

Colorado Health Benefit Plan Description Form

Rocky Mountain Health Care Options

SOLO VIEW HSA (HSA-Eligible)

PPO Individual \$2,500/\$3,250/\$5,000

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Preferred Provider Plan
2. OUT-OF-NETWORK CARE COVERED?¹	Yes, but patient pays more for out-of-network care.
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado.

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

	IN-NETWORK	OUT-OF-NETWORK
4. Deductible Type²	Calendar Year	
4a. ANNUAL DEDUCTIBLE^{2a}	<u>SOLO View HSA \$2,500/100</u>	<u>SOLO View HSA \$2,500/100</u>
a) Individual^{2b} – amount is per individual – separate deductible	a) \$2,500	a) \$5,000
b) Family^{2c} – amount is per family – aggregate deductible	b) \$5,000	b) \$10,000
	<u>SOLO View HSA \$3,250/100</u>	<u>SOLO View HSA \$3,250/100</u>
	a) \$3,250	a) \$7,500
	b) \$6,500	b) \$15,000
	<u>SOLO View HSA \$5,000/100</u>	<u>SOLO View HSA \$5,000/100</u>
<i>If family membership is selected, individual deductibles will apply for each family member until either that individual's deductible is met or until the family aggregate deductible is met.</i>	a) \$5,000	a) \$10,000
	b) \$10,000	b) \$20,000
	- Deductibles shall be applied to satisfy the out-of-pocket maximum.	- Deductibles shall be applied to satisfy the out-of-pocket maximum.
	- Deductible must be satisfied before services will be covered, except as noted.	- Deductible must be satisfied before services will be covered, except as noted.
5. OUT-OF-POCKET ANNUAL MAXIMUM³	<u>SOLO View HSA \$2,500/100</u>	<u>SOLO View HSA \$2,500/100</u>
a) Individual	a) \$2,500 - per individual	a) \$7,500 - per individual
b) Family	b) \$5,000 – per family of 2 or more	b) \$15,000 – per family of 2 or more
c) Is deductible included in the out-of-pocket maximum?	c) Deductible is included in the out-of-pocket maximum.	c) Deductible is included in the out-of-pocket maximum.
	<u>SOLO View HSA \$3,250/100</u>	<u>SOLO View HSA \$3,250/100</u>
	a) \$3,250 - per individual	a) \$10,000 - per individual
	b) \$6,500 – per family of 2 or more	b) \$20,000 – per family of 2 or more
	c) Deductible is included in the out-of-pocket maximum.	c) Deductible is included in the out-of-pocket maximum.
	<u>SOLO View HSA \$5,000/100</u>	<u>SOLO View HSA \$5,000/100</u>
<i>All copayments apply toward the out-of-pocket maximum. Out-of-pocket maximum is calculated separately for in-network and out-of-network benefits.</i>	a) \$5,000 - per individual	a) \$17,500 - per individual
	b) \$10,000 – per family of 2 or more	b) 35,000 – per family of 2 or more
	c) Deductible is included in the out-of-pocket maximum.	c) Deductible is included in the out-of-pocket maximum.

6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	\$2 million per member per lifetime for all health care services combined. Transplants have a lifetime maximum of \$1 million per member per transplant. (in-network and out-of-network benefits combined)	
7A. COVERED PROVIDERS	<u>In Colorado:</u> Rocky Mountain HCO Network <u>Outside Colorado:</u> MultiPlan/PHCS Network <u>Behavioral Health:</u> Life Strategies See participating provider directory for a complete list of current providers.	All providers licensed or certified to provide covered benefits
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes – some network providers are available outside of Colorado.	Not applicable
8. MEDICAL OFFICE VISITS⁴ a) Primary Care Providers b) Specialists	a) No copayment (100% covered) after deductible b) No copayment (100% covered) after deductible	a) 50% coinsurance after deductible b) 50% coinsurance after deductible
9. PREVENTIVE CARE a) Children’s services (well-child services as age appropriate) b) Adults’ services (routine physical and gynecological exam – 1 per member per calendar year) c) Routine screening mammograms, pap smears, prostate screenings d) Immunizations (excluding Travel) e) Preventive blood screenings: <i>Lipid panel, Type 2 diabetes, and LDL cholesterol – 1 per member per calendar year.</i>	a) \$35 per visit copayment, not subject to deductible. b) No copayment (100% covered), not subject to deductible. Maximum Benefit Level: \$200 paid by health plan per member per calendar year. c) No copayment (100% covered), not subject to deductible – limited to 1 screening each per member per calendar year. d) No copayment (100% covered), not subject to deductible. e) \$10 per visit copayment, not subject to deductible.	a) Not covered b) Not covered c) Not covered d) Not covered e) Not covered
10. MATERNITY Maternity coverage is limited to treatment for complications of pregnancy only. a) Prenatal care – complications only b) Delivery & inpatient well baby care ⁵ – complications only	a) Not covered, except for complications, which will have no copayment (100% covered) after deductible. b) Not covered, except for complications, which will have no copayment (100% covered) after deductible. <u>Inpatient well-baby care:</u> No copayment (100% covered) after deductible	a) Not covered, except for complications, which will have 50% coinsurance after deductible. b) Not covered, except for complications, which will have 50% coinsurance after deductible. <u>Inpatient well-baby care:</u> 50% coinsurance after deductible

