was created to explain significant aspects of the plan to our participating members and partners. Read this Handbook carefully and be sure to ask questions as they arise.

WHO TO CONTACT?

Purpose	Department	Contact
-Business and employee questions about benefits, enrollments, terminations, physician changes, and new cards. -Form requests. -Web site and publications. *-Any issues not listed elsewhere.*	Member Services	719-589-3696
-Claims payments or issues. -Pharmacy issues. -Provider contracts and physician updates. -Business payment questions, monthly charge billing (not terminations or additions), and late payments.	Claims, Administration and Billing	719-589-3696
-Referrals, Preauthorization, and Medical Documentation. -Medical, treatment and protocol questions. -To schedule health advising appointments and classes with the Health Advisor. -To schedule workshops: Nutrition, Stress Management, and Health Consumer.	Health Administration	719-589-3696
-Businesses interested in offering CarePoint. -Business applications. -If your business is interested in doing CHAT group meetings or workshops.	CarePoint Sales Representative	719-589-3696

We look forward to helping members reach their full potential and prosper in good health.

Yours for Enhanced Community Health,
The CarePoint Team

About CarePoint

CarePoint is *not* insurance but a "community partnership" and is an effort to provide affordable, appropriate health coverage for the uninsured working residents of the San Luis Valley.

CarePoint is a community-based, not-for-profit organization developed to provide affordable, basic health coverage. CarePoint is an employer-sponsored program for the working uninsured employees in the San Luis Valley. Our program has the support of community leaders, businesses, providers and the local hospital systems.

CarePoint will evolve over the years and will continue to improve and change. We realize that we simply cannot be modeled like traditional health programs because we want to emphasize health improvement and empowerment. In order for our program to be successful in improving health and maintaining costs, we must strive to do things differently. CarePoint has developed several community partnerships to assist us in achieving our goals. We strongly believe in education and offer classes on chronic disease and other health issues for our members.

CarePoint provides support for members in lifestyle issues so members can achieve their optimal health. We have health advisors and staff who will work with members, and their physicians, to assist them in improving their health status. Most importantly, we care about your health and wellness and would like to be your partner in improving your health today so you can have a better quality of life.

For a better understanding of our requirements, benefit design, your responsibilities, and how to access care; we have designed this Handbook to summarize and explain the features of our program. Please take the time to review it carefully and ask questions as they arise. Please also review the "Important Notice" following the Table of Contents page.

The CarePoint Vision and Mission

Vision
Helping to improve lives, in the San Luis Valley, by providing access to affordable health care.

Mission
To provide an affordable basic health care program targeted to qualified employer groups so that we improve the lives of thousands of Valley Residents by 2014. We will accomplish this through our community partners and resources.

Community partners include providers, employers and citizens of the San Luis Valley. Community Resources include health care and education services available to Valley residents.

CarePoint Goals

- Provide members & their families with access to affordable, appropriate health care services.
- Use health data to improve the delivery of health services in the San Luis Valley.
- Provide health education and support for individual and community health improvement.

CarePoint Call to Action

The rise in health care costs is a problem affecting every facet of our community. The problem is complex and cannot be solved in one day, by one person. It takes a village to solve the problem, or in our case, a community making a conscious effort to improve our health. At the heart of the community are individuals. CarePoint recognizes this in making each individual member a key part of the solution to affordable health improvement. CarePoint would like to become your partner in health.

The Role of CarePoint

CarePoint's role is to provide affordable access to health services and education for its members and business partners on the importance of maintaining good health.

The Role of the Individual Member

The Member's role is to seek optimal health through lifestyle choices, including increasing physical activity, improving nutrition, receiving physical exams, and quitting smoking.

The Role of Business Partners

The Employer's role is to promote healthy workplace environments, physical activity, non-smoking policies, healthy nutrition, and to provide health promotions for customers and employees.

The Role of the Community

The community is a partner in making CarePoint available to local businesses and working families. In addition, the community is encouraged to provide inexpensive and accessible ways for citizens to increase physical activity. Simple things like sidewalks, accessible parks and bike paths will help to promote health and wellness.

Eligibility

Employee Eligibility Criteria
For an employee to be considered an Eligible Employee to participate in the CarePoint program, he or she must meet all of the following criteria both at the time of application and, except as specified otherwise below, throughout the entire period of participation:

- Be an active, bona fide, paid Permanent Employee, to whom the employer issues a W-2, and not an independent contractor, temporary worker or retiree.
- Have been continuously and actively employed as a Permanent Employee subject to the waiting period established by the Employer.
- Is not eligible to participate in, either directly or as a dependent, in any type of federal, state, business-sponsored, or individual health insurance or health benefit plan, including but not limited to Medicare, Medicaid, Child Health Plan Plus (CHP+), Veterans Affairs Healthcare, or Native American Health Care.

CarePoint may formally review an employee's eligibility for continued program participation at least annually and may terminate the employee's participation at any time that he/she fails to meet any of the employer eligibility criteria.

The employee must notify CarePoint immediately upon discovering that he/she fails to meet any of the employee eligibility criteria.

Spouse and Dependent Coverage

The Employer is not required to offer CarePoint to dependents (including spouse) of its employees. However, if the Employer does offer dependent coverage for any of the Eligible Employees in a Designated Employee Group, then CarePoint must be offered to all Eligible Dependents within that Designated Employee Group. A Designated Employee is a group of employees that have common characteristics of work hours or employment status Remember the Employer is responsible for defining Designated Employee Groups.

Eligible Employee's dependents are eligible to participate in CarePoint if the dependent meets the following criteria:

- Is not eligible to participate in, either directly or as a dependent, in any type of federal, state, business-sponsored, or individual health insurance or health benefit plan, including but not limited to Medicare, Medicaid, Child Health Plan Plus (CHP+), Veterans Affairs Healthcare, or Native American Health Care.
- A spouse is eligible if he or she is both legally married to, and resides with, the Eligible Employee.
- Child dependents are eligible until the end of the month in which they have their 19th birthday.
- New dependent children are eligible to enroll within 30 days of the qualifying event.

These Eligible Dependents will be terminated from the program, effective at the end of the month they are no longer meet the above definition.

