



ROCKY MOUNTAIN
HEALTH PLANS®

We understand Colorado. We understand you.

Business Group of One Manual

Revised March 2010

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Section One

Welcome to Rocky Mountain Health Plans

Thank you for making Rocky Mountain Health Plans (RMHP) part of your health benefits program.

We are pleased to provide this Business Group of One (BG1) Manual as a service to assist you in 1) processing Change Forms, 2) submitting monthly premium payments, 3) understanding the procedures of Rocky Mountain Health Plans, and 4) meeting certain state and federal requirements for employer groups.

When discussing eligibility, we will be referring to three main levels. These levels are defined as:

- **Employer Group:** An employer or other group having an agreement with RMHP to provide medical benefits for its eligible employees and their eligible dependents.
- **Subscriber:** An employee who chooses RMHP benefits, meets all applicable eligibility requirements for coverage, has signed an Enrollment Form, and for whom the required premium payment has been received by RMHP. In a BG1, there is only one subscriber.
- **Plan Member (Member):** An enrolled individual who is either a Subscriber or a dependent, who meets all applicable eligibility requirements for coverage, and for whom the required premium payment has been received by RMHP. The Subscriber and his/her enrolled dependents collectively are referred to as a Subscriber Contract.

Rocky Mountain Health Plans Products

Plans underwritten by Rocky Mountain HMO (RMHMO)	Plans underwritten by Rocky Mountain HealthCare Options, Inc. (RMHCO)
C1, C3, C8, C15K C1000 C5000 NC50 Good Health Savings Plans HDHP HMO Rocky Mountain Choice HMO Rocky Mountain Direct HMO RMHMO HMO Standard Health Benefit Plan for Colorado* RMHMO HMO Basic Limited Mandate Health Benefit Plan for Colorado*	Good Health Savings Plans HDHP PPO Indemnity Plans Rocky Mountain Choice PPO Rocky Mountain Direct EPO Rocky Mountain Direct PPO RMHCO PPO Standard Health Benefit Plan for Colorado* RMHCO PPO Basic Limited Mandate Health Benefit Plan for Colorado*
* Known as Basic & Standard Plans	

A Colorado Family of Health Plans

Rocky Mountain Health Plans (RMHP) is headquartered in Grand Junction and has been serving Coloradans exclusively since 1974, when it was formed as a not-for-profit, federally qualified health maintenance organization licensed by the Colorado Division of Insurance. RMHP has regional offices in Denver, Durango, and Pueblo.

Commercial Plans

Rocky Mountain Health Plans offers health benefits coverage to private and public employer groups and individuals through contracts with participating providers. Plans offered are underwritten by Rocky Mountain HMO and Rocky Mountain HealthCare Options.

Government Programs

Contracts with the Centers for Medicare & Medicaid Services (CMS) and the Colorado Department of Healthcare Policy and Financing allow RMHP to:

- offer Medicare HMO plans in all Colorado counties except Baca, Routt, and Moffat;
- administer the state's Medicaid program in several Western Slope counties; and
- administer the Child Health Plan Plus (CHP+) program for children in Delta, Mesa, and Montrose counties.

General Guidelines

- When making any enrollment changes, additions or deletions, be sure to complete the appropriate RMHP forms and submit promptly.
- Submit your forms immediately upon completion or with the billing affected to RMHP.
- **Retroactive disenrollment of dependent coverage is not accepted.** Please read Section Two of this manual to understand the requirements for notifying RMHP about dependent disenrollment and employer group termination.
- Be sure all forms are clear, complete, and signed.
- Premium payments are due on the first day of the month for which coverage is to be effective.
- Dependent children are eligible to apply for coverage according to the general eligibility requirements outlined in the Health Plan Guide and Health Benefits Contract for Group Plans, subject to medical underwriting (except for Basic and Standard plans).
- A Certificate of Creditable Coverage (CCC) must be issued to all plan members who terminate coverage under a group health plan. RMHP will issue CCCs for our employer groups to meet our requirements of the law. Please refer to Section Four for additional information on CCCs and Colorado Continuation of Coverage.
- Conversion plans are available to RMHP Business Groups of One upon termination of group coverage and continuation of coverage benefits (if eligible). Any conversion plan must be requested within 31 days of termination (if the member is not eligible for Colorado Continuation of Coverage) or within 31 days of the termination of coverage under Colorado Continuation of Coverage. Conversion coverage must begin immediately following termination of Colorado Continuation of Coverage; there cannot be a lapse in coverage.
- Members may change their Primary Care Physician (PCP) by contacting a Customer Service representative by phone or by e-mail (customer_service@rmhp.org) prior to receiving services.
- If a Rocky Mountain Health Plans member receives a claim or bill from a participating provider, please call RMHP Customer Service at 800-346-4643 or 970-243-7050.
- Members may call RMHP Customer Service if they have questions about their coverage or have questions about their Member Billing Statement (MBS) or Explanation of Benefits (EOB).
- When in doubt on any matter, please call for clarification.

