

Colorado Health Benefit Plan Description Form

Rocky Mountain Health Care Options

PPO Standard Health Benefit Plan for Colorado

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} a) Individual ^{2b} b) Family ^{2c}	a) \$1,500 b) \$4,500 Amounts paid toward deductible shall be applied to satisfy the out-of-pocket maximum.	a) \$3,000 b) \$9,000 Amounts paid toward deductible shall be applied to satisfy the out-of-pocket maximum.
5. OUT-OF-POCKET ANNUAL MAXIMUM³ a) Individual b) Family c) Is deductible included in the out-of-pocket maximum?	a) \$4,500 b) \$9,000 c) Yes 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) \$9,000 b) \$18,000 c) Yes 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	No Lifetime Maximum	
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.	Not applicable

<p>8. MEDICAL OFFICE VISITS⁴ a) Primary Care Providers b) Specialists</p>	<p>a) \$30 per visit copayment, not subject to deductible b) \$50 per visit copayment, not subject to deductible Copayments do not apply toward annual out-of-pocket maximum.</p>	<p>a) 50% coinsurance after deductible b) 50% coinsurance after deductible</p>
<p>9. PREVENTIVE CARE <u>Preventive Services recommended by the U.S. Preventive Services Task Force, including:</u> a) Children’s services (well-child services as age appropriate) b) Adults’ services (routine physical and gynecological exam) c) Colorectal cancer screenings d) Other covered preventive services (immunizations, screening mammograms, routine pap smears, routine prostate screenings, alcohol misuse screening and behavioral counseling, tobacco use screening and cessation intervention and cholesterol screening for lipid disorders)</p>	<p>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</p>	<p>a) 50% coinsurance, not subject to deductible. b) 50% coinsurance after deductible c) \$30 per office visit copayment; \$250 per outpatient/ambulatory surgery procedure copayment, not subject to deductible d) \$30 per visit copayment, not subject to deductible, except vaccination for cervical cancer will be covered in full with no copayment.</p> <p>Copayments do not apply toward annual out-of-pocket maximum.</p>
<p>10. MATERNITY a) Prenatal care (routine) b) Delivery & inpatient well baby care⁵ Non-routine prenatal care will have the applicable copayment/coinsurance for the type of service except for services recommended by the U.S. Preventive Services Task Force which are covered in full.</p>	<p>a) 20% coinsurance after deductible b) 20% coinsurance after deductible</p>	<p>a) 50% coinsurance after deductible b) 50% coinsurance after deductible</p>

<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 (including injectables, disposable and diabetic supplies and medical foods)</p> <p>c) Outpatient injectable medication (except Insulin) – administered in a physician’s office or outpatient facility</p> <p>Injectable medication (excluding Insulin) is limited to a 31-day supply when obtained from a mail-order pharmacy.</p> <ul style="list-style-type: none"> - Prescription drugs are covered only through participating retail and mail order pharmacies. See the Participating Provider Directory for a list of participating 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. 	<p>a) Included in inpatient hospital copayment</p> <p>b)</p> <p><u>Retail pharmacy:</u> <u>Generic (Tier 1): \$10</u> copay per prescription for a 31-day supply <u>Preferred (Tier 2): \$40</u> copay per prescription for a 31-day supply <u>Non-Preferred (Tiers 3, 4 & 5): \$60</u> copay per prescription for a 31-day supply</p> <p><u>Mail order pharmacy:</u> <u>Generic (Tier 1): \$25</u> copay per prescription for a 90-day supply <u>Preferred (Tier 2): \$100</u> copay per prescription for a 90-day supply <u>Non-Preferred (Tiers 3, 4): \$150</u> copay per prescription for a 90-day supply</p> <p><i>Tier 5 is limited to certain injectables which are only available in a 31-day supply.</i></p> <p>c) No copayment (100% covered) in addition to the office visit copayment.</p>	<p>a) 50% coinsurance after deductible</p> <p>b) <u>Retail pharmacy:</u> <u>Generic (Tier 1): \$10</u> copay per prescription for a 31-day supply <u>Preferred (Tier 2): \$40</u> copay per prescription for a 31-day supply <u>Non-Preferred (Tiers 3, 4 & 5): \$60</u> copay per prescription for a 31-day supply</p> <p><i>Tier 5 is limited to certain injectables which are only available in a 31-day supply.</i></p> <p>c) 50% coinsurance after deductible</p>
<p>12. INPATIENT HOSPITAL</p>	<p>20% coinsurance after deductible</p>	<p>50% coinsurance after deductible</p>
<p>13. OUTPATIENT/AMBULATORY SURGERY</p>	<p>20% coinsurance after deductible for outpatient surgery and invasive diagnostic tests</p>	<p>50% coinsurance after deductible for outpatient surgery and invasive diagnostic tests</p>
<p>14. DIAGNOSTICS a) Laboratory & x-ray b) MRI, nuclear medicine, CT, CTA, MRA and PET scans</p>	<p>a) 20% coinsurance after deductible b) 20% coinsurance after deductible</p>	<p>a) 50% coinsurance after deductible b) 50% coinsurance after deductible</p>
<p>15. EMERGENCY CARE^{7, 8}</p>	<p>\$150 per visit copayment, then 20% coinsurance, not subject to deductible</p>	
<p>16. AMBULANCE</p>	<p>20% coinsurance after in-network deductible</p>	
<p>17. URGENT, NON-ROUTINE, AFTER HOURS CARE</p>	<p>\$75 per visit copayment, not subject to deductible. Copayment does not apply toward annual out-of-pocket maximum.</p>	<p>50% coinsurance after deductible</p>
<p>18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE⁹</p>	<p>Coverage is no less extensive than the coverage provided for any other physical illness. Coverage is not duplicative of other mental health care.</p>	<p>Coverage is no less extensive than the coverage provided for any other physical illness. Coverage is not duplicative of other mental health care.</p>
<p>19. OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care</p>	<p>a) 50% coinsurance after deductible. Maximum Benefit Level: 45 days or 90 partial days per member per calendar year b) 50% coinsurance after deductible.</p>	<p>a) 50% coinsurance after deductible. Maximum Benefit Level: 45 days or 90 partial days per member per calendar year. b) 50% coinsurance after deductible.</p>