Member Cards
You will receive two identification cards. Your CarePoint Member card should be presented each time you receive Covered Services for medical care. Your Pharmacy ID card should be used when you have a prescription filled. If you lose or misplace your ID cards, call CarePoint to request a new card.

Member Program Benefits
CarePoint has two benefit plans available. They are designed to help you take careful, managed steps toward improving your long-term health. These plans require a commitment on your part, but you are not alone. Your Health Advisor and CarePoint will provide you with the help and encouragement for you to be successful.

Participation Requirements

- You and all of your Eligible Dependents must complete a Health Assessment.
- You and your Health Advisor will develop a Health Action Plan to address any current health issues or risks.
- You will carry out the activities from this Health Action Plan.
- Attend two health classes within six (6) months of enrolling, as applicable.
- If you have a persistent or chronic health condition such as diabetes, high blood pressure or obesity, you will need to conference with a Health Advisor and participate in educational classes related to your chronic health condition.

Active Participation in Your Health Care
You must be committed to being an active participant in your own health care. The goal of CarePoint is to provide affordable, appropriate health care to improve your long-term health. CarePoint encourages Preventive care and encourages you to receive tests that are recommended for persons of similar age to prevent potentially serious medical problems before they occur.

Chronic Disease Management
If you are diagnosed with a persistent or chronic condition, you agree to comply with a treatment plan and work with physicians in the appropriate course of treatment. If you do not follow the recommended protocols, treatments or recommendations, or make lifestyle changes that will improve your health, the services you received may not be covered and you would be financially responsible for them.

Members' Rights & Responsibilities

As a member of CarePoint (either directly or as a covered dependent) you have many rights. They include the right to privacy, to receive prompt medical care (as covered by this access program) and to have the information you need to participate in decisions about your treatment. You also have responsibilities. Your responsibilities include, but are not necessarily, limited to the following:

- You agree to be bound by the CarePoint Benefit Handbook. If you have any questions or do not understand any aspects of the plan, it is important for you to contact CarePoint.
- Comply with the requirements described or referenced in this Benefit Handbook.
- Coordinate all medical services through your Primary Care Provider and/or CarePoint. It is your responsibility to ensure a referral or preauthorization is obtained for any service that requires one.
- Show your individual CarePoint Member Card to the provider when medical services are received. Each CarePoint member receives a card and unique member number.
- Pay all copay amounts when medical services are provided.
- Provide accurate information needed for proper medical care.
- Tell us if you become eligible for health benefits from any other program or discover that you no longer meet any of the employee eligibility criteria.
- Tell us if your address and/or phone number changes.
- Tell us if your member card is lost or stolen.
- Tell us if you have applied for disability or Workers' Compensation benefits, even if you have not received a determination or have been denied.
- Tell us if a third party is or may be responsible for some or all of your health care costs (examples: another person, a business, your employer or an auto, homeowners or liability insurance company), or if you file or settle a lawsuit regarding personal injuries or health care costs or benefits or receive a payment, judgment, settlement or other award for personal injuries or health care costs or benefits.
- Sign any document, and take any other action, reasonably requested by CarePoint to permit CarePoint to obtain reimbursement from a responsible third party for health care costs or benefits CarePoint has provided on your behalf.

Covered Services

Medically Necessary services provided by a Participating Provider are covered as follows provided that they are not available through another public or private program. Coverage is provided only for services listed, all others services are not covered. Some services require Preauthorization and completion of Protocol prior to being covered.

Preventive, Routine, & Specialty Care:

How to Access Preventive, Routine & Specialty Care

You must choose a Primary Care Provider (PCP). Your PCP coordinates all of your health care needs. Whenever you need medical care, call your PCP first. Health care service Preauthorization requests must be referred through your PCP this includes referrals to specialists and hospitals. Contact Member Services if you want to change your PCP. The change will be effective the first of the month following notification to CarePoint.

Your PCP will refer you to a specialist, who is a CarePoint Participating Provider, if necessary. Any health care services provided by a physician other than your PCP will be considered specialist care and subject to a higher copay. To be sure that the specialty care is covered, it is your responsibility to make sure CarePoint receives a referral from your PCP or other appropriate provider. The Referral will be used to help understand your health needs and to better coordinate your care. CarePoint will review the Referral and identify any Protocol requirements, then issue a Preauthorization for the requested services if appropriate. It is your responsibility to obtain the Preauthorization prior to scheduling a medical service that requires a Preauthorization. If you do not obtain the Preauthorization from CarePoint, you will be responsible for any unpaid charges for the unauthorized services.

Newborn and Pediatric Care – Pediatric care, as determined by your Primary Care Provider. Sick child care is covered as any other medical condition regardless of age.

Well Child and Adult Visits – Age appropriate physical exams, history, anticipatory guidance and education, exercise and nutrition counseling (including folate counseling for women of child bearing age), Complete Blood Count (CBC), history and physical, Urinalysis (UA), chemical profile, fasting lipid panel, and stool hemoccult, are covered. Scheduled Physical Examinations do not include stress test or EKG. More frequent examinations are covered only in support of a diagnosis, as determined by your Primary Care Provider.

Men – When provided by a Participating Provider, screening for the early detection of prostate cancer is covered according to the following schedule:

- One screening per year shall be covered for any man fifty years of age or older; and
- One screening per year shall be covered for any man from forty to fifty years of age who is at increased risk of developing prostate cancer as determined by a Participating Provider

The prostate screening shall consist of the following tests:

- A prostate-specific antigen (“PSA”) blood test; and
- Digital rectal examination.

Women – The following services may be provided by the Breast and Cervical Cancer Screening Program (BCCSP) if eligible (see community resources for more information on this program). If ineligible, then services must be provided by a Participating Provider.

Yearly breast and pelvic exam, PAP test, and at the Physician's discretion, hematocrit and urinalysis, are covered. Screening and diagnostic mammography are covered according to the following schedule:

- Single baseline mammogram and clinical breast exam for women thirty-five years of age and under forty years of age (once during 35 to 39 year period);
- One mammogram and clinical breast exam once every two years for women forty years of age and under fifty years of age but at least once a year for women with risk factors of breast cancer as determined by her Primary Care Provider; and
- One mammogram and clinical breast exam annually for women over fifty years of age.

