

Premier Advantage by Rocky Mountain Health Plans
2000 70/50 20/35 OV Plan
Employee Medical Plan Summary of Benefits
July 1, 2009

The following is only a brief summary of the Medical benefits of the Group Name Employee Benefit Plan. The detailed information concerning all coverages, limitations, restrictions or exclusions is contained in the Plan Document and Summary Plan Description. If there are any discrepancies, the Plan Document will prevail.

Schedule of Service	Network Providers	Non-Network Providers
Calendar Year Deductible*	Individual - \$2,000 Family - \$4,000	
Calendar Year Out of Pocket Maximum (Does NOT include Deductible)	Individual - \$5,000 Family - \$10,000	Individual - \$7,500 Family - \$15,000
Lifetime Maximum (All Benefits, All Plans)	\$2,000,000	
Plan benefits for Eligible Expenses after satisfaction of the Deductible or Co-Payment as follows:		
Office Visits	\$20 PCP/ \$35 Specialist copay per visit	50% coinsurance after deductible
Diagnostic X-Ray and Laboratory Services as part of office visit	Covered as part of office visit	50% coinsurance after deductible
Durable Medical Equipment – includes disposable medical supplies, oxygen, orthotics and prosthetics in annual max	30% coinsurance after deductible up to \$2,500 per calendar year (No limit on diabetic supplies)	Not Covered
Emergency Room /Ambulance	30% coinsurance after deductible	30% coinsurance after (In-Network) deductible
Urgent Care	\$45 per visit	50% coinsurance after deductible
Home Healthcare	30% coinsurance after deductible Limited to 60 visits per member per calendar year. Combined for in and out-of-network	50% coinsurance after deductible Limited to 60 visits per member per calendar year. Combined for in and out-of-network
Hospice Care	30% coinsurance not subject to deductible Limited to 5 days per calendar year. Combined for in and out-of-network	50% coinsurance after deductible limited to 5 days per calendar year. Combined for in and out-of-network
Respite Care	Limited to 5 days per calendar year (combined in and out-of-network)	Limited to 5 days per calendar year (combined in and out-of-network)
Bereavement Counseling	Covered under Hospice Benefit	Covered under Hospice Benefit
Hospital Services	30% coinsurance after deductible	50% coinsurance after deductible
Infertility and Impotence Benefits	Not Covered	Not Covered
Dental Care (Non-routine)	30% coinsurance after deductible for repair to sound and natural teeth due to accidental injury	50% coinsurance after deductible for repair to sound and natural teeth due to accidental injury
Mental Health and Substance Abuse Treatment		
Mental Disorder Treatment		
Inpatient	30% coinsurance after deductible. Limited to 45 days or 90 partial days per member per calendar year.	Not Covered
Partial hospitalization	30% coinsurance after deductible Limited to 90 days per member per calendar year.	Not Covered

Schedule of Service	Network Providers	Non-Network Providers
Outpatient	\$35 per visit Up to 20 visits per calendar year	Not Covered
Substance/Alcohol Abuse Treatment		
Inpatient*	50% coinsurance after deductible Limited to 45 days or 90 partial days per member per calendar year. Combined for in and out-of-network	Not Covered
Outpatient	50% coinsurance after deductible Limited to \$500 per member per calendar year.	Not Covered
Alcoholism or drug abuse inpatient or partial treatment combined	50% coinsurance after deductible Limited to 90 partial days per member per calendar year.	Not Covered
*Admissions solely for detoxification are not covered. Patient must complete the full continuum of the treatment program as certified by the attending physician.		
Occupational/Speech and Physical Therapy		
Per visit, combined benefit	Office Visit: \$35 copay Limited to 20 visits per member per calendar year for each type of therapy. Combined for in and out-of-network.	Office Visit: 50% coinsurance after deductible. Limited to 20 visits per member per calendar year for each type of therapy. Combined for in and out-of-network.
Organ Transplants	30% coinsurance after deductible	Not Covered
Outpatient Private Duty Nursing	Not Covered	Not Covered
Physician Services		
Inpatient visits	30% coinsurance after deductible	50% coinsurance after deductible
Office visits	\$20 PCP/ \$35 Specialist copay per visit	50% coinsurance after deductible
Injections without office visit	30% coinsurance after deductible	50% coinsurance after deductible
All other covered expenses	Covered as part of office visit	50% coinsurance after deductible
Lab/Xray MRI/PET/CAT	\$15/\$30 30% coinsurance after deductible	50% coinsurance after deductible
Maternity – Prenatal and Delivery & Inpatient well-bay care Non-routine prenatal care will have the applicable copayment/ coinsurance for that type of service	30% coinsurance after deductible	50% coinsurance after deductible
Preventive Care Services		
Routine Well Care	100% Covered	Not Covered
Includes: routine physical examination, pap smear, mammogram, prostate screening, immunizations/flu shots, preventive shots and well-baby care.		
Colonoscopies (including Associated Services)	30% coinsurance, Not subject to deductible	Not Covered
Prosthetic Devices	30% coinsurance after deductible up to \$2,500 per calendar year (arm, leg and breast prosthetics have no limit)	Not covered except for arm, leg and breast prosthetics
Skilled Nursing Facility	30% coinsurance after deductible Limited to 60 days per calendar year Combined for in and out-of-network	50% coinsurance after deductible
Routine Vision Screening	Not Covered	Not Covered
Spinal Manipulation/ Chiropractic Services	Not Covered	Not Covered
All Other Eligible Services and Supplies	30% coinsurance after deductible	50% coinsurance after deductible
Prescription Drug Benefit (Mail Order Benefit = 2.5 times retail copay. Tier 4 = 20% up to \$375. Tier 5 = only available in 31 day supply)	\$10 Generic or 5-Tier Drug Benefit Tier 1 - \$10 Tier 2 - \$35 Tier 3 - \$50 Tier 4 – 20% up to \$150 Tier 5 – 30% up to 250	Not Covered

PPO PROVIDERS: Rocky Mountain ASO Network