ROCKY MOUNTAIN HEALTH PLANS®
Good health. That's the plan.

Colorado Health Benefit Plan Description Form

Rocky Mountain Health Care Options

SOLO SELECT
PPO Individual $500/$1,000/$1,500/$2,500 Plan Options

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 Type[2]	Calendar Year	Calendar Year
4a. ANNUAL DEDUCTIBLE[2a] **1) SOLO Select $500** **a) Individual[2b]** **b) Family[2c]** **2) SOLO Select $1,000** **a) Individual** **b) Family** **3) SOLO Select $1,500** **a) Individual** **b) Family** **4) SOLO Select $2,500** **a) Individual** **b) Family**	1) SOLO Select $500: a) $500 b) $500 per individual 2) SOLO Select $1,000: a) $1,000 b) $1,000 per individual 3) SOLO Select $1,500: a) $1,500 b) $1,500 per individual 4) SOLO Select $2,500: a) $2,500 b) $2,500 per individual Deductibles shall not be applied to satisfy the out-of-pocket maximum. Deductible must be satisfied before services will be covered, except as noted.	1) SOLO Select $500: a) $1,000 b) $1,000 per individual 2) SOLO Select $1,000: a) $2,000 b) $2,000 per individual 3) SOLO Select $1,500: a) $3,000 b) $3,000 per individual 4) SOLO Select $2,500: a) $4,000 b) $4,000 per individual Deductibles shall not be applied to satisfy the out-of-pocket maximum. Deductible must be satisfied before services will be covered, except as noted.

5. OUT-OF-POCKET ANNUAL MAXIMUM[3] **<u>SOLO Select</u>** **<u>$500, $1,000, $1,500 $2,500:</u>** **a) Individual** **b) Family** **c) Is deductible included in the out-of-pocket maximum?**	a) and b) $3,000 per individual c) Deductible is excluded from the out-of-pocket maximum. Deductible shall not be applied to satisfy the out-of-pocket maximum. All copayments apply toward the out-of-pocket maximum, unless otherwise noted. Out-of-pocket maximum is calculated separately for in-network and out-of-network benefits. Services for which the copayments do not apply toward the annual out-of-pocket maximum will remain payable after the out-of-pocket maximum has been reached.	a) and b) $6,000 per individual c) Deductible is excluded from the out-of-pocket maximum. Deductible shall not be applied to satisfy the out-of-pocket maximum. All copayments apply toward the out-of-pocket maximum, unless otherwise noted. Out-of-pocket maximum is calculated separately for in-network and out-of-network benefits. Services for which the copayments do not apply toward the annual out-of-pocket maximum will remain payable after the out-of-pocket maximum has been reached.
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	$2 million per member per lifetime for all health care services combined. Mental Health services have $10,000 per member lifetime maximum. Transplants have a lifetime maximum of $1 million per member per transplant. (in-network and out-of-network benefits combined)	$2 million per member per lifetime for all health care services combined. Mental Health services have $10,000 per member lifetime maximum. 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> PHCS Healthy Directions 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 VISITS[4] **a) Primary Care Providers** **b) Specialists**	a) and b) $30 per visit copayment, not subject to deductible. Copayments do not apply toward annual out-of-pocket maximum.	a) and b) 40% 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) Colorectal cancer screenings (preventive and diagnostic)** **e) Immunizations**	a) $30 per visit copayment, not subject to deductible for office visit only. Copayment does not apply toward annual out-of-pocket maximum. Any associated services will have applicable copayment for the type of service. b) No copayment (100% covered), not subject to deductible – limited to $100 per member per calendar year. c) No copayment (100% covered), not subject to deductible – limited to 1 per type of service per member per calendar year. Office visit copayment may apply d) 20% coinsurance, not subject to deductible e) No copayment (100% covered), not subject to deductible	a) Not covered b) Not covered c) Not covered d) Not covered e) 40% coinsurance, not subject to deductible