Immunizations and Injections for Children and Adults– Immunizations are covered through programs offered by the Public Health Departments throughout the San Luis Valley. Both Child & Adult immunizations are offered as well as the Flu Vaccine. Most Departments offer free Blood Pressure checks and Pulse Oximeter testing as well. Contact the applicable Department to find out more when these low-cost services are available.

COUNTY	PHONE
Alamosa	719-589-6639
Conejos	719-274-4307
Costilla	719-672-3332
Mineral	719-658-2416
Rio Grande	719-657-3352
Saguache	719-655-2533
Saguache – Center office	719-754-2773

Injections covered when administered in the Participating Provider's office are:

- Steroid injections of intra-articular joint
- Steroid injections for acute asthma exacerbations or allergic reactions
- Epinephrine for acute allergic reactions
- Chemotherapy and related agents, Preauthorization required
- Administration of allergy injection is covered, although the antigen is covered under the prescription drug benefit

Diagnostic Services – Diagnostic services, including radiology (X-ray), pathology and laboratory tests are covered. Magnetic resonance imaging (MRI) and computerized tomography (CT) require a Preauthorization.

Routine Office Visits – A Member's routine office visits to a Primary Care Provider are covered.

Services While Hospitalized – The services of Participating Providers while a Member is hospitalized, including services of Primary Care Providers, specialist surgeons, assistant surgeons, anesthesiologists, and other appropriate medical personnel are covered.

Specialty Physician Services – Services of Participating Providers who are specialty Physicians are covered in accordance with the Preauthorization requirements.

Urgent & Emergency Care:

How to Access Urgent Care & Emergency Care

Urgent Care

Urgent Care in the San Luis Valley is covered only when obtained from a Participating urgent care center. The Member must be able to establish the Medical Necessity and urgent nature of the care.

If you have an urgent medical problem that is not an emergency, but needs timely attention, call your PCP's office first. Your PCP knows you and your medical history and is the best person to help you with your medical needs. If you can't reach your PCP after making reasonable attempts, and you require urgent care, go to one of the participating urgent care centers.

Be sure to call your PCP's office after receiving care at the urgent care center so that your PCP may coordinate any follow-up care if it is needed.

Do not go to an urgent care center or a hospital emergency department for an illness or accident that can be treated in your doctor's office during regular office hours.

Emergency Care

Emergency Room Care in the San Luis Valley is covered only when obtained from a participating Emergency Room, provided the condition meets the criteria described below.

An "Emergency Medical Condition" is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (a) serious jeopardy to the health of the individual or, in the case of a pregnant woman, to the health of the woman or her unborn child; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

CarePoint does not cover emergency department services for conditions that do not meet its definition of an Emergency Medical Condition even if referred by a physician. You will have to pay for emergency department services if they are not for an Emergency Medical Condition. Non-emergency care provided in an emergency department is not a covered benefit. Emergencies outside the San Luis Valley are not covered.

Emergency Medical Conditions include, but are not necessarily limited to, these types of symptoms or injuries, which are usually present less than 24 hours:

- Head injuries—resulting in the loss of consciousness, severe headache, dizziness, confusion, disorientation, vomiting, a cut over one inch in length or other obvious injury.
- Nervous System—weakness or paralysis, loss of sensation, first or prolonged seizure.
- Eyes—obvious injury or chemical in eyes, loss of or sudden alteration of vision.
- Nose–severe or uncontrolled nosebleed, foreign object lodged in the nose.
- Throat—difficulty breathing or swallowing, any bleeding in mouth or throat.
- Chest—any chest pain or shortness of breath.

- Abdomen—severe pain, serious blunt injury or penetration injury, rapid bleeding from the rectum.
- Genital/Urinary—severe, sudden or recent onset of belly or pelvic pain, vaginal bleeding during pregnancy.
- Back—difficulty in walking with severe pain or injury, excluding chronic pain.
- Limbs/Skin—injury resulting in deformity or swollen joints, deep or long cuts, facial cuts, severe burns.
- If you exhibit any of the above symptoms, seek emergency care immediately.

If you have any questions as to whether or not you should go to the emergency department, call your PCP or if after hours, your PCP's on-call physician. Be sure to call your PCP's office within 48 hours of receiving care at the emergency room so that your PCP may coordinate any follow-up care that is needed. Also, contact CarePoint within 48 hours of the emergency.

Non-emergency Symptoms:

Symptoms Where Emergency Department Treatment Is *Not* Appropriate
Common urgent situations that are *not* appropriately treated in the emergency room are listed below. When these symptoms are present, you should seek treatment first with your PCP. If you can't reach your PCP, then go to an urgent care center.

- Dental pain or diagnosis
- Chronic pain from injuries or illnesses
- Chronic recurring headaches
- Sprains
- Simple cuts less than 1 inch
- Bruises
- Back or joint strain
- Depression-unless suicidal
- Urinary tract infection
- Suture removal
- Alcohol intoxication without life threatening symptoms
- Substance abuse without life threatening symptoms
- Follow-up care or treatment of non-emergency, chronic conditions
- Absent extraordinary circumstances, a second emergency room visit within 24 hours is not a covered benefit.

Medical Emergency Ambulance Transport
Members should call "911" whenever a Member is confronted with a life or limb threatening emergency. For the purposes of this section, a "life or limb threatening emergency" means any event which the Member believes threatens his or her life or to prevent death or serious impairment of health. *Air ambulance services are never a covered benefit.*

Outpatient & Inpatient Care:

How to Access Outpatient & Inpatient Hospital Care
Your PCP coordinates all of your health care needs, including any hospital testing, surgical procedures or inpatient admissions. CarePoint must receive a Referral from your PCP for any surgical procedure, and for certain diagnostic tests, performed at a hospital. This Handbook includes a complete listing of services and their requirements. You are responsible for obtaining the Referral and contacting CarePoint for the Preauthorization. *Elective Surgery is not covered during the first six (6) months of enrollment in CarePoint.*

CarePoint provides health administration services for all members and will work closely with you to help you manage any significant health problems. The Health Advisor is here to assist our members and providers regarding medical services and may be reached at 719-589-3696 or by fax 719-589-4995.

