ROCKY MOUNTAIN HEALTH PLANS®
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Premier Advantage by Rocky Mountain Health Plans
1000 80/60 Plan
Employee Medical Plan Summary of Benefits
October 1, 2010

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 - $1,000 Family - $2,000	
Calendar Year Out-of-Pocket Maximum (Does NOT include Deductible)	Individual - $3,000 Family - $6,000	Individual - $6,000 Family - $12,000
Lifetime Maximum (All Benefits, All Plans)	No Lifetime Maximum	
Plan benefits for Eligible Expenses after satisfaction of the Deductible or Co-Payment as follows:		
Office Visits	$20 PCP/ $35 Specialist copay per visit	40% coinsurance after deductible
Diagnostic X-Ray and Laboratory Services as part of office visit	Covered as part of office visit	40% coinsurance after deductible
Durable Medical Equipment – includes disposable medical supplies, oxygen, orthotics and prosthetics in annual max	20% coinsurance after deductible up to $2,500 per calendar year (No limit on diabetic supplies)	Not Covered
Emergency Room /Ambulance	20% coinsurance after deductible	20% coinsurance after (In-Network) deductible
Urgent Care	$45 per visit	40% coinsurance after deductible
Home Healthcare	20% coinsurance after deductible Limited to 60 visits per member per calendar year. Combined for in and out-of-network	40% coinsurance after deductible Limited to 60 visits per member per calendar year. Combined for in and out-of-network
Hospice Care	20% coinsurance not subject to deductible	40% coinsurance after deductible
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	20% coinsurance after deductible	40% coinsurance after deductible
Infertility and Impotence Benefits	Not Covered	Not Covered
Dental Care (Non-routine)	20% coinsurance after deductible for repair to sound and natural teeth due to accidental injury	40% coinsurance after deductible for repair to sound and natural teeth due to accidental injury
Mental Disorder Treatment		
Inpatient	20% coinsurance after deductible. Limited to 45 days or 90 partial days per member per calendar year.	Not Covered
Partial hospitalization	20% coinsurance after deductible Limited to 90 days per member per calendar year.	Not Covered
Outpatient	$35 per visit Up to 20 visits per calendar year	Not Covered
Substance/Alcohol Abuse Treatment		

Schedule of Service	Network Providers	Non-Network Providers
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	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: 40% 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	20% coinsurance after deductible	Not Covered
Outpatient Private Duty Nursing	Not Covered	Not Covered
Physician Services		
Inpatient visits	20% coinsurance after deductible	40% coinsurance after deductible
Office visits	$20 PCP/ $35 Specialist copay per visit	40% coinsurance after deductible
Injections without office visit	20% coinsurance after deductible	40% coinsurance after deductible
All other covered expenses	Covered as part of office visit	40% coinsurance after deductible
Lab/Xray **MRI/PET/CAT**	$15/$30 20% coinsurance after deductible	40% 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	20% coinsurance after deductible	40% coinsurance after deductible
Preventive Care Services recommended by the U.S. Preventive Services Task Force, including:		
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)	100% covered	Not Covered
Prosthetic Devices	20% coinsurance after deductible up to $2,500 per calendar year (Arm, leg and breast prosthetics, mastectomy bras, rehabilitative and habilitative devices are not subject to the annual limit.)	Not covered except for arm, leg and breast prosthetics
Skilled Nursing Facility	20% coinsurance after deductible Limited to 60 days per calendar year Combined for in and out-of-network	40% coinsurance after deductible
Routine Vision Screening	Not Covered	Not Covered
Spinal Manipulation/ Chiropractic Services	Not Covered	Not Covered
All Other Eligible Services and Supplies	20% coinsurance after deductible	40% 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