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 20% coinsurance after deductible b) Not covered, except for complications, which will have 20% coinsurance after deductible. Inpatient well-baby care: 20% coinsurance after deductible	a) Not covered, except for complications, which will have 40% coinsurance after deductible b) Not covered, except for complications, which will have 40% coinsurance after deductible. Inpatient well-baby care: 40% coinsurance after deductible
10A. OPTIONAL ADDITIONAL MATERNITY COVERAGE **Additional maternity coverage may be obtained as an optional benefit** **a) Prenatal Care** - **SOLO Select $500** **b) Delivery & inpatient well-baby care** - **SOLO Select $500** Optional additional maternity coverage not available for SOLO Select $1,000, $1,500 or $2,500 plans	a) and b)50% coinsurance after deductible. Coinsurance does not apply toward annual out-of-pocket maximum. Inpatient well-baby care – 20% coinsurance after deductible.	a) and b) 50% coinsurance after deductible. Coinsurance does not apply toward annual out-of-pocket maximum. Inpatient well-baby care – 40% coinsurance after deductible.
11. PRESCRIPTION DRUGS[6] **Level of coverage and restrictions on prescriptions** **a) Inpatient prescription drugs and injectables** **b) Outpatient prescription drugs and Insulin (not including injectables)** **c) Self-administered injectable medication (except insulin)**	a) 20% coinsurance after deductible b) Retail (31-day supply) Generic: $10 copayment per prescription Mail Order: (90-day supply) Generic: $25 copayment per prescription Additional coverage may be obtained as an optional benefit – See Benefit Schedule Attached c) Not covered For Drugs on our approved list, contact Customer Service at 800-346-4643.	a) 40% coinsurance after deductible b) Not covered c) Not covered For Drugs on our approved list, contact Customer Service at 800-346-4643.
12. INPATIENT HOSPITAL	20% coinsurance after deductible	40% coinsurance after deductible
13. OUTPATIENT/AMBULATORY SURGERY	20% coinsurance after deductible for outpatient surgery and invasive diagnostic tests	40% coinsurance after deductible for outpatient surgery and invasive diagnostic tests
14. DIAGNOSTICS **a) Laboratory & x-ray** **b) MRI, nuclear medicine, and other high-tech services**	a) 20% coinsurance after deductible b) 50% coinsurance after deductible	a) 40% coinsurance after deductible b) 50% coinsurance after deductible
15. EMERGENCY CARE[7,8]	20% coinsurance after deductible	40% coinsurance after deductible
16. AMBULANCE	20% coinsurance after deductible Maximum Benefit Level (air ambulance services): $5,000 per trip	
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	20% coinsurance after deductible	40% coinsurance after deductible
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]	See Other Mental Health Care	