The Health Advisor will help you with the following:

- Communicate with your PCP and providers to coordinate your health care services.
- Review and manage any Referrals and Preauthorization for services requested from you or your PCP.
- Work closely with you if you are diagnosed with a chronic disease, such as asthma, diabetes or if you have an identified health risk.
- Assist you in the completion of the Protocols prior to receiving certain medical services.
- Monitor your progress while hospitalized and assist your physician to identify potential discharge planning needs.
- Identify and enroll in health classes that would be valuable to you.
- Work with you to find other community resources to help you pay for any medical services not covered by CarePoint.
- Coordinate mammogram services.

Hospital Inpatient Services:

Hospital Inpatient Services. Inpatient services due to Medical Emergency or an unforeseen illness or injury are covered. When Preauthorized and Protocol is completed, other scheduled admissions are covered.

In the event of an emergency hospitalization, notice of the admission and the institution to which the member was admitted must be given to CarePoint within 48 hours.

Maternity Hospitalization. Refer to Maternity Benefits.

Hospital Room and Board. While a Member is a patient in a Hospital, a semi-private accommodation, general nursing care, meals, special diets, use of operating room and related facilities, intensive care unit and services, X-ray, laboratory, and other diagnostic tests, drugs, medications, biologicals, anesthesia and oxygen services, radiation therapy, chemotherapy (other than high dose chemotherapy which requires the support of a non-covered bone marrow transplant or autologous stem cell rescue procedure), physical therapy, inhalation therapy, Prosthetic Devices approved by the Food and Drug Administration and implanted during a surgery performed pursuant to a Preauthorization (such as pacemakers and hip joints), and administration of whole

blood, blood plasma and other blood products and special duty nurses as Medically Necessary, are covered.

Outpatient Services:

Upon Preauthorization and completion of Protocol, other Medically Necessary outpatient services are covered as follows:

Chemotherapy. Medically Necessary chemotherapy, other than chemotherapy administered orally and other than high dose chemotherapy which requires the support of a *non-covered* bone marrow transplant or autologous stem cell rescue procedure, are covered.

Outpatient Surgery. Medically Necessary outpatient surgery is covered.

Outpatient Services. Outpatient services, including diagnostic services, treatment services, rehabilitation services and X-ray services are covered.

Outpatient Mental Health. Four (4) outpatient mental health visits per member per contract year are covered.

Maternity Benefits:

Special Circumstances. Pregnancy is *only* a covered benefit on the CarePoint program if the member is not eligible for a government program. All children and pregnant women are required to participate in screening to determine if they are eligible for Medicaid or Child Health Plan Plus (CHP+). Call your local County Department of Social Services to schedule an appointment to apply for these programs, be sure to ask them what documentation you will need to bring with you to the screening. If you are declined you must provide CarePoint with a copy of the determination. If you are eligible for a government program you are NOT eligible for participation on CarePoint. All pregnancies are subject to screening.

COUNTY	PHONE
Alamosa	719-589-2581
Conejos	719-376-5455
Costilla	719-672-4131
Mineral	719-657-3381
Rio Grande	719-657-3381
Saguache	719-655-2537

Medically Necessary maternity care is covered as follows:

Availability. Maternity benefits are only available for Members if they do not qualify for Medicaid.

Prenatal and Postnatal Care. Prenatal and postnatal care are covered.

Hospital Room and Board. Hospital room and board is covered for routine vaginal delivery or cesarean section, if Medically Necessary.

Delivery and Nursing Care. Delivery services and facilities and nursing care are covered in a Hospital only.

Physicians' Services. Physician obstetrical services are covered.

Prenatal Diagnosis. Prenatal diagnosis of congenital disorders of the fetus by means of screening and diagnostic procedures during the pregnancy are covered as Medically Necessary.

Complications. Medically Necessary care for complications including miscarriages, caesarian sections, ectopic pregnancies, is covered.

Other Services:

The following Medically Necessary services are covered when provided by a Participating Provider:

Diabetes. Coverage includes approved equipment and supplies, outpatient self-management training and education. Equipment such as a glucometer are covered as Durable Medical Equipment. Supplies such as test strips and lancets are covered under the Pharmacy benefit. Insulin pumps are not covered.

Home Health Care. Care provided to a Member who is under the direct care of a Participating Provider shall be covered as part of an authorized Home Health Treatment Plan as follows:

1. Services will be covered only if hospitalization or confinement of the Member would be required if such home health services and benefits were not provided.
2. Services shall include visits to the Member by the Participating Providers of services specified below for the usual and customary time required to perform that particular service.

Only the following services will be covered:

1. Professional services of a registered or licensed vocational nurse
2. Short term physical therapy, subject to limits as described in Rehabilitative Services below.

Rehabilitative Services. Upon Preauthorization, services of licensed therapists for short term rehabilitative services, including physical, occupational and speech therapies, are covered for up to ten (10) outpatient visits per contract year, providing that such services can be expected to result in the significant improvement of the Member's condition within that period. These benefits shall not cover chronic or recurring conditions which are not subject to sustained significant improvement within the allowed time frame.

Durable Medical Equipment. The Durable Medical Equipment benefit is limited per contract year and must be determined as Medically Necessary and only if provided or distributed through a Participating Provider upon a Preauthorization. Coverage includes fitting, rental; purchase; maintenance or repair of Durable Equipment, when necessitated by accidental irreparable damage or due to changes in the condition or size of the patient; home administered oxygen, corrective appliances and artificial aids and braces; prosthetic or orthotic appliances, and/or fittings for such devices; and prescription lenses following a cataract operation or to replace organic lenses missing because of congenital absence, and diabetic equipment (i.e. glucometer).

Prescription Drug Program:

Using the Prescription Drug Program

To utilize your prescription drug benefit, you will need to present your Pharmacy ID Card and the prescription written by your PCP or a specialist authorized by CarePoint to one of the CarePoint Participating pharmacies. If you do not have your prescription filled at a Participating pharmacy, you will be responsible for the entire cost of the prescription.

Please be sure to show your pharmacy ID card each time a prescription is filled. The pharmacy electronically verifies your coverage and the copay amount with our Pharmacy Benefit Manager, Prescription Solutions, based upon the information shown on your ID card. If the pharmacy has a problem determining eligibility, it may call Prescription Solutions Customer Service directly. The Prescription Solutions Customer Service can be reached at 800-797-9791. If you know you are eligible for CarePoint coverage and are having a problem, please verify that the information on your card is correct and that it matches what the pharmacy has on record. Members or the pharmacy may call the CarePoint office during business hours for further assistance.