Section Two

Enrollment

Changes During Group Anniversary Period

During the annual group anniversary period, the BG1 may request a plan change to any plan except state mandated Basic and Standard plans. All plan change requests must be submitted in writing at least one month before the anniversary date. All RMHP BG1 plans except state mandated Basic and Standard plans are subject to medical underwriting. If approved, the plan change requested will be effective on the BG1's anniversary date.

Changes During Statutory Open Enrollment Period

During the annual statutory open enrollment period, the 31 days **after** the birthday of the principal subscriber of the BG1, the BG1 can request a plan change to state mandated Basic and Standard plans. All plan change requests must be submitted in writing during the open enrollment period. A BG1 plan change to the state mandated Basic or Standard plan is not subject to medical underwriting (however, RMHP will request medical information for case management purposes). When changing to a state mandated Basic or Standard plan, the principal subscriber of the BG1 may also add dependents during the open enrollment period without medical underwriting (however, RMHP will request medical information for case management purposes).

Adding Dependents Generally

The principal subscriber of BG1 plans may request that eligible dependents be added to the plans at any time, subject to medical underwriting and approval. If eligible dependents fail medical underwriting and are denied approval, then BG1s during the statutory open enrollment period (but not sooner) may change plans to state mandated Basic or Standard plans and add those dependents to such plan without medical underwriting (however, RMHP will request medical information for case management purposes). The annual open enrollment period provides the opportunity for BG1s already enrolled in RMHP's state mandated Basic and Standard plans to add eligible dependents without medical underwriting. **Dependents who choose not to enroll with Rocky Mountain Health Plans at the same time that the principal subscriber of the BG1 enrolls must complete a Waiver Form. This form must be sent to Rocky Mountain Health Plans at the time of initial enrollment.**

Conditions for Special Enrollment

Because RMHP provides care to enrolled members on a prepaid basis rather than on the basis of approving claims for payment, it is extremely important that RMHP records of members' eligibility be maintained accurately. Your assistance in reporting all changes to us promptly is greatly appreciated. To help simplify this procedure, we have designed a Change Form (*see Exhibit B*) to be used to report all changes.

1. **Addition of Newborn or Adopted Child:** If you add a newborn or adopted child, the effective date of coverage will be the date of birth or the date of the adoption or placement for adoption. A legally adopted child will be deemed "adopted" when the child is placed for adoption with the subscriber or dependent spouse by the state or an adoption agency such that the subscriber or dependent spouse assumes or retains a legal obligation to partially or to fully support a child in anticipation of the child's adoption.

Notification and Billing Requirements: The newborn or adopted child must be added to the plan within 31 days of birth or adoption, and changes in premium are due the first billing period following such event. Please submit a completed and signed Change Form and include a copy of the adoption records.

2. **Court or Administrative Order to Cover a Dependent:** If you or your spouse are subject to a newly issued court or administrative order to provide health care coverage for a dependent child, you may apply with Rocky Mountain Health Plans to add the dependent child.

Notification and Billing Requirements: All RMHP plans, with the exception of the state mandated Basic and Standard plans, are subject to medical underwriting review. Please submit a Change Form, Health Status Questionnaire, and

Previous Health Insurance Information sections of Application — Business Group of One and the legal documents requiring coverage. If approved, the effective date of coverage will be the first day of the month following approval.

For BG1s enrolled in the state mandated Basic and Standard Plans, can add a dependent child by sending notice within 30 days from the date of the court order. Changes in premium are due the first billing period following the court or administrative order. Please submit a Change Form, Previous Health Insurance Information, and legal documents requiring coverage.