<p>20. ALCOHOL & SUBSTANCE ABUSE <u>Rehabilitation:</u> a) Inpatient care b) Outpatient care</p> <p><u>Detoxification:</u> c) Inpatient care d) Outpatient care</p>	a) Not covered b) Not covered c) 50% coinsurance after deductible. Maximum Benefit Level: 5 days per episode/2 episodes per lifetime for removal of the toxic substances from the body. d) 50% coinsurance after deductible. Maximum Benefit Level: 5 days per episode/2 episodes per lifetime for removal of the toxic substances from the body.	a) Not covered b) Not covered c) 50% coinsurance after deductible. Maximum Benefit Level: 5 days per episode/2 episodes per lifetime for removal of the toxic substances from the body. d) 50% coinsurance after deductible. Maximum Benefit Level: 5 days per episode/2 episodes per lifetime for removal of the toxic substances from the body.
<p>21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY a) Inpatient care b) Outpatient care</p>	a) 20% coinsurance after deductible b) 20% coinsurance after deductible. Maximum Benefit Level: 25 visits per therapy per member per calendar year. Maximum Benefit Level for in-network and out-of-network combined.	a) 50% coinsurance after deductible b) 50% coinsurance after deductible. Maximum Benefit Level: 25 visits per therapy per member per calendar year. Maximum Benefit Level for in-network and out-of-network combined.
<p>22. DURABLE MEDICAL EQUIPMENT a) Durable Medical Equipment (DME) and repairs b) Prosthetic devices (not including arm and leg prostheses) c) Prosthetic devices – arm and leg prostheses</p> <p>Arm, leg, and breast prosthetics, mastectomy bras, rehabilitative and habilitative devices are not subject to the annual limit.</p>	a) and b) 20% coinsurance after deductible - Maximum Benefit Level: \$2,500 per member per calendar year paid by health benefit plan for DME and Oxygen combined. c) 20% coinsurance after deductible Maximum Benefit Level for in-network and out-of-network combined.	a) and b) 50% coinsurance after deductible - Maximum Benefit Level: \$2,500 per member per calendar year paid by health benefit plan for DME and Oxygen combined. c) 20% coinsurance after deductible Maximum Benefit Level for in-network and out-of-network combined.
<p>23. OXYGEN</p>	20% coinsurance after deductible - Maximum Benefit Level: \$2,500 per member per calendar year paid by health benefit plan for DME and Oxygen combined. Maximum Benefit Level for in-network and out-of-network combined.	50% coinsurance after deductible - Maximum Benefit Level: \$2,500 per member per calendar year paid by health benefit plan for DME and Oxygen combined. Maximum Benefit Level for in-network and out-of-network combined.
<p>24. ORGAN TRANSPLANTS a) Inpatient care b) Outpatient care</p>	a) 20% coinsurance after deductible b) 20% coinsurance after deductible	a) 50% coinsurance after deductible b) 50% coinsurance after deductible
<p>25. HOME HEALTH CARE</p>	20% coinsurance after deductible	50% coinsurance after deductible
<p>26. HOSPICE CARE</p>	20% coinsurance after deductible Maximum Benefit Level: Respite care is limited to periods of 5 days or less.	50% coinsurance after deductible Maximum Benefit Level: Respite care is limited to periods of 5 days or less.
<p>27. SKILLED NURSING FACILITY CARE</p>	20% coinsurance after deductible. Maximum Benefit Level: 100 days per member per calendar year. Maximum Benefit Level for in-network and out-of-network combined.	50% coinsurance after deductible. Maximum Benefit Level: 100 days per member per calendar year. Maximum Benefit Level for in-network and out-of-network combined.

