

**Premier Advantage by Rocky Mountain Health Plans**  
**HSA 2650 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
<b>Calendar Year Deductible*</b>	Individual - \$2,650 Family - \$5,000	
<b>Calendar Year Out of Pocket Maximum (Does include Deductible)</b>	Individual - \$2,650 Family - \$5,000	Individual - \$5,000 Family - \$10,000
<b>Lifetime Maximum (All Benefits, All Plans)</b>	No Lifetime Maximum	
<b>Plan benefits for Eligible Expenses after satisfaction of the Deductible or Co-Payment as follows:</b>		
<b>Office Visits</b>	No copayment after deductible	50% coinsurance after deductible
<b>Diagnostic X-Ray and Laboratory Services as part of office visit</b>	No copayment after deductible	50% coinsurance after deductible
<b>Durable Medical Equipment – includes disposable medical supplies, oxygen, orthotics and prosthetics in annual max</b>	No copayment after deductible, up to \$2,500 per calendar year (No limit on diabetic supplies)	Not Covered
<b>Emergency Room /Ambulance</b>	No copayment after deductible	No copayment after (In-Network) deductible
<b>Urgent Care</b>	No copayment after deductible	50% coinsurance after deductible
<b>Home Healthcare</b>	No copayment 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
<b>Hospice Care</b>	No copayment after deductible	50% 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
<b>Hospital Services</b>	No copayment after deductible	50% coinsurance after deductible
<b>Infertility and Impotence Benefits</b>	Not Covered	Not Covered
<b>Dental Care (Non-routine)</b>	No copayment 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
<b>Mental Health and Substance Abuse Treatment</b>		
<b>Mental Disorder Treatment</b>		
Inpatient	No copayment after deductible. Limited to 45 days or 90 partial days per member per calendar year.	Not Covered
Partial hospitalization	No copayment after deductible Limited to 90 days per member per calendar year.	Not Covered
Outpatient	No copayment after deductible Up to 20 visits per calendar year	Not Covered

Schedule of Service	Network Providers	Non-Network Providers
<b>Substance/Alcohol Abuse Treatment</b>		
Inpatient*	No copayment 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	No copayment after deductible	Not Covered
Alcoholism or drug abuse inpatient or partial treatment combined	No copayment after deductible Limited to 90 partial days per member per calendar year.	Not Covered
Detoxification: Inpatient Outpatient	No copayment after deductible No copayment after deductible	50% coinsurance after deductible 50% coinsurance after deductible
*Patient must complete the full continuum of the treatment program as certified by the attending physician.		
<b>Occupational/Speech and Physical Therapy</b>		
Per visit, combined benefit	No copayment after deductible OV - Limited to 20 visits per member per calendar year for each type of therapy. Combined for in and out-of-network.	50% coinsurance after deductible. OV -Limited to 20 visits per member per calendar year for each type of therapy. Combined for in and out-of-network.
<b>Organ Transplants</b>	No copayment after deductible	Not Covered
<b>Outpatient Private Duty Nursing</b>	Not Covered	Not Covered
<b>Physician Services</b>		
Inpatient visits	No copayment after deductible	50% coinsurance after deductible
Office visits	No copayment after deductible	50% coinsurance after deductible
Injections without office visit	No copayment after deductible	50% coinsurance after deductible
All other covered expenses	No copayment after deductible	50% coinsurance after deductible
<b>Lab/Xray MRI/PET/CAT</b>	No copayment after deductible	50% coinsurance after deductible
<b>Maternity – Prenatal and Delivery &amp; Inpatient well-bay care Non-routine prenatal care will have the applicable copayment/ coinsurance for that type of service</b>	No copayment after deductible	50% coinsurance after deductible
<b>Preventive Care Services recommended by the U.S. Preventive Services Task Force, including:</b>		
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.		
<b>Colonoscopies (including Associated Services)</b>	100% covered	50% coinsurance Not subject to deductible
<b>Prosthetic Devices</b>	No copayment 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
<b>Skilled Nursing Facility</b>	No copayment after deductible Limited to 60 days per calendar year Combined for in and out-of-network	50% coinsurance after deductible
<b>Routine Vision Screening</b>	Not Covered	Not Covered
<b>Spinal Manipulation/ Chiropractic Services</b>	Not Covered	Not Covered
<b>All Other Eligible Services and Supplies</b>	No copayment after deductible	50% coinsurance after deductible
<b>Prescription Drug Benefit</b>	No copayment after deductible <b>Preventive Generic Drugs:</b> Certain preventive generic drugs will be covered with a \$10 copay, not subject to deductible.	Not Covered