- 3. Addition of a New Spouse:** Medical underwriting is required to add a new spouse to any RMHP BG1 plan except the state mandated Basic and Standard plans. Please submit a Change Form, Health Status Questionnaire, and Previous Health Insurance Information sections from the Application — Business Group of One. If your spouse is age 45 years or older, a copy of his or her medical records is also required. If approved, coverage for your spouse will begin on the first day of the month following approval.

BG1s enrolled in Basic and Standard plans can add coverage for a new spouse by sending notice before the marriage or within 30 days after the marriage. If the request for enrollment is made **prior** to the date of marriage, coverage begins on the date of the marriage. If the request for enrollment is made after the date of marriage, coverage will begin the first day of the month following the date of marriage. Please submit a Change Form and Previous Health Insurance Information.

Billing Requirements: For coverage effective the first day of the month following the marriage or upon underwriting approval, changes in premium shall occur the first billing period after the marriage. For coverage effective on the date of marriage, changes in premium shall occur on ***the first day of the month following the date of marriage if the date of marriage is between the 16th and the last day of the month or the first day of the month preceding the date of marriage if the date of marriage is between the 1st and the 15th of the month.***

- 4. Enrollment of Dependents Age 19 - 25:** A dependent of the subscriber or spouse between the ages of 19 and 25 and not currently enrolled as a covered dependent may apply to enroll in the plan if he/she becomes eligible as a result of newly meeting dependent requirements.

Notification and Billing Requirements: Medical underwriting is required for all RMHP BG1 plans except the state mandated Basic and Standard Plans. Please submit a Change Form, a Health Status Questionnaire, Previous Health Insurance Information sections from the Application — Business Group of One, and a Certification of Dependent Status form. If approved, coverage will begin the first day of the month following approval.

BG1s enrolled in Basic and Standard plans must request coverage within 30 days of the dependent becoming eligible as a result of newly meeting dependent requirements. Please submit a Change Form, Previous Health Insurance Information, and Certification of Dependent Status form (*see Exhibit C*).

Adding a Dependent When Other Coverage Is Lost

Eligible dependents of BG1s may apply for enrollment when loss of coverage occurs under the following conditions:

- The dependent was covered by other creditable coverage under another carrier or RMHP plan at the time of the initial enrollment period and stated on the RMHP Waiver Form that coverage under another plan was the reason for declining enrollment. Medicare, Medicaid, Group, Individual, or other federal or state public health plan coverage qualifies as creditable coverage for meeting this requirement. Enrollment is allowed when there is a loss of coverage on the other health plan for the following reasons:
 - Termination of employment or eligibility
 - Loss of eligibility due to reduction in hours
 - Termination of employer contributions toward such Creditable Coverage

Notification and Billing Requirements: Medical underwriting is required for all RMHP BG1 plans except state mandated Basic and Standard plans. Please submit a Change Form and a Health Status Questionnaire, and Previous Health Insurance Information sections from the Application — Business Group of One. If approved, coverage will begin the first day of the month following approval.

For state mandated Basic and Standard plans, the dependent must request enrollment no later than 30 days after termination of the other prior creditable coverage. Coverage will be effective the first day of the month following the termination date of the other creditable coverage. There cannot be a lapse of coverage. Please submit a Change Form and proof of the prior creditable coverage.

Other Changes

- For changes of name or address, and other information that do not affect the amount due, please submit a completed Change Form so RMHP member records are up to date.
- Primary Care Physician (PCP) changes may be made by contacting RMHP in writing or by telephone or e-mail. A PCP change must be reported to RMHP prior to any visits to the newly selected PCP. Call 970-243-7050 or 800-346-4643, or e-mail customer_service@rmhp.org.

All coverage changes and terminations, if made by the 10th of the month, will normally be reflected in the billing of the first of the month following the month in which we receive the Change Form.

Disenrollment

Notification Requirement: To end coverage for your Business Group of One and all dependents or to drop coverage for a dependent only, Rocky Mountain Health Plans must receive notification **no later than 5:00 p.m. Mountain Time on the first business day of the month of the disenrollment effective date**. Notification received by RMHP later than the first business day of the month following the disenrollment date will result in an extension of coverage for an additional month with the required premium due to Rocky Mountain Health Plans.

