

## Colorado Health Benefit Plan Description Form

### Rocky Mountain Health Care Options

#### SOLO Smart Choice Plans (HSA-Eligible)

#### PPO Individual \$2,800-80/\$2,800-100 Plan Options

#### PART A: TYPE OF COVERAGE

<b>1. TYPE OF PLAN</b>	Preferred Provider Plan
<b>2. OUT-OF-NETWORK CARE COVERED?<sup>1</sup></b>	Yes, but patient pay more for out-of-network care.
<b>3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE</b>	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
	<b>\$2,800/80</b>		<b>\$2,800/100</b>	
<b>4. Deductible Type<sup>2</sup></b>	Calendar Year		Calendar Year	
<b>4a. ANNUAL DEDUCTIBLE<sup>2a</sup></b> a) Individual <sup>2b</sup> b) Family <sup>2c</sup>	a) \$2,800 b) \$5,600 aggregate  Deductibles shall be applied to satisfy the out-of-pocket maximum. Deductible must be satisfied before services will be covered, except as noted.	a) \$5,000 b) \$10,000 aggregate  Deductibles shall be applied to satisfy the out-of-pocket maximum. Deductible must be satisfied before services will be covered, except as noted.	a) \$2,800 b) \$5,600 aggregate  Deductibles shall be applied to satisfy the out-of-pocket maximum. Deductible must be satisfied before services will be covered, except as noted.	a) \$5,000 b) \$10,000  Deductibles shall 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
	<b>\$2,800/80</b>		<b>\$2,800/100</b>	
<b>5. OUT-OF-POCKET ANNUAL MAXIMUM<sup>3</sup></b> <b>a) Individual</b> <b>b) Family</b> <b>c) Is deductible included in the out-of-pocket maximum?</b>	a) \$5,000 b) \$10,000 c) Deductible is included in the out-of-pocket maximum. All copayments apply toward the out-of-pocket maximum. Out-of-pocket maximum is calculated separately for in-network and out-of-network benefits.	a) \$10,000 b) \$20,000 c) Deductible is included in the out-of-pocket maximum. All copayments apply toward the out-of-pocket maximum. Out-of-pocket maximum is calculated separately for in-network and out-of-network benefits.	a) \$2,800 b) \$5,600 c) Deductible is included in the out-of-pocket maximum. All copayments apply toward the out-of-pocket maximum. Out-of-pocket maximum is calculated separately for in-network and out-of-network benefits.	a) \$8,000 b) \$16,000 c) Deductible is included in the out-of-pocket maximum. All copayments apply toward the out-of-pocket maximum. Out-of-pocket maximum is calculated separately for in-network and out-of-network benefits.
<b>6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE</b>	\$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)			
<b>7A. COVERED PROVIDERS</b>	<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.	<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.
<b>7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?</b>	Yes – some network providers are available outside of Colorado.	Not applicable	Yes – some network providers are available outside of Colorado.	Not applicable
<b>8. MEDICAL OFFICE VISITS<sup>4</sup></b> <b>a) Primary Care Providers</b> <b>b) Specialists</b>	a) and b) 20% coinsurance after deductible	a) and b) 40% coinsurance after deductible	a) and b) No copayment (100% covered) after deductible	a) and b) 40% coinsurance after deductible