Only formulary drugs are covered by CarePoint. The formulary is primarily a generic only formulary. Contact CarePoint with any questions related to what drugs are covered. Prescriptions covered by another entity are not covered.

Diabetic and Asthmatic Supplies

Diabetic supplies such as syringes, monitoring strips and glucometers are covered at participating pharmacies. Only approved glucometers and strips are covered by CarePoint. If you select any other type of glucometers, it will not be covered and will be your responsibility to purchase. For Asthma and Pulmonary supplies, such as nebulizers, call 719-589-3696.

Community Resources

CarePoint is a "community-based program" and works in partnership with the following community health care resources as often as possible. Contact the Health Advisor at CarePoint at (719) 589-3696 for assistance in enrollment. Please note that these Programs are subject to change.

The Breast and Cervical Cancer Screening Program (BCCSP)

BCCSP is a Colorado program of the Department of Health Care Policy and Financing. The eligibility requirements and benefits are set by them, not CarePoint, Inc., and are subject to change at their discretion. BCCSP covers clinical breast exams, diagnostic mammograms, pelvic exams, pap smears and certain diagnostic tests for women that qualify. If you qualify, you must participate in this program and are required to register annually. Contact CarePoint for information to register.

If you qualify and do not participate in the program, *you* will be responsible for the cost of care relating to breast or cervical cancer while covered by CarePoint.

Child Health Plan Plus (CHP+)

All children and pregnant women are required to participate in screening to determine if they are eligible for Medicaid or Child Health Plan Plus (CHP+). Call your local County Department of Social Services to schedule an appointment to apply for these programs, be sure to ask them what documentation you will need to bring with you to the screening. If you are declined you must provide CarePoint with a copy of the determination. If you are eligible for a government program you are NOT eligible for participation on CarePoint.

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Eye Exams and Glasses for Children

Sight for Students is a Vision Services Plan (VSP) charity that provides free vision exams and glasses to low-income, uninsured children. The program operates nationally through a network of community partners who identify children in need and VSP network doctors who provide the eyecare services. Go to http://vsp.via.infonow.net/sight/ or call 1-888-290-4964 to locate a community partner in the San Luis Valley.

Family Planning – Planned Parenthood of the Rocky Mountains has been helping women, men and teens make responsible choices for 90 years. They are committed to delivering the highest quality reproductive health care, teaching responsible and age-appropriate sexuality education. Family Planning Services available at the Alamosa Planned parenthood location include:

- Well woman physical, breast and pelvic exams, including pap smears
- Pregnancy testing and options counseling
- Counseling and assessment for birth control
- Contraception (birth control)

- HIV, STD and pregnancy testing and treatment

Call 719-589-4906 to schedule an appointment

Counseling and assessment for birth control as provided by County Health Departments. Eligibility is subject to income and family size. They cover the HPV vaccine.

The Women's Wellness Connection (WWC)
The WWC is a program administered by the Colorado Department of Public Health and Environment. The program provides breast and cervical cancer screening (mammograms, clinical breast exams, Pap tests and pelvic exams) and selected diagnostic services. These exams are provided free of charge to women with limited income 40 to 64 years of age. Emphasis is placed on recruiting women who have not had a mammogram and/or Pap test in the past 12 months or women who have lost insurance, had an abnormal Pap, and need follow-up. To find out if you qualify please call 1-866-951-WELL (9355) or go to www.womenswellnessconnection.org.

Immunizations
Immunizations are covered through programs offered by the Public Health Departments throughout the San Luis Valley. Both Child & Adult immunizations are offered as well as the Flu Vaccine. Most Departments offer free Blood Pressure checks and Pulse Oximeter testing as well. Contact the applicable Department to find out more when these low-cost services are available.

COUNTY	PHONE
Alamosa	719-589-6639
Conejos	719-274-4307
Costilla	719-672-3332
Mineral	719-658-2416
Rio Grande	719-657-3352
Saguache	719-655-2533
Saguache – Center office	719-754-2773

Smoking Cessation
Colorado offers the 'Colorado QuitLine", an excellent and effective resource free of charge to all Coloradans who are uninsured and want to quit smoking. The Colorado QuitLine is a telephone-based coaching service that connects people who want to quit smoking with highly-trained coaches who provide guidance and support throughout the process. The QuitLine also offers a free supply of nicotine patches. Call 1-800-QUIT-NOW.

Preauthorization

In order to be a Covered Benefit certain medical services require a Referral and/or Preauthorization, which is approval by CarePoint, before you receive the service.

To be sure that the service is a Covered Benefit, it is your responsibility to make certain that your PCP faxes a Referral form to CarePoint at (719) 589-3696 at least 72 hours *before* the service is to be performed and that CarePoint has approved or preauthorized the service *before* it is performed.

Certain medical services are covered only if you complete a CarePoint Protocol. Once you have completed the Protocol with the assistance of the Health Advisor, the services will be authorized. If you have any questions about which services require a Referral, Preauthorization and/or a Protocol, call CarePoint. You, the member, are responsible for obtaining a required Referral and Preauthorization and for completing any required Protocol before the service is performed. If you fail to do so, you may be financially responsible for the full cost of the service.

Covered Services That Require Preauthorization:

Covered Services that require Preauthorization are listed below. Services that require completion of a CarePoint Protocol in addition to a Preauthorization are also shown.

Medical Service	Pre Authorization Required	Subject to CarePoint Protocol	Treatment Plan Required
Allergy Testing	X	X	X
Angiography	X		
Apnea & Sleep Study Testing	X	X	
Bone Density (Under 50)	X		
Cardiac Rehabilitation	X		X
Chemotherapy & Radiation Therapy—Inpatient/ Outpatient	X		X
Colonoscopy Screening	X		
Durable Medical Equipment, Orthotics & devices over $100	X		
Holter Monitor–24 Hour	X		
Home Care	X		
Inpatient Hospitalization	X	X	
MRI, nuclear medicine, and	X	X	

Medical Service	Pre Authorization Required	Subject to CarePoint Protocol	Treatment Plan Required
other high-tech services			
Needle Biopsy	X		
Outpatient Services over $500	X	X	
Physical, Occupational & Speech Therapy	X		
Pulmonary Function Testing	X	X	
Respiratory Therapy	X		X
Specialist office visit(s)	X		
Stress Test	X		
Wound Care	X		X

Covered Services Not Requiring Preauthorization:

The following services do not require any notification from the member or provider.