To end coverage for your Business Group of One, please notify your RMHP representative by letter.

To end coverage for a dependent only, complete a Change Form. If the dependent being dropped qualifies for self-paid continuation of coverage, you must also complete the Notice of Qualifying Event for Continuation of Coverage. To print the Change Form from our website, click http://www.rmhp.org/pdf/Employer%20Groups/MK158_Change_Form_one_page.pdf

To print the Notice of Qualifying Event for Continuation of Coverage from our website, click http://www.rmhp.org/pdf/Employer%20Groups/Mk210_Notice_of_Qualifying_Event_COBRA_CCOC.pdf

Accepted Methods of Disenrollment Notification:

Fax your disenrollment notification to Rocky Mountain Health Plans at:

970-244-7769

Attn: ENROLLMENT DEPARTMENT

OR

Mail your disenrollment notification by Certified Mail to:

Rocky Mountain Health Plans

Attn: ENROLLMENT DEPARTMENT

PO Box 10600

Grand Junction, CO 81502

Colorado Continuation of Coverage (CCOC)

Rocky Mountain Health Plans will provide administrative support to assist with compliance with some of the provisions of the law to participating employer groups requesting this assistance. There is no charge. Rocky Mountain Health Plans will notify the qualified dependent of his or her right to continue group coverage if the BG1 submits the Notice to RMHP of Qualifying Event for Continuation of Coverage Form.

A brief explanation of the Continuation of Coverage Laws affecting your company is provided in Section Four.

The continuation of coverage period is 18 months following loss of coverage or until the dependent becomes eligible for other group coverage, whichever occurs first.

The BG1 is obligated to notify the dependent of his/her right to continue coverage at the current applicable premium rate. The dependent has 30 days from the date of termination to elect continued coverage, or up to 60 days after termination if the BG1 does not give proper notice.

Conversion

Rocky Mountain Health Plans will notify the qualified dependent of his/her right to a conversion plan following the exhaustion of Colorado Continuation of Coverage. Conversion coverage will also be available to enrollees who are not eligible for Colorado Continuation of Coverage when his/her coverage under the BG1 plan ends.

Conversion is also available to dependents should the BG1 terminate health coverage through RMHP and no other group coverage is obtained.

Should the business sell or discontinue or the owner dies.

If the business is sold or is discontinued, the plan will terminate and the former BG1 and any dependents then on the plan would be eligible for an individual conversion plan but not for CCOC.

Should the business owner die and a covered dependent continue the business, the group plan remains, but a new Group Service Agreement will be required. Should the owner die and the business discontinue or continue under another owner not currently covered under the contract, the group plan will terminate and dependents will be eligible for a conversion plan but not CCOC.

Exhibit A — Application — Business Group of One

Self-employed individuals applying for coverage for themselves and dependents must complete this form.

You will also complete the Medical Questionnaire (page 2) and Previous Health Insurance Information (page 4) sections of this form when you apply to add coverage for dependents who were not enrolled initially, such as your spouse or any children who initially waived coverage or a new spouse.

To print this form from our website, click

http://www.rmhp.org/pdf/Employer%20Groups/MK453_Uniform_Employee_Application.pdf

Exhibit B — Change Form

The Change Form is used to change existing member information. The most important uses of this form are to:

- Add newly eligible dependents
- Change member names and addresses
- Drop a dependent from the coverage

Important information when dropping a dependent:

- RMHP requires notification from the group no later than 5:00 p.m. Mountain Time on the first business day of the month following the disenrollment effective date.
- If the dependent being dropped qualifies for self-paid continuation of coverage, you must also complete the Notice to RMHP of Qualifying Event for Continuation of Coverage. To print it from our website, click http://www.rmhp.org/pdf/Employer%20Groups/Mk210_Notice_of_Qualifying_Event_COBRA_CCOC.pdf

To print a Change Form from our website, click

http://www.rmhp.org/pdf/Employer%20Groups/MK158_Change_Form_one_page.pdf

Exhibit C — Dependent Children Age 19 - 25

Rocky Mountain Health Plans covers eligible dependent children through the end of the calendar month in which the dependent becomes 19 years of age. An eligible dependent child who meets dependent status requirements will be eligible for coverage through the end of the calendar month in which the dependent becomes 25 years of age