	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
	<b>\$2,800/80</b>		<b>\$2,800/100</b>	
<b>9. PREVENTIVE CARE</b> <b>a) Children’s services (well-child services as age appropriate)</b> <b>b) Adults’ services (routine physical and gynecological exam – 1 per member per calendar year)</b> <b>c) Routine screening mammograms, pap smears, prostate screenings</b> <b>d) Immunizations</b>	a) 20% coinsurance, not subject to deductible b) No copayment (100% covered), not subject to deductible. Maximum Benefit Level: \$100 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 – office visit coinsurance may apply.	a) Not covered b) Not covered c) Not covered d) 40% coinsurance, not subject to deductible	a) 20% coinsurance, not subject to deductible b) No copayment (100% covered), not subject to deductible. Maximum Benefit Level: \$100 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 – office visit coinsurance may apply.	a) Not covered b) Not covered c) Not covered d) 40% coinsurance, not subject to deductible
<b>10. MATERNITY</b> <b>Maternity coverage is limited to treatment for complications of pregnancy only.</b> <b>a) Prenatal care – complications only</b> <b>b) Delivery &amp; inpatient well baby care<sup>5</sup> - complications only</b>	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. <u>Inpatient well-baby care: 20% coinsurance after deductible</u>	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. <u>Inpatient well-baby care: 40% coinsurance after deductible</u>	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: No copayment (100% covered) after deductible</u>	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. <u>Inpatient well-baby care: 40% coinsurance after deductible</u>

	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
	<b>\$2,800/80</b>		<b>\$2,800/100</b>	
<b>11. PRESCRIPTION DRUGS<sup>6</sup></b> <b>Level of coverage and restrictions on prescriptions</b> <b>a) Inpatient prescription drugs and injectables</b>  <b>b) Outpatient prescription drugs and Insulin (not including injectables)</b> - Retail pharmacy: 31-day supply - Mail order pharmacy: 90-day supply  <b>c) Self-administered injectable medication (except Insulin)</b>	a) 20% coinsurance after deductible b) <u>Generic</u> : 20% coinsurance after deductible  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	a) No copayment (100% covered) after deductible b) <u>Generic</u> : No copayment (100% covered) after deductible  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
<b>12. INPATIENT HOSPITAL</b>	20% coinsurance after deductible	40% coinsurance after deductible	No copayment (100% covered) after deductible	40% coinsurance after deductible
<b>13. OUPATIENT/ AMBULATORY SURGERY</b>	20% coinsurance after deductible for outpatient surgery and invasive diagnostic tests	40% coinsurance after deductible for outpatient surgery and invasive diagnostic tests	No copayment (100% covered) after deductible for outpatient surgery and invasive diagnostic tests	40% coinsurance after deductible for outpatient surgery and invasive diagnostic tests
<b>14. DIAGNOSTICS</b> <b>a) Laboratory &amp; x-ray</b> <b>b) MRI, nuclear medicine, and other high-tech services</b>	a) 20% coinsurance after deductible b) 20% coinsurance after deductible	a) 40% coinsurance after deductible b) 40% coinsurance after deductible	a) No copayment (100% covered) after deductible b) No copayment (100% covered) after deductible	a) 40% coinsurance after deductible b) 40% coinsurance after deductible
<b>15. EMERGENCY CARE<sup>7, 8</sup></b>	20% coinsurance after deductible for emergency room	40% coinsurance after deductible for emergency room	No copayment (100% covered) after deductible for emergency room	40% coinsurance after deductible for emergency room
<b>16. AMBULANCE</b>	20% coinsurance after deductible Maximum Benefit Level (air ambulance services): \$5,000 per trip		No copayment (100% covered) after deductible Maximum Benefit Level (air ambulance services): \$5,000 per trip	
<b>17. URGENT, NON-ROUTINE, AFTER HOURS CARE</b>	20% coinsurance after deductible	40% coinsurance after deductible	No copayment (100% covered) after deductible	40% coinsurance after deductible
<b>18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE<sup>9</sup></b> <b>a) Inpatient care</b> <b>b) Outpatient care</b>	a) Not covered b) See Other Mental Health Care			