- Ambulance
- Durable Medical Equipment under $100 (If over $100, requires preauthorization)
- Primary Care Visit
- Routine Outpatient Labs
- Diabetic Supplies
- Urgent Care Visit
- X-ray & similar services *not* requiring a Preauthorization
- Outpatient Mental Health Services

The following steps may need to be completed if applicable before surgery will be authorized:

1. Participate in physical therapy
2. Tobacco cessation classes
3. Begin action to reduce weight
4. Submit Medical Records

Asthma

Nebulizers will not be covered if the member does not choose to attend Asthma Education sessions.

Other Services

There may be other services that require a Protocol and this is not an exhaustive list. Please see the section "Covered Services Requiring Preauthorization" for other services that may require Protocol.

Members should call 719-589-3696 to discuss Protocols with the CarePoint Health Advisor.

Exclusions

Exclusions & Non-Covered Benefits:

This section describes services, supplies and medications that are *not* covered benefits under the CarePoint Program. Any and all costs related to the services, supplies and medications listed below will *not* be paid by CarePoint and will be your responsibility. If a service was not specifically mentioned in the Covered Services Section as covered, then there is no coverage for that service.

1. Any medical services performed or received outside of the San Luis Valley or from any provider or facility that is not a CarePoint Participating Provider.
2. Prescription drugs or supplies not obtained from a participating pharmacy in the San Luis Valley or not covered by the CarePoint formulary.
3. Organ and Tissue Transplants.
4. Medical services, supplies or medications of any type for treatment of any injury or condition that occurred or arose out of the member's operation or occupancy of, collision or contact with, or fall or descent from, any licensed motorized or powered vehicle or conveyance used for purposes of ground or air transportation or sport, whether powered by a gasoline or other fuel-burning engine or by battery or electric motor or combination or hybrid thereof, or by any means other than purely human effort, regardless of whether such vehicle or conveyance is or is not covered by or subject to Colorado law.
5. Medical services, supplies or medications which, as determined by CarePoint, are experimental, investigational, or not medically necessary, or which are received after the member ceases treatment against medical advice.
6. Medical services, supplies or medications received from or paid for by any tribal, federal, state or local government plan or program, including but not limited to, Medicaid, Medicare, Breast and Cervical Cancer Program, Veteran's Benefits, CHAMPUS, Railroad Retirement, CHP+ and tribal medical programs.
7. Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem, or medical services, supplies or medications for treatment of any complication resulting from such surgery or surgical procedure. This exclusion does not apply to reconstructive surgery to correct the results of an injury, surgery to treat congenital defects (such as a cleft lip and cleft palate) necessary to restore normal bodily function.
8. Medications deemed by CarePoint to be lifestyle medications, including but not limited to those intended to treat hair loss or erectile dysfunction, or any medical services, supplies or medications for treatment of sexual dysfunction or for sexual enhancement.
9. Transsexual surgery, sex change or transformation. CarePoint does not cover any medical services, supplies or medications designed to alter, or related to alteration of, a member's physical characteristics from his/her biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.
10. Medical services, diagnosis, supplies or medications for infertility, fertility testing, reversal of voluntary or involuntary sterilization, artificial insemination, in-vitro fertilization and/or any other reproductive technology, or any related charges for procurement, storage or implantation.

11. Medical services, supplies or medications for any injury or condition resulting from:
    a.) military service or acts of war, declared or undeclared;
    b.) failure to use standard safety equipment;
    c.) chronic abuse of alcohol or any controlled substance.
12. Medical services, supplies or medications for any self-inflicted injury or any injury sustained while:
    a.) practicing for, or competing in, any professional or semi-professional athletic contest, or for any condition resulting from such participation or practice;
    b.) participating in any high-risk behavior including, but not limited to, skydiving, scuba diving, bungee jumping, rappelling, or white-water rafting;
    c.) engaged in the commission of a crime;
    d.) intoxicated or under the influence of any illegal or "street" drug, or any controlled substance unless administered on the advice of a physician.
13. Medical services or testing to determine the existence or extent of disability; any medical services or reports required as the result of, or in connection with, litigation or any legal proceeding; and any special medical report not directly related to the medical treatment of a member.
14. Adult vaccines for travel.
15. Testing, physical exams, immunizations or other medical services, supplies or medications required by a third party, including (but not limited to) physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state or federal government, securing insurance coverage, travel or school admission or attendance, including examinations required to participate in athletics, unless the service is preauthorized by CarePoint as part of an appropriate schedule of Preventive services.
16. Dental, Hearing, Vision and Chiropractic Services:
    a.) Dental, oral surgery, dental anesthesia services, or orthodontic services of any kind;
    b.) Corrective lenses, frames, contact lenses, laser or radial keratotomy or any other procedure designed to surgically correct refractive errors and any exams related to such items or services;
    c.) Routine hearing or vision exams;
    d.) Hearing aids;
    e.) Chiropractic services of any kind.
17. Chronic or Long-Term Care
    a.) Skilled nursing, physical, occupational or home health care, if not homebound, except for acute conditions when preauthorized;
    b.) Private-duty nursing or CNA services;

c.) Nursing home care, residential treatment center care, hospital extended care facility care, long-term rehabilitation facility and any medical services, supplies or medications received in a long-term care facility.