<p>11. PRESCRIPTION DRUGS⁶ Level of coverage and restrictions on prescriptions</p> <p>a) Inpatient prescription drugs and injectables</p> <p>b) Outpatient prescription drugs and Insulin (not including injectables)</p> <p>c) Self-administered injectable medication (except Insulin)</p> <p>a) Prescription drugs are covered only through participating retail and mail order pharmacies.</p> <p>b) Access to participating pharmacies is available nationwide. To locate participating pharmacies or for more information about drugs on our approved list (RMHP Good Health Formulary), refer to our website at www.rmhp.org or contact Rocky Mountain Health Plans, Customer Service at 800-346-4643.</p>	<p>a) No copayment (100% covered) after deductible</p> <p>b) <u>Generic (Tier 1):</u> No copayment (100% covered) after deductible</p> <p>Other prescription drug coverage may be obtained as an optional benefit – See Benefit Schedule Attached</p> <p>c) Not covered</p>	<p>a) 50% coinsurance after deductible</p> <p>b) Not covered</p> <p>c) Not covered</p>
<p>12. INPATIENT HOSPITAL</p>	<p>No copayment (100% covered) after deductible</p>	<p>50% coinsurance after deductible</p>
<p>13. OUTPATIENT/AMBULATORY SURGERY</p>	<p>No copayment (100% covered) after deductible</p>	<p>50% coinsurance after deductible</p>
<p>14. DIAGNOSTICS</p> <p>a) Laboratory & x-ray</p> <p>b) MRI, nuclear medicine, and other high-tech services</p>	<p>a) No copayment (100% covered) after deductible</p> <p>b) No copayment (100% covered) after deductible</p>	<p>a) 50% coinsurance after deductible</p> <p>b) 50% coinsurance after deductible</p>
<p>15. EMERGENCY CARE^{7, 8}</p>	<p>No copayment (100% covered) after deductible</p>	<p>No copayment (100% covered) after in-network deductible</p>
<p>16. AMBULANCE Ground and Air</p>	<p>No copayment (100% covered) after deductible</p>	<p>No copayment (100% covered) after in-network deductible</p>
<p>17. URGENT, NON-ROUTINE, AFTER HOURS CARE</p>	<p>No copayment (100% covered) after deductible</p>	<p>50% coinsurance after deductible</p>
<p>18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE⁹</p> <p>a) Inpatient care</p> <p>b) Outpatient care</p>	<p>a) Not covered</p> <p>b) See Other Mental Health Care</p>	
<p>19. OTHER MENTAL HEALTH CARE</p> <p>a) Inpatient care</p> <p>b) Outpatient care</p> <p>Maximum Benefit Levels for in-network and out-of-network services are combined.</p>	<p>a) Not covered</p> <p>b) No copayment (100% covered) after deductible. Maximum Benefit Level: \$1,000 paid by health benefit plan per member per calendar year</p>	<p>a) Not covered</p> <p>b) 50% coinsurance after deductible. Maximum Benefit Level: \$1,000 paid by health benefit plan per member per calendar year.</p>
<p>20. ALCOHOL & SUBSTANCE ABUSE</p> <p>a) Rehabilitation</p> <p>b) Detoxification</p>	<p>a) Not covered</p> <p>b) Not covered</p>	
<p>21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY</p> <p>a) Inpatient care</p> <p>b) Outpatient care</p> <p>Maximum Benefit Levels for in-network and out-of-network are combined.</p>	<p>a) No copayment (100% covered) Maximum Benefit Level: 60 days per episode per medical condition</p> <p>b) No copayment (100% covered) after deductible. Maximum Benefit Level: \$2,000 per member per calendar year - combined limit for rehabilitative therapies (PT, OT, & ST).</p>	<p>a) 50% coinsurance after deductible. Maximum Benefit Level: 60 days per episode per medical condition</p> <p>b) 50% coinsurance after deductible. Maximum Benefit Level: \$2,000 per member per calendar year - combined limit for rehabilitative therapies (PT, OT, & ST)</p>