	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
	<b>\$2,800/80</b>		<b>\$2,800/100</b>	
<b>19. OTHER MENTAL HEALTH CARE</b> a) Inpatient care b) Outpatient care	a) Not covered b) 50% coinsurance after deductible. Maximum Benefit Level: \$1,000 paid by health benefit plan per member per calendar year.  Maximum Benefit Levels for in-network and out-of-network services combined.	a) Not covered b) 50% coinsurance after deductible. Maximum Benefit Level: \$1,000 paid by health benefit plan per member per calendar year.  Maximum Benefit Levels for in-network and out-of-network services combined.	a) Not covered b) No copayment (100% covered) after deductible. Maximum Benefit Level: \$1,000 paid by health benefit plan per member per calendar year.  Maximum Benefit Levels for in-network and out-of-network services combined.	a) Not covered b) 50% coinsurance after deductible. Maximum Benefit Level: \$1,000 paid by health benefit plan per member per calendar year.  Maximum Benefit Levels for in-network and out-of-network services combined.
<b>20. ALCOHOL &amp; SUBSTANCE ABUSE</b> a) Rehabilitation b) Detoxification			a) Not covered. b) Not covered.	
<b>21. PHYSICAL, OCCUPATIONAL, &amp; SPEECH THERAPY</b> 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).  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.	a) No copayment (100% covered) after deductible Maximum Benefit Level: 60 days per episode per medical condition b) No copayment (100% covered) 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.	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.
<b>22. DURABLE MEDICAL EQUIPMENT</b> a) Durable Medical Equipment (DME) and repairs b) Disposable Medical Supplies (DMS) c) Diabetic and Injectable Supplies d) Orthotics/Prosthetics  <u>Maximum Benefit Level:</u> \$1,000 per member per calendar year for DME, DMS, Orthotics, Prosthetics, and Oxygen combined.	a) and b) 20% coinsurance after deductible. c) 20% coinsurance after deductible d) 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) and b) 40% coinsurance after deductible when obtained in a physician's office or outpatient facility. Services are not covered when obtained from a pharmacy. c) Not covered d) 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.	a) and b) No copayment (100% covered) after deductible. c) No copayment (100% covered) after deductible d) No copayment (100% covered) 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) and b) 40% coinsurance after deductible when obtained in a physician's office or outpatient facility. Services are not covered when obtained from a pharmacy. c) Not covered d) 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.

	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
	<b>\$2,800/80</b>		<b>\$2,800/100</b>	
<b>23. OXYGEN</b>	20% coinsurance after deductible. Maximum Benefit Level: \$1,000 per member per calendar year paid by health benefit plan for DME/DMS/Oxygen/Orthotics & Prosthetics combined.  Maximum Benefit Level for in-network and out-of-network combined.	40% coinsurance after deductible. Maximum Benefit Level: \$1,000 per member per calendar year paid by health benefit plan for DME/DMS/Oxygen/Orthotics & Prosthetics combined.  Maximum Benefit Level for in-network and out-of-network combined.	No copayment (100% covered) after deductible. Maximum Benefit Level: \$1,000 per member per calendar year paid by health benefit plan for DME/DMS/Oxygen/Orthotics & Prosthetics combined.  Maximum Benefit Level for in-network and out-of-network combined.	40% coinsurance after deductible. Maximum Benefit Level: \$1,000 per member per calendar year paid by health benefit plan for DME/DMS/Oxygen/Orthotics & Prosthetics combined.  Maximum Benefit Level for in-network and out-of-network combined.
<b>24. ORGAN TRANSPLANTS</b> <b>a) Inpatient care</b> <b>b) Outpatient care</b>	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.	a) No copayment (100% covered) after deductible b) No copayment (100% covered) 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.
<b>25. HOME HEALTH CARE</b>	20% coinsurance after deductible. Maximum Benefit Level: 60 days per member per calendar year. Maximum Benefit Levels for in-network and out-of-network combined.	40% coinsurance after deductible. Maximum Benefit Level: 60 days per member per calendar year. Maximum Benefit Levels for in-network and out-of-network combined.	No copayment (100% covered) after deductible. Maximum Benefit Level: 60 days per member per calendar year. Maximum Benefit Levels for in-network and out-of-network combined.	40% coinsurance after deductible. Maximum Benefit Level: 60 days per member per calendar year. Maximum Benefit Levels for in-network and out-of-network combined.
<b>26. HOSPICE CARE</b>	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.	40% 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.	No copayment (100% covered) 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.	40% 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.
<b>27. SKILLED NURSING FACILITY CARE</b>	Not covered			
<b>28. DENTAL CARE</b>	Not covered			
<b>29. VISION CARE</b>	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.	No copayment (100% covered) 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.
<b>30. CHIROPRACTIC CARE</b>	Not covered			