18. Orthopedic shoes, orthotics or footwear inserts of any kind.
19. Personal comfort and convenience items and Custodial Care.
20. Implants of any type, unless in connection with a surgical procedure authorized in advance by CarePoint and only if the member does not qualify for any assistance program offered by the manufacturer or distributor of the implant.
21. Behavioral Health
    a.) Inpatient or outpatient mental health services which the member qualifies to receive from Community Mental Health or from any other community-based service;
    b.) Any inpatient or outpatient substance abuse services.
22. Medical services, supplies or medications in excess of any of the CarePoint annual, and lifetime benefit maximums.
    a.) CarePoint will pay a maximum of $75,000 of benefits per member over each member's lifetime. This lifetime maximum includes any and all payments for any and all services, supplies and medications covered by CarePoint.
    b.) Pharmacy benefits in excess of the annual per-member benefit limit specified in the Benefit Schedule are not a covered benefit.
23. Inpatient private rooms or private-room differential, or any personal comfort or convenience item, including services and supplies that are not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, take-home supplies and other similar items.
24. PET scans of any kind.
25. Insulin pumps
26. Medical services, supplies or medications (a) to which a CarePoint Protocol applies but has not been satisfied or completed; or (b) for which preauthorization is required but is not obtained.
27. Medical services, supplies or medications for the treatment of sickness or injury (including without limitation Carpal Tunnel Syndrome) which is both:
    (a) sustained by the member while at the member's place of work, regardless of whether the member was on-duty or off-duty at the time, or exacerbated by the member's work or is more than 50% exacerbated by the member's work; and
    (b) covered by the Colorado Workers' Disability Compensation Act ("Workers' Compensation") or by United States Longshoreman's and Harbor Worker's Compensation Act.

    This coverage exclusion applies regardless of whether the member's employer does or does not have Workers' Compensation insurance in place. If, in the judgment of CarePoint, the sickness or injury is one to which this coverage exclusion applies, the member must apply for Workers' Compensation benefits and diligently pursue them,

including but not limited to supplying additional information requested by CarePoint and, if requested by CarePoint, appealing or requesting reconsideration of any denial of Workers' Compensation benefits.

Upon a final legal determination that the injury or condition is not one for which the member is eligible to receive Workers' Compensation benefits, this exclusion will not apply and the member will be eligible for any otherwise available CarePoint benefits.

28. Any air ambulance services.
29. Provision or payment of services when not rendered in accord with CarePoint policies or procedures, or by Non-participating Providers.
30. Any care deemed not Medically Necessary by the Medical Director, or not in accordance with accepted medical standards, and any hospital or medical care services not specifically provided for in this Handbook.

Other Coverage, Subrogation & Assigned Benefits

CarePoint coverage is always deemed to be secondary to any other health care coverage or benefits for which the member qualifies or is eligible, and the financial liability of CarePoint for a member's health care is always secondary to the liability of any insurer or other third party.

Accordingly, if any or all of the member's medical services, supplies or medications are a covered benefit under any automobile or motor vehicle insurance, homeowner's or commercial liability insurance, or other insurance policy or contract, the member must apply for and diligently pursue such benefits.

Any medical services, supplies or medications for a member which are paid for or reimbursed by any insurer, or for which a third party pays (whether as the result of a settlement or judgment or otherwise), are not CarePoint Covered Services for that member.

If CarePoint pays for any medical services, supplies or medications and you receive payment or reimbursement from or on behalf of any insurer for those same medical services, supplies or medications, you must immediately notify CarePoint of that payment or reimbursement and must also repay to CarePoint 100% of the amount that CarePoint paid for those same medical services, supplies or medications.

By applying for CarePoint coverage, you automatically and irrevocably assign to CarePoint all rights in and to all such payments and reimbursements paid to you by or on behalf of any insurer and further agree to execute all documents, and to take all actions, as are reasonably requested by CarePoint to enable it to recover those payments and reimbursements. (As used in this paragraph and the following two paragraphs, "you" includes you and any covered dependent.)

If you file or pursue any claim (whether by arbitration, lawsuit or otherwise) against a third party for injuries for which you receive medical services, supplies or medications paid for by CarePoint, and you subsequently receive a payment from or on behalf of that third party, whether as the result of an arbitration award, a settlement, a judgment or otherwise, and regardless of whether the payment is or is not designated as, or claimed to be, payment for injuries or for medical services, supplies or medications, you must immediately notify CarePoint of that payment and must also repay to CarePoint 100% of the amount that CarePoint paid for medical services, supplies and medications related to the injuries that were alleged in the claim against the third party to be the responsibility of that third party.

By applying for CarePoint coverage, you automatically and irrevocably assign to CarePoint all rights in and ownership of all such payments that you receive from third parties and further agree to execute all documents, and to take all actions, as are reasonably requested by CarePoint to enable it to recover those payments.

In addition, if you suffer an injury or sickness as a result of a negligent or wrongful act or omission of any third party, CarePoint reserves the right to seek payment or reimbursement (where permitted by law) from that third party for sums that it paid for medical services, supplies or medications for you. By applying for CarePoint coverage, you automatically and irrevocably assign to CarePoint your rights to recover all such payment or reimbursement and further agree to execute all documents, and to take all actions, as are reasonably requested by CarePoint to enable it to obtain such payment or reimbursement and to otherwise enforce its rights under this provision.

Grievance Procedure

We hope that you are satisfied with the services you receive from CarePoint. We know, however, that from time to time you may have an issue or concern that you want us to address. If you have an issue that our staff cannot resolve informally, then you may initiate formal grievance proceedings.

The following procedure must be followed if a member or medical provider disagrees with a decision by CarePoint to deny coverage for a medical service, medical supply or medication. This procedure may be used when a claim for benefits is denied or another dispute arises. The Grievance Procedure is as follows:

- The person filing the Grievance should contact Member Services to obtain a Grievance Form.
- The Grievance Form must be returned to CarePoint within 10 business days of receiving notice of the denial or issue.
- CarePoint will notify the person filing the Grievance when it is received.
- CarePoint will review the Grievance and will notify the person filing the Grievance as to what additional information, if any, is needed to complete CarePoint's review of the Grievance.
- Once all necessary information is obtained from medical providers, the member and other pertinent sources, the Grievance will be reviewed and a determination will be made. The person filing the Grievance will be notified when all necessary information has been received by CarePoint. CarePoint will make a final decision and notify the member within 10 business days.
- The Executive Director, the Medical Director and other appropriate professional resources may participate in the decision on the Grievance.
- If the person filing the Grievance disagrees with CarePoint's ruling on the Grievance, he/she may file another Grievance following the same steps for filing the initial Grievance.
- The second Grievance will be reviewed. Once any additional information needed by CarePoint is obtained, the person filing the second Grievance will be notified, and will subsequently receive a decision on the second Grievance within 10 business days. All second Grievances will be reviewed and approved by the CarePoint Peer Review Committee.
- The Peer Review Committee's decision shall be final and binding on all parties. The Clinical Committee, in its sole discretion, may refer the matter at issue to an outside consultant for an opinion to assist the Committee in making its decision.