19. OTHER MENTAL HEALTH CARE **a) Inpatient care** **b) Outpatient care**	a) 50% coinsurance after deductible. b) 50% coinsurance after deductible. Maximum Benefit Level: $500 per member per calendar year paid by health benefit plan. Coinsurance does not apply toward annual out-of-pocket maximum. Maximum Benefit Level: Lifetime maximum of $10,000 per member for inpatient and outpatient combined.	a) Not covered b) Not covered
20. ALCOHOL & SUBSTANCE ABUSE **a) Inpatient care** **b) Outpatient care**	a) Not covered b) Not covered	a) Not covered b) Not covered
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY **a) Inpatient care** **b) Outpatient care**	a) 20% coinsurance after deductible. Maximum Benefit Level: 60 days per episode per medical condition b) 20% coinsurance after deductible. Maximum Benefit Level: $2,000 combined limit for rehabilitative therapies (PT, OT, & ST) per member per calendar year. Maximum Benefit Level for in-network and out-of-network combined.	a) 40% coinsurance after deductible. Maximum Benefit Level: 60 days per episode per medical condition b) 40% coinsurance after deductible. Maximum Benefit Level: $2,000 combined limit for rehabilitative therapies (PT, OT, & ST). Maximum Benefit Level for in-network and out-of-network combined.
22. DURABLE MEDICAL EQUIPMENT **a) Durable Medical Equipment (DME)** **b) Disposable Medical Supplies (DMS) – obtained from a pharmacy** **c) Orthotics/Prosthetics** **<u>Maximum Benefit Level:</u>** **$1,500 per member per calendar year for DME, Orthotics, Prosthetics and Oxygen combined**	a) 20% coinsurance after deductible b) 20% coinsurance, not subject to deductible. Coinsurance does not apply toward annual out-of-pocket maximum. c) 20% coinsurance after deductible. Arm/leg/breast prosthetics are not subject to the annual limit. Orthotics covered only for diabetes. Maximum Benefit Level for in-network and out-of-network combined.	a) 40% coinsurance after deductible b) Not covered c) 40% coinsurance after deductible. Arm/leg/breast prosthetics are not subject to the annual limit. Orthotics covered only for diabetes. Maximum Benefit Level for in-network and out-of-network combined.
23. OXYGEN	20% coinsurance after deductible. Maximum Benefit Level: $1,500 per member per calendar year paid by plan for DME/DMS/Orthotics/ Prosthetics and Oxygen combined. Maximum Benefit Level for in-network and out-of-network combined.	40% coinsurance after deductible. Maximum Benefit Level: $1,500 per member per calendar year paid by plan for DME/DMS/Orthotics/ Prosthetics and Oxygen combined. Maximum Benefit Level for in-network and out-of-network combined.
24. ORGAN TRANSPLANTS **a) Inpatient care** **b) Outpatient care**	a) 20% coinsurance after deductible b) 20% coinsurance after deductible Maximum Benefit Level: $1 million per covered transplant per lifetime. Maximum Benefit Level for in-network and out-of-network combined.	a) 40% coinsurance after deductible b) 40% coinsurance after deductible Maximum Benefit Level: $1 million per covered transplant per lifetime. Maximum Benefit Level for in-network and out-of-network combined.
25. HOME HEALTH CARE	20% coinsurance after deductible. Maximum Benefit Level: 60 visits per member per calendar year	Not covered
26. HOSPICE CARE	20% coinsurance after deductible. Maximum Benefit Level: $100 paid by plan per day. Respite care is limited to periods of 5 days or less.	40% coinsurance after deductible. Maximum Benefit Level: $100 paid by plan per day. Respite care is limited to periods of 5 days or less.

27. SKILLED NURSING FACILITY CARE	Not covered	Not covered
28. DENTAL CARE	Not covered	Not covered
29. VISION CARE	20% coinsurance after deductible for treatment due to injury or disease of the eye	40% coinsurance after deductible for treatment due to injury or disease of the eye
30. CHIROPRACTIC CARE	Not covered	40% coinsurance, not subject to deductible. Coinsurance does not apply toward annual out-of-pocket maximum. Maximum Benefit Level: $500 paid by health benefit plan per member per calendar year
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	1) **Cancer Screening Coverages and Parameters:** 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: • Breast – Mammogram • Cervical – PAP test • Colorectal – Colonoscopy, Sigmoidoscopy, Fecal Occult Blood • Ovarian – CA125 • Prostate – PSA Coverage for these cancer screening tests are subject to the following parameters: a) the test must be ordered by your physician, and b) you must comply with plan procedures 2) **Accident-related medical services:** No copayment (100% covered), not subject to deductible, up to $500 per member per accident, then applicable deductible and copayment or coinsurance. 3) **Vision Access Plan:** Discounts on the fees for these eye-care services from participating doctors in the Vision Service Plan network: • 20% discount on annual eye exam • 20% discount on full set of prescription eye glasses • 15% discount on contact lens fitting and evaluation exam • 15% discount on laser vision correction	1) Not covered 2) **Accident-related medical services:** No copayment (100% covered), not subject to deductible, up to $500 per member per accident, then applicable deductible and copayment or coinsurance. 3) Not covered

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.[10]	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.
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No.
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	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.
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.

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 SOLO Select 500-1000-1500-2500 - 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 provider (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 by a non-HSA qualified policy 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 by a non-HSA qualified policy 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 my 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.