	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
	<b>\$2,800/80</b>		<b>\$2,800/100</b>	
<b>31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)</b>	<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 copayments/coinsurance, and maximum benefit levels:</p> <ul style="list-style-type: none"> <li>• Breast – Mammogram</li> <li>• Cervical – PAP test</li> <li>• Colorectal – Colonoscopy, Sigmoidoscopy, Fecal Occult Blood</li> <li>• Ovarian – CA125</li> <li>• Prostate – PSA</li> </ul> <p>Coverage for these cancer screening tests are subject to the following parameters:</p> <ol style="list-style-type: none"> <li>a) the test must be ordered by your physician, and</li> <li>b) you must comply with plan procedures</li> </ol> <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 \$500 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"> <li>• 20% discount on annual eye exam</li> <li>• 20% discount on full set of prescription eye glasses</li> <li>• 15% discount on contact lens fitting and evaluation exam</li> <li>• 15% discount on laser vision correction</li> </ul>	<p>1) Not covered</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 \$500 per member per accident, then applicable deductible and coinsurance.</p> <p>3) Not covered</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 copayments/coinsurance, and maximum benefit levels:</p> <ul style="list-style-type: none"> <li>• Breast – Mammogram</li> <li>• Cervical – PAP test</li> <li>• Colorectal – Colonoscopy, Sigmoidoscopy, Fecal Occult Blood</li> <li>• Ovarian – CA125</li> <li>• Prostate – PSA</li> </ul> <p>Coverage for these cancer screening tests are subject to the following parameters:</p> <ol style="list-style-type: none"> <li>a) the test must be ordered by your physician, and</li> <li>b) you must comply with plan procedures</li> </ol> <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 \$500 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"> <li>• 20% discount on annual eye exam</li> <li>• 20% discount on full set of prescription eye glasses</li> <li>• 15% discount on contact lens fitting and evaluation exam</li> <li>• 15% discount on laser vision correction</li> </ul>	<p>1) Not covered</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 \$500 per member per accident, then applicable deductible and coinsurance.</p> <p>3) Not covered</p>

**PART C: LIMITATIONS AND EXCLUSIONS**

<b>32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.<sup>10</sup></b>	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.
<b>33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?</b>	No.
<b>34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?</b>	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.
<b>35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?</b>	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**

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?</b>	No	No
<b>37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?</b>	Yes	Yes
<b>38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?</b>	No	Yes
<b>39. What is the main customer service number?</b>	<b>800-346-4643</b>	
<b>40. Who do I write/call if I have a complaint or want to file a grievance?<sup>11</sup></b>	<b>Rocky Mountain Health Plans Member Concerns Coordinator P.O. Box 60007 Grand Junction, CO 81506-8758</b>	
<b>41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?</b>	<b>Write to: Colorado Division of Insurance, ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202</b>	
<b>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.</b>	Policy Form <u>SOLO Smart Choice Plans 2800-80/2800-100</u> - Individual	
<b>43. Does the plan have a binding arbitration clause?</b>	Yes, to the extent permitted by law.	

<sup>1</sup> "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).



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<sup>2</sup> “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”.

<sup>2a</sup> “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.

<sup>2b</sup> “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.

<sup>2c</sup> “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”).

<sup>3</sup> “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.

<sup>4</sup> “Medical office visits” include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically based mental illness.

<sup>5</sup> “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.

<sup>6</sup> “Prescription drugs” otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

<sup>7</sup> “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.

<sup>8</sup> “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.

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

<sup>10</sup> “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.

<sup>11</sup> “Grievances.” Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.