Termination of Coverage

Termination due to loss of Eligibility
The Employer must notify CarePoint of the termination of coverage for any employee when the employee fails to meet any of the Employee Eligibility criteria. CarePoint must receive notice of the termination prior to the 25th day of the final month of coverage. If the termination notice is received after the 25th day of that month, the termination will become effective on the last day of the following month, and the member and employer will be obligated to pay the monthly charge for that following month. There are no refunds or proration of charges.

Termination by CarePoint
CarePoint may prospectively or retroactively terminate the CarePoint coverage of an entire employer group and/or an individual member for, among other things, any of the following:

- The Employer or member fails to meets applicable eligibility criteria;
- Non-payment or untimely payment of monthly coverage charges;
- Abusive language or actions toward the CarePoint staff or Participating Providers;
- The employer or member knowingly or unknowingly provides any false or misleading information to CarePoint at any time;
- Failure or refusal by the employer or member to provide information reasonably requested by CarePoint, including but not limited to information necessary to determine program eligibility, process claims, resolve Grievances or coordinate a member's medical care;
- Failure to maintain in place all legally required Workers' Compensation insurance coverage;
- Breach of the CarePoint Employer Contract, any CarePoint policy or procedure, or any obligation under this Handbook or another CarePoint document;
- Failure to cooperate or comply with obligations and policies regarding assignment or coordination of benefits and/or subrogation, including failure or refusal to pay or reimbursement to CarePoint any sum required in connection with those activities;
- Termination of the entire CarePoint program.

Definitions

The following definitions may help you better understand terms used in this Handbook. These definitions are summarized and may be superseded by other provisions of this Handbook.

Covered Benefits or Services—Medical services, supplies or medications that are medically necessary, are not provided primarily for the convenience of the member, are described as being an CarePoint benefit, and are not included on any list of coverage Exclusions.

Copay—The member's portion of the cost for the service. You are required to pay this amount when you receive the service.

Designated Employee Group—A group of employees that have common characteristics of work hours (full time, part time, etc.) or employment status (hourly, exempt, non-exempt, job grade, not considered part of management, etc.).

Eligible Employee- An employee that meets the CarePoint eligibility guidelines.

Eligible Member or Eligible Dependent—An employee or dependent that is eligible for benefits under the CarePoint Program as outlined in the Eligibility section.

Exclusions & Non-covered Services—Services that are not a Covered Benefit or Service.

Experimental Service or Treatment—A service, procedure, treatment, device or supply that has not been found to be scientifically safe and/or effective for treatment of a medical condition.

Emergency Medical Condition—A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (a) serious jeopardy to the health of the individual or, in the case of a pregnant woman, to the health of the woman or her unborn child; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

Member ID Card—A card that you will receive after you become a member of CarePoint and which you should present each time you receive services.

Preauthorization—Issued by CarePoint to permit certain services. Medical services that require Preauthorization prior to receiving the service will not be covered unless the Preauthorization is issued.

Primary Care Provider (PCP)—The medical professional who serves as the member's point of contact and, partnering with CarePoint, coordinates all of the member's medical care.

Protocols—Requirements that must be met prior to certain services being authorized or being Covered Services.

Provider—A person or entity that provides medical services or care. Providers include doctors, nurses, nurse practitioners, labs, X-ray facilities, hospitals, and pharmacists.

Participating Provider—Someone who has an agreement with CarePoint to provide services to our members. A list of Participating Providers is available by contacting CarePoint or going to the CarePoint website at www.CarePointHealthAccess.org.

Referral—A request made by your PCP for you to receive a specified medical service that is not performed by the PCP.

How to Reach Us

CarePoint:

Location/Mailing Address: 700 Main St., Ste 100, Alamosa, CO 81101

Phone: 719-589-3696
Fax: 719-589-4901

Hours: 8 a.m. to 5 p.m. Monday–Friday and closed holidays

Web site: www.CarePointHealthAccess.org
Check the Web site often for current plan information, updates and forms.

Colorado Choice Health Plans (Colorado Choice):

Colorado Choice Health Plans provides administrative services for CarePoint.

Colorado Choice Phone: 719-589-3696
Colorado Choice Fax: 719-589-4901

Colorado Choice Website: www.coloradochoicehp.com

ATTACHMENT

SCHEDULE OF BENEFITS

Health Access Plan

Benefit Designs

Item Description	*Plan A*	*Plan B*
Pricing	$150	$135
Pricing per Share	$50	$45
Care outside the San Luis Valley	None	None
Annual Deductible	None	None
Annual Benefit Maximum (does not apply to all services)	$30,000	$25,000
Benefits below ARE NOT subject to the Annual Benefit Maximum		
Preventive Care	No Copay	No Copay
Primary Care Physician Office Visit	$10 per visit copay	$15 per visit copay
Specialtist Physician Office Visit	$25 per visit copay	$25 per visit copay
Routine Laboratory & X-Ray	No Copay	$10 copay
Mental Health Outpatient Visits (Benefit limit of 4 visits)	$15 copay	$20 copay
Diabetic Supplies	$20 for 30 day supply	$20 for 30 day supply
Durable Medical Equipment & Oxygen (Benefit limit of $500)	30% copay	30% copay
Prescriptions (Generic only, Closed Formulary, $2000 Max Benefit)	$15	$15
Benefits below ARE subject to the Annual Benefit Maximum		
Inpatient Hospital	$50 per day up to $300 per admission	$75 per day up to $525 per admission
Outpatient Surgeries and Procedures	$75 per procedure copay	$125 per procedure copay
Imaging (CT/MRI/PET, Ultrasounds, etc)	$75 per service	$100 per service
Non-Routine Lab and X-ray	$25 copay	$25 copay
Emergency Care	$75 per visit copay	$75 per visit copay
Ambulance (Ground only)	30% copay	30% copay
Physical/Occupational & Speech Therapy (limited to 10 visits each)	$25 per visit copay	$25 per visit copay
Home Health Care	$15 per visit copay	$15 per visit copay
Exclusions (Partial list only): Dialysis, transplants, inpatient mental health and substance abuse, care outside of the San Luis Valley		

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