ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

Colorado Health Benefit Plan Description Form

Rocky Mountain Health Care Options

SOLO OUTLOOK

PPO Individual $500/$1,500/$2,500/$4,000 Plan Options

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Preferred Provider Plan
2. OUT-OF-NETWORK CARE COVERED?[1]	Yes, but patient pay 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	IN-NETWORK	OUT-OF-NETWORK
	SOLO Outlook $500/$1,500		**SOLO Outlook $2,500/$4,000**	
4. Deductible Type[2]	Calendar Year		Calendar Year	
4a. ANNUAL DEDUCTIBLE[2a] **a) Individual[2b]** **b) Family[2c]**	SOLO Outlook $500 a) $500 b) $1,000 aggregate SOLO Outlook $1,500 a) $1,500 b) $3,000 aggregate Deductibles shall not be applied to satisfy the out-of-pocket maximum. Deductible must be satisfied before services will be covered, except as noted.	SOLO Outlook $500 a) $1,000 b) $2,000 aggregate SOLO Outlook $1,500 a) $3,000 b) $6,000 aggregate Deductibles shall not be applied to satisfy the out-of-pocket maximum. Deductible must be satisfied before services will be covered, except as noted.	SOLO Outlook $2,500 a) $2,500 b) $5,000 aggregate SOLO Outlook $4,000 a) $4,000 b) $8,000 aggregate Deductibles shall not be applied to satisfy the out-of-pocket maximum. Deductible must be satisfied before services will be covered, except as noted.	SOLO Outlook $2,500 a) $5,000 b) $10,000 aggregate SOLO Outlook $4,000 a) $8,000 b) $16,000 aggregate Deductibles shall not be applied to satisfy the out-of-pocket maximum. Deductible must be satisfied before services will be covered, except as noted.

	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
	SOLO Outlook $500/$1,500		**SOLO Outlook $2,500/$4,000**	
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] **a) Individual** **b) Family** **c) Is deductible included in 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) $3,000 b) $6,000 c) No	a) $6,000 b) $12,000 c) No	a) $3,000 b) $6,000 c) No	a) $6,000 b) $12,000 c) No
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No Lifetime Maximum			
7A. COVERED PROVIDERS	In Colorado: Rocky Mountain HCO Network Outside Colorado: MultiPlan/PHCS Network Behavioral Health: Life Strategies See participating provider directory for a complete list of current providers.	All providers licensed or certified to provide covered benefits.	In Colorado: Rocky Mountain HCO Network Outside Colorado: MultiPlan/PHCS Network Behavioral Health: 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	Yes – some network providers are available outside of Colorado.	Not applicable
8. MEDICAL OFFICE VISITS[4] **a) Primary Care Providers** **b) Specialists** In-network copayments do not apply toward annual out-of-pocket maximum.	a) and b) $35 per visit copayment, not subject to deductible	a) and b) 50% coinsurance after deductible	SOLO Outlook $2,500 a) and b) $35 per visit copayment, not subject to deductible SOLO Outlook $4,000 a) and b) $45 per visit copayment, not subject to deductible	a) and b) 50% coinsurance after deductible

	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
	SOLO Outlook $500/$1,500		**SOLO Outlook $2,500/$4,000**	
9. PREVENTIVE CARE **Preventive Services recommended by the U.S. Preventive Services Task Force, including:** **a) Children's services (well-child services as age appropriate)** **b) Adults' services (routine physical and gynecological exam – *limited to 1 per member per calendar year*** **c) Routine screening mammograms, pap smears, prostate screenings – *limited to 1 screening each per member per calendar year*** **d) Colorectal cancer screenings – *limited to 1 per member per calendar year*** **e) Immunizations (excluding Travel)**	a) No copayment (100% covered), not subject to deductible. b) No copayment (100% covered), not subject to deductible. c) No copayment (100% covered), not subject to deductible d) No copayment (100% covered), not subject to deductible e) No copayment (100% covered), not subject to deductible	a) 50% coinsurance, not subject to deductible b) Not covered c) Mammograms: No copayment (100% covered), not subject to deductible, Pap smears: $75 copayment, not subject to deductible. Prostate screenings: No copayment (100% covered), not subject to deductible d) $500 copayment, not subject to deductible. Copayment does not apply toward annual out-of-pocket maximum. e) $30 copayment, not subject to deductible Copayments do not apply toward annual out-of-pocket maximum.	a) No copayment (100% covered), not subject to deductible. b) No copayment (100% covered), not subject to deductible. c) No copayment (100% covered), not subject to deductible d) No copayment (100% covered), not subject to deductible. e) No copayment (100% covered), not subject to deductible	a) 50% coinsurance, not subject to deductible b) Not covered c) Mammograms: No copayment (100% covered), not subject to deductible, Pap smears: $75 copayment, not subject to deductible. Prostate screenings: No copayment (100% covered), not subject to deductible d) $500 copayment, not subject to deductible. Copayment does not apply toward annual out-of-pocket maximum. e) $30 copayment, not subject to deductible Copayments do not apply toward annual out-of-pocket maximum.
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) Delivery - 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 50% coinsurance after deductible b) Delivery - Not covered, except for complications, which will have 50% coinsurance after deductible. Inpatient well-baby care: 50% coinsurance after deductible	a) Not covered, except for complications, which will have 30% coinsurance after deductible b) Delivery - Not covered, except for complications, which will have 30% coinsurance after deductible. Inpatient well-baby care: 30% coinsurance after deductible	a) Not covered, except for complications, which will have 50% coinsurance after deductible b) Delivery - Not covered, except for complications, which will have 50% coinsurance after deductible. Inpatient well-baby care: 50% coinsurance after deductible