<p>22. DURABLE MEDICAL EQUIPMENT</p> <p>a) Durable Medical Equipment (DME) and repairs b) Disposable Medical Supplies (DMS) c) Orthotics and Prosthetics</p> <p>Maximum Benefit Level: \$1,000 per member per calendar year paid by health benefit plan for DME, Repairs, DMS, Oxygen, and Orthotics/Prosthetics combined. Diabetic and injectable supplies are not subject to the annual limit.</p>	<p>a) No copayment (100% covered) after deductible b) No copayment (100% covered) after deductible c) No copayment (100% covered) after deductible. Orthotics covered only for diabetes. Arm, leg, and breast prosthetics and mastectomy bras are not subject to the annual limit.</p> <p>Certain items obtained from a pharmacy (as designated on the Rocky Mountain Formulary) are not subject to the Maximum Benefit Level.</p>	<p>a) 50% coinsurance after deductible when obtained in a physician's office or outpatient facility. Services are not covered when obtained from a pharmacy. b) 50% coinsurance after deductible when obtained in a physician's office or outpatient facility. Services are not covered when obtained from a pharmacy. c) 50% coinsurance after deductible. Orthotics covered only for diabetes. Arm, leg, and breast prosthetics and mastectomy bras are not subject to the annual limit.</p>
<p>23. OXYGEN</p> <p>Maximum Benefit Level: \$1,000 per member per calendar year paid by health benefit plan for DME, Repairs, DMS, Oxygen and Orthotics/Prosthetics combined.</p>	<p>No copayment (100% covered) after deductible.</p>	<p>50% coinsurance after deductible</p>
<p>24. ORGAN TRANSPLANTS</p> <p>a) Inpatient care b) Outpatient care</p> <p>Maximum Benefit Levels for in-network and out-of-network are combined.</p>	<p>a) No copayment (100% covered) after deductible b) No copayment (100% covered) after deductible</p> <p>Maximum Benefit Level: \$1 million per covered transplant per lifetime.</p>	<p>a) 50% coinsurance after deductible b) 50% coinsurance after deductible</p> <p>Maximum Benefit Level: \$1 million per covered transplant per lifetime.</p>
<p>25. HOME HEALTH CARE</p> <p>Maximum Benefit Levels for in-network and out-of-network are combined.</p>	<p>No copayment (100% covered) after deductible</p> <p>Maximum Benefit Level: 60 visits per member per calendar year.</p>	<p>50% coinsurance after deductible</p> <p>Maximum Benefit Level: 60 visits per member per calendar year.</p>
<p>26. HOSPICE CARE</p>	<p>No copayment (100% covered) after deductible</p> <p>Maximum Benefit Level: Respite care is limited to periods of 5 days or less.</p>	<p>50% coinsurance after deductible</p> <p>Maximum Benefit Level: Respite care is limited to periods of 5 days or less.</p>
<p>27. SKILLED NURSING FACILITY CARE</p>	<p>Not covered</p>	<p>Not covered</p>
<p>28. DENTAL CARE</p>	<p>Not covered</p>	<p>Not covered</p>
<p>29. VISION CARE</p>	<p>No copayment (100% covered) after deductible for treatment due to injury or disease of the eye.</p>	<p>50% coinsurance after deductible for treatment due to injury or disease of the eye</p>
<p>30. CHIROPRACTIC CARE</p>	<p>Not covered</p>	<p>Not covered</p>

<p>31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)</p>	<p>1) <u>Cancer Screening Coverages and Parameters:</u> Subject to the parameters set forth below, cancer screening tests for the following items are covered subject to any applicable plan deductibles, copayments/ coinsurance, and maximum benefit levels:</p> <ul style="list-style-type: none"> • Breast – Mammogram • Cervical – PAP test • Colorectal – Colonoscopy, Sigmoidoscopy, Fecal Occult Blood • Ovarian – CA125 • Prostate – PSA <p>Coverage for these cancer screening tests are subject to the following parameters:</p> <p>a) the test must be ordered by your physician, and</p> <p>b) you must comply with plan procedures</p> <p>2) <u>Accident-related medical services:</u> Additional coverage may be obtained as an optional benefit. Coverage is as follows: No copayment (100% covered), not subject to deductible, up to \$1,000 per member per accident, then applicable deductible and coinsurance.</p> <p>3) <u>Vision Access Plan:</u> Discounts on the fees for these eye-care services from participating doctors in the Vision Service Plan network:</p> <ul style="list-style-type: none"> • 20% discount on annual eye exam • 20% discount on full set of prescription eye glasses • 15% discount on contact lenses • 15% discount on laser vision correction <p>4) <u>Preventive lab blood work:</u> See Preventive Care (Box #9)</p>	<p>1) <u>Cancer Screening Coverages and Parameters:</u> Subject to the parameters set forth below, cancer screening tests for the following items are covered subject to any applicable plan deductibles, copayments/ coinsurance, and maximum benefit levels:</p> <ul style="list-style-type: none"> • Breast – Mammogram • Cervical – PAP test • Colorectal – Colonoscopy, Sigmoidoscopy, Fecal Occult Blood • Ovarian – CA125 • Prostate – PSA <p>Coverage for these cancer screening tests are subject to the following parameters:</p> <p>a) the test must be ordered by your physician, and</p> <p>b) you must comply with plan procedures</p> <p>2) <u>Accident-related medical services:</u> Additional coverage may be obtained as an optional benefit. Coverage is as follows: No copayment (100% covered), not subject to deductible, up to \$1,000 per member per accident, then applicable deductible and coinsurance.</p> <p>3) Not covered</p> <p>4) Not covered</p>
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PART C: LIMITATIONS AND EXCLUSIONS