28. DENTAL CARE	<p>Routine: Not covered.</p> <p>Non-Routine: \$30 per visit copayment/PCP, not subject to deductible \$50 per visit copayment/Any other participating provider, not subject to deductible</p> <ul style="list-style-type: none"> - For repair of sound and natural teeth due to accidental injury. - Copayments do not apply toward annual out-of-pocket maximum. 	<p>Routine: Not covered</p> <p>Non-Routine: 50% coinsurance after deductible for treatment due to injury to sound and natural teeth.</p>
29. VISION CARE	<p>Annual Routine Vision Screening: Not covered</p> <p>Non Routine: \$30 per visit copayment/PCP, not subject to deductible \$50 per visit copayment/Any other participating provider, not subject to deductible</p> <ul style="list-style-type: none"> - For treatment due to injury or disease of the eye. - Copayments do not apply toward annual out-of-pocket maximum. 	<p>Annual Routine Vision Screening: Not covered</p> <p>Non-Routine: 50% coinsurance after deductible for treatment due to injury or disease of the eye</p>
30. CHIROPRACTIC CARE	Not covered	Not covered
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	<ol style="list-style-type: none"> 1) <u>Spinal manipulation</u>: \$30 per visit copayment 2) <u>Hearing Aids (for members up to 18 years of age)</u>: Benefit level determined by place of service. 3) <u>Treatment for Autism Spectrum Disorders (ASD)</u>: All plans issued or renewed on or after July 1, 2010, will provide coverage for autism spectrum disorders as follows: Copayment/Coinsurance determined by place/type of service. For members from birth up to 9 years of age, the annual maximum benefit level for applied behavior analysis for ASD is \$34,000. For members from 9 years of age up to 19 years of age, the annual maximum benefit level for applied behavior analysis for ASD is \$12,000. No day, visit, or dollar limits other than the annual maximum benefit levels apply. 	

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.¹⁰	<p>For Business Groups of One: Up to twelve months for all pre-existing conditions (18 months for late enrollees) unless the covered person is a HIPAA-eligible individual as defined under federal and state law or a child under the age of 19, in which case there are no pre-existing condition exclusions.</p> <p>For small groups (with less than 51 employees): Up to six months for all pre-existing conditions (18 months for late enrollees) unless the covered person is a HIPAA-eligible individual as defined under federal and state law or a child under the age of 19, in which case there are no pre-existing condition exclusions.</p>
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No.

<p>34. HOW DOES THE POLICY DEFINE A “PRE-EXISTING CONDITION”?</p>	<p>For Business Groups of One: A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last twelve months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on children under the age of 19, a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.</p> <p>For small groups: A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last six months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on children under the age of 19, a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.</p>
<p>35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?</p>	<p>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.</p>

PART D: USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
<p>36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?</p>	No	No
<p>37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?</p>	Yes	Yes
<p>38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?</p>	No	Yes
<p>39. What is the main customer service number?</p>	800-346-4643	
<p>40. Who do I write/call if I have a complaint or want to file a grievance?¹¹</p>	<p>Rocky Mountain Health Plans Member Concerns Coordinator P.O. Box 10600 Grand Junction, CO 81502-5600</p>	
<p>41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?</p>	<p>Write to: Colorado Division of Insurance, ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202</p>	
<p>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.</p>	Policy Form <u>PPO STD Group Plan</u> - Group - all sizes	
<p>43. Does the plan have a binding arbitration clause?</p>	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 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 and the provision of injections of injectable drugs.

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.

GRANDFATHERED PLAN NOTICE FOR GROUP PLANS

THIS GRANDFATHERED PLAN NOTICE FOR GROUP PLANS is provided to you in connection with Rocky Mountain Health Plan (“RMHP”) plan materials, as required by the Patient Protection and Affordable Care Act (“Affordable Care Act”) and related regulations.

This plan is available to both grandfathered and non-grandfathered group health plans under 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 Affordable Care Act. Your Evidence of Coverage will state if the carrier 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 (although most grandfathered RMHP plans provide coverage for preventive services without 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 or your plan administrator identified in your Summary Plan Description. 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.