	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
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10A. OPTIONAL ADDITIONAL MATERNITY COVERAGE **SOLO View 500 Plan** **a) Prenatal Care** **b) Delivery & inpatient well-baby care** Optional additional maternity coverage not available for SOLO View $1,500, $2,500, or $4,000 plans.	**SOLO Outlook 500 Plan** a) and b) 50% coinsurance after deductible. Coinsurance does not apply toward annual out-of-pocket maximum.	**SOLO Outlook 500 Plan** a) and b) 50% coinsurance after deductible. Coinsurance does not apply toward annual out-of-pocket maximum.	a) Not covered b) Not covered	a) Not covered b) Not covered
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) Outpatient and self-administered injectable medication (except Insulin)** - Prescription drugs are covered only through participating retail and mail order pharmacies. - Access to participating pharmacies is available nationwide. Refer to our website at www.rmhp.org or contact Rocky Mountain Health Plans, Customer Service at 800-346-4643 to locate participating pharmacies, or for more information about drugs on our approved lists (**RMHP Good Health Formulary** and **SOLO Injectable/Infusion Inclusion List).**	a) 20% coinsurance after deductible b) **$15 Generic** ***Retail Pharmacy: (31-day supply):*** Tier 1: $15 copayment per fill ***Mail-Order Pharmacy (90-day supply)*** Tier 1: $37.50 copayment per fill **Other prescription drug coverage may be obtained as an optional benefit – See Benefit Schedule Attached** *c)* Not covered (unless the injectable medication is listed on the SOLO Injectable/Infusion Inclusion List). *(For coverage of these drugs, See Benefit Schedule Attached).*	a) 50% coinsurance after deductible b) Not covered c) Not covered	a) 30% coinsurance after deductible b) **$15 Generic** ***Retail Pharmacy: (31-day supply):*** Tier 1: $15 copayment per fill ***Mail-Order Pharmacy (90-day supply)*** Tier 1: $37.50 copayment per fill **Other prescription drug coverage may be obtained as an optional benefit – See Benefit Schedule Attached** c) Not covered (unless the injectable medication is listed on the SOLO Injectable/Infusion Inclusion List). *(For coverage of these drugs, See Benefit Schedule Attached).*	a) 50% coinsurance after deductible b) Not covered c) Not covered
12. INPATIENT HOSPITAL	20% coinsurance after deductible	50% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible

	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
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13. OUPATIENT/ AMBULATORY SURGERY	20% coinsurance after deductible for outpatient surgery and invasive diagnostic tests	50% coinsurance after deductible for outpatient surgery and invasive diagnostic tests	30% coinsurance after deductible for outpatient surgery and invasive diagnostic tests	50% 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) 50% coinsurance after deductible b) 50% coinsurance after deductible	a) 30% coinsurance after deductible b) 50% coinsurance after deductible	a) 50% coinsurance after deductible b) 50% coinsurance after deductible
15. EMERGENCY CARE[7],[8]	20% coinsurance after deductible	20% coinsurance after in-network deductible	30% coinsurance after deductible	30% coinsurance after in-network deductible
16. AMBULANCE **Ground and Air**	20% coinsurance after deductible	20% coinsurance after in-network deductible	30% coinsurance after deductible	30% coinsurance after in-network deductible
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	20% coinsurance after deductible	50% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9] **a) Inpatient care** **b) Outpatient care**	a) and b) See Other Mental Health Care			
19. OTHER MENTAL HEALTH CARE **a) Inpatient care** **b) Outpatient care** **Maximum Benefit Levels for in-network and out-of-network services are combined.** **Maximum Benefit Levels for biologically-based and non-biologically based are combined.**	a) 30% coinsurance after deductible – coinsurance does not apply toward annual out-of-pocket maximum. b) 50% coinsurance, not subject to deductible – coinsurance does not apply toward annual out-of-pocket maximum. Maximum Benefit Level: 20 visits per member per calendar year.	a) Not covered b) 50% coinsurance after deductible. Maximum Benefit Level: 20 visits per member per calendar year.	a) 30% coinsurance after deductible – coinsurance does not apply toward annual out-of-pocket maximum. b) 50% coinsurance, not subject to deductible – coinsurance does not apply toward annual out-of-pocket maximum. Maximum Benefit Level: 20 visits per member per calendar year.	a) Not covered b) 50% coinsurance after deductible. Maximum Benefit Level: 20 visits per member per calendar year.
20. ALCOHOL & SUBSTANCE ABUSE **a) Rehabilitation** **b) Detoxification**	a) Not covered b) Not covered			

	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
	SOLO Outlook $500/$1,500		**SOLO Outlook $2,500/$4,000**	
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY **a) Inpatient care** **b) Outpatient care** **Maximum Benefit Levels for in-network and out-of-network services are combined.**	a) 20% coinsurance after deductible Maximum Benefit Level: 60 days per episode per medical condition b) 20% coinsurance after deductible. Maximum Benefit Level: 20 visits per member per calendar year for each type of therapy.	a) 50% coinsurance after deductible Maximum Benefit Level: 60 days per episode per medical condition b) 50% coinsurance after deductible. Maximum Benefit Level: 20 visits per member per calendar year for each type of therapy.	a) 30% coinsurance after deductible Maximum Benefit Level: 60 days per episode per medical condition b) 30% coinsurance after deductible. Maximum Benefit Level: 20 visits per member per calendar year for each type of therapy.	a) 50% coinsurance after deductible Maximum Benefit Level: 60 days per episode per medical condition b) 50% coinsurance after deductible. Maximum Benefit Level: 20 visits per member per calendar year for each type of therapy.
22. DURABLE MEDICAL EQUIPMENT **a) Durable Medical Equipment (DME) and repairs** **b) Durable Medical Equipment (DME) – *obtained from a pharmacy <u>and</u> listed on the Rocky Mountain Formulary*** **c) Disposable Medical Supplies (DMS) – *obtained from a pharmacy <u>and</u> listed on the Rocky Mountain Formulary*** **d) Disposable Medical Supplies (DMS) – *not obtained from a pharmacy*** **e) Orthotics/Prosthetics** **<u>Maximum Benefit Level:</u>** **$1,500 per member per calendar year for DME, Repairs, DMS, Orthotics, Prosthetics, and Oxygen received in-network and out-of-network are combined.** **Diabetic and injectable supplies are not subject to the annual limit.**	a) 20% coinsurance after deductible b) 20% coinsurance, not subject to deductible c) 20% coinsurance, not subject to deductible d) 20% coinsurance after deductible. e) 20% coinsurance after deductible Orthotics covered only for diabetes. Arm, leg, and breast prosthetics, mastectomy bras, rehabilitative and habilitative devices are not subject to the annual limit. Coinsurance for b) and c) does not apply toward annual out-of-pocket maximum. Certain DME/DMS items obtained from a pharmacy (as designated on the Rocky Mountain Formulary) are not subject to the Maximum Benefit Level.	a) 50% coinsurance after deductible b) Not covered c) Not covered d) 50% coinsurance after deductible. e) 50% coinsurance after deductible Orthotics covered only for diabetes. Arm, leg, and breast prosthetics, mastectomy bras, rehabilitative and habilitative devices are not subject to the annual limit.	a) 30% coinsurance after deductible b) 30% coinsurance, not subject to deductible c) 30% coinsurance, not subject to deductible d) 30% coinsurance after deductible. e) 30% coinsurance after deductible Orthotics covered only for diabetes. Arm, leg, and breast prosthetics, mastectomy bras, rehabilitative and habilitative devices are not subject to the annual limit. Coinsurance for b) and c) does not apply toward annual out-of-pocket maximum. Certain DME/DMS items obtained from a pharmacy (as designated on the Rocky Mountain Formulary) are not subject to the Maximum Benefit Level.	a) 50% coinsurance after deductible b) Not covered c) Not covered d) 50% coinsurance after deductible. e) 50% coinsurance after deductible Orthotics covered only for diabetes. Arm, leg, and breast prosthetics, mastectomy bras, rehabilitative and habilitative devices are not subject to the annual limit.