<p>32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.¹⁰</p>	<p>12 months for all pre-existing conditions, unless the covered person is a HIPAA-eligible individual as defined under federal and state law, in which case there are no pre-existing condition exclusions.</p>
<p>33. EXCLUSIONARY RIDERS. Can an individual’s specific, pre-existing condition be entirely excluded from the policy?</p>	<p>No.</p>
<p>34. HOW DOES THE POLICY DEFINE A “PRE-EXISTING CONDITION”?</p>	<p>A pre-existing condition is an injury, sickness or pregnancy for which a person incurred charges, received medical treatment, consulted a health care professional or took prescription drugs within 12 months, immediately preceding the effective date of coverage.</p>

35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review the list to see if a service or treatment you may need is excluded from the policy.
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PART D: USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	No
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes	Yes
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes
39. What is the main customer service number?	800-346-4643	
40. Who do I write/call if I have a complaint or want to file a grievance?¹¹	Rocky Mountain Health Plans Member Concerns Coordinator P.O. Box 60007 Grand Junction, CO 81506-8758	
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance, ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202	
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy Form <u>SOLO View HSA 2500/3250/5000</u> – Individual	
43. Does the plan have a binding arbitration clause?	Yes, to the extent permitted by law.	

¹ “Network” refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don’t (i.e., go out-of-network).

² “Deductible Type” indicates whether the deductible period is “Calendar Year” (January 1 through December 31) or “Benefit Year” (i.e., based on a benefit year beginning on the policy’s anniversary date) or if the deductible is based on other requirements such as a “Per Accident or Injury” or “Per Confinement”.

^{2a} “Deductible” means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year or benefit year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible should be noted in boxes 8 through 31.

^{2b} “Individual” means the deductible amount you and each individual covered will have to pay for allowable covered expenses before the carrier will cover those expenses.

^{2c} “Family” is the maximum deductible amount that is required to be met for all family members covered and it may be an aggregated amount (e.g., “\$3,000 per family”) or specified as the number of individual deductibles that must be met (e.g., “3 deductibles per family”)

³ “Out-of-pocket maximum” means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductibles or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy. Expenses that are applied toward the out-of-pocket maximum should be noted in boxes 8 through 31.

⁴ Medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically based mental illness.

⁵ Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together; there are not separate copayments.

⁶ Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

⁷ “Emergency care” means all services delivered in an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.

⁸ Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours care, then urgent care copayments apply.

⁹ “Biologically based mental illnesses” means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

¹⁰ Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

¹¹ Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

Selected Benefit Descriptions
Colorado Health Benefit Plan Description Form Addendum
Rocky Mountain HealthCare Options

Brand Name Prescription Drug Option for SOLO View HSA 2500/100, 3250/100, & 5000/100 Plans
 Coinsurance options reflect the amount the covered person will pay.

	<p align="center">IN-NETWORK ONLY (out of network care is not covered except as noted)</p>
<p>11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions</p> <p>a) Outpatient prescription drugs and Insulin (not including injectables)</p> <p>b) Self-administered Injectable medication</p>	<p>a)</p> <p><u>BRAND NAME DRUG COVERAGE:</u></p> <p><u>Retail pharmacy (31-day supply):</u></p> <ul style="list-style-type: none"> • No copayment (100% covered) after medical plan deductible <p><u>Mail order pharmacy (90-day supply):</u></p> <ul style="list-style-type: none"> • No copayment (100% covered) after medical plan deductible <p>b) Not covered</p>
	<ul style="list-style-type: none"> - Prescription drugs are covered only through participating retail and mail order pharmacies. - Access to participating pharmacies is available nationwide. To locate participating pharmacies or for more information about drugs on our approved list (RMHP Good health Formulary), refer to our website at www.rmhp.org or contact Rocky Mountain Health Plans, Customer Service at 800-346-4643.