	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
	SOLO Outlook $500/$1,500		**SOLO Outlook $2,500/$4,000**	
23. OXYGEN **<u>Maximum Benefit level</u>: $1,500 per member per calendar year paid by health benefit plan for DME, Repairs, DMS, Oxygen, and Orthotics/Prosthetics combined.**	20% coinsurance after deductible. Maximum Benefit Level for in-network and out-of-network combined.	50% coinsurance after deductible. Maximum Benefit Level for in-network and out-of-network combined.	30% coinsurance after deductible. Maximum Benefit Level for in-network and out-of-network combined.	50% coinsurance after deductible. 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	a) 50% coinsurance after deductible b) 50% coinsurance after deductible	a) 30% coinsurance after deductible b) 30% coinsurance after deductible	a) 50% coinsurance after deductible b) 50% coinsurance after deductible
25. HOME HEALTH CARE	20% coinsurance after deductible. Maximum Benefit Level: 60 days per member per calendar year.	Not covered	30% coinsurance after deductible. Maximum Benefit Level: 60 days per member per calendar year.	Not covered
26. HOSPICE CARE	20% coinsurance after deductible. Maximum Benefit Level: $100 per day paid by plan. Respite care is limited to periods of 5 days or less. Maximum Benefit Levels for in-network and out-of-network combined.	50% coinsurance after deductible. Maximum Benefit Level: $100 per day paid by plan. Respite care is limited to periods of 5 days or less. Maximum Benefit Levels for in-network and out-of-network combined.	30% coinsurance after deductible. Maximum Benefit Level: $100 per day paid by plan. Respite care is limited to periods of 5 days or less. Maximum Benefit Levels for in-network and out-of-network combined.	50% coinsurance after deductible. Maximum Benefit Level: $100 per day paid by plan. Respite care is limited to periods of 5 days or less. Maximum Benefit Levels for in-network and out-of-network combined.
27. SKILLED NURSING FACILITY CARE	Not covered			
28. DENTAL CARE	Not covered			
29. VISION CARE	Applicable copayment/coinsurance based on type of service for treatment due to injury or disease of the eye.	50% coinsurance after deductible for treatment due to injury or disease of the eye.	Applicable copayment/coinsurance based on type of service for treatment due to injury or disease of the eye.	50% coinsurance after deductible for treatment due to injury or disease of the eye.
30. CHIROPRACTIC CARE	Not covered	50% 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.	Not covered	50% 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.

	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
	SOLO Outlook $500/$1,500		**SOLO Outlook $2,500/$4,000**	
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 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: 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. 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 • Not covered out-of-network 4) Tobacco cessation: Specialized health education services when available. Currently, a tobacco cessation program is available through the Colorado QuitLine 1-800-QUITNOW (800-784-8669). The program is available at no cost to members and includes counseling services and nicotine replacement therapy. Prescription smoking cessation drugs are provided at no cost for the first course of therapy in conjunction with counseling services provided through the program.		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 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: 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. 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 • Not covered out-of-network 4) Tobacco cessation: Specialized health education services when available. Currently, a tobacco cessation program is available through the Colorado QuitLine 1-800-QUITNOW (800-784-8669). The program is available at no cost to members and includes counseling services and nicotine replacement therapy. Prescription smoking cessation drugs are provided at no cost for the first course of therapy in conjunction with counseling services provided through the program.	

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 or a child under age 19 on a non-grandfathered plan, 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 10600 Grand Junction, CO 81502-5600**	
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 Outlook 500-1500-2500-4000 - 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.

This plan is available to both grandfathered and non-grandfathered health plans under the Patient Protection and Affordable Care Act ("the Affordable Care Act"). Grandfathered health plans are group health plans in which an individual was enrolled on March 23, 2010, and which maintain grandfathered status in accordance with Affordable Care Act regulations. Your group health plan may be a grandfathered health plan under the Patient Protection and Affordable Care Act. Your Evidence of Coverage will state if Rocky Mountain Health Plans ("RMHP") believes that your group health plan is a grandfathered health plan.

As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Evidence of Coverage may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your employer, your plan administrator identified in your Summary Plan Description, or RMHP at 800-346-4643. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1–866–444–3272 or *www.dol.gov/ebsa/healthreform.* This website has a table summarizing which protections do and do not apply to grandfathered health plans.

ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

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

Prescription Drug Options for SOLO Outlook Plans
Coinsurance and copayment options reflect the amount the covered person will pay.

	IN-NETWORK ONLY (out of network care is not covered except as noted)	
	SOLO Outlook $500/$1,500	**SOLO Outlook $2,500/$4,000**
11. PRESCRIPTION DRUGS **Level of coverage and restrictions on prescriptions** **a) Outpatient prescription drugs and Insulin (not including injectables)** **b) Outpatient and self-administered Injectable medication** - Prescription drugs are covered only through participating retail and mail order pharmacies. - Access to participating pharmacies is available nationwide. Refer to our website at www.rmhp.org or contact Rocky Mountain Health Plans, Customer Service at 800-346-4643 to locate participating pharmacies, or for more information about drugs on our approved lists (**RMHP Good Health Formulary** and **SOLO Injectable/Infusion Inclusion List).**	a) ***BRAND NAME OPTION*** Retail pharmacy (31-day supply) • Tier 1: **$15** copayment per fill • Tier 2: **$40** copayment per fill • Tier 3: **$60** copayment per fill • Tier 4: **20%** coinsurance up to maximum member copayment of $250 • Tier 5: **20%** coinsurance Mail order pharmacy (90-day supply) • Tier 1: **$37.50** copayment per fill • Tier 2: **$100** copayment per fill • Tier 3: **$150** copayment per fill • Tier 4: **20%** coinsurance up to maximum member copayment of $625 • Tier 5: **20%** coinsurance ***BRAND NAME OPTION WITH DEDUCTIBLE*** $250 Deductible (*Per Member Per Calendar Year)* Retail pharmacy (31-day supply) • Tier 1: **$15** copayment per fill, not subject to deductible • Tier 2: **$40** copayment per fill after deductible • Tier 3: **$60** copayment per fill after deductible • Tier 4: **20%** coinsurance after deductible, up to maximum member copayment of $250 • Tier 5: **20%** coinsurance after deductible Mail order pharmacy (90-day supply) • Tier 1: **$37.50** copayment per fill, not subject to deductible • Tier 2: **$100** copayment per fill after deductible • Tier 3: **$150** copayment per fill after deductible • Tier 4: **20%** coinsurance after deductible up to maximum member copayment of $625 • Tier 5: **20%** coinsurance after deductible ***DISCOUNT PLAN*** • Members may purchase outpatient prescription drugs included in the RMHP Good Health Formulary from participating retail or mail order pharmacies at 100% of the RMHP contract rate. b) Not covered (unless the injectable medication is listed on the SOLO Injectable/Infusion Inclusion List).	a) ***BRAND NAME OPTION*** Retail pharmacy (31-day supply) • Tier 1: **$15** copayment per fill • Tier 2: **$40** copayment per fill • Tier 3: **$60** copayment per fill • Tier 4: **30%** coinsurance up to maximum member copayment of $250 • Tier 5: **30%** coinsurance Mail order pharmacy (90-day supply) • Tier 1: **$37.50** copayment per fill • Tier 2: **$100** copayment per fill • Tier 3: **$150** copayment per fill • Tier 4: **30%** coinsurance up to maximum member copayment of $625 • Tier 5: **30%** coinsurance ***BRAND NAME OPTION WITH DEDUCTIBLE*** $250 Deductible (*Per Member Per Calendar Year)* Retail pharmacy (31-day supply) • Tier 1: **$15** copayment per fill, not subject to deductible • Tier 2: **$40** copayment per fill after deductible • Tier 3: **$60** copayment per fill after deductible • Tier 4: **30%** coinsurance after deductible, up to maximum member copayment of $250 • Tier 5: **30%** coinsurance after deductible Mail order pharmacy (90-day supply) • Tier 1: **$37.50** copayment per fill, not subject to deductible • Tier 2: **$100** copayment per fill after deductible • Tier 3: **$150** copayment per fill after deductible • Tier 4: **30%** coinsurance after deductible up to maximum member copayment of $625 • Tier 5: **30%** coinsurance after deductible ***DISCOUNT PLAN*** • Members may purchase outpatient prescription drugs included in the RMHP Good Health Formulary from participating retail or mail order pharmacies at 100% of the RMHP contract rate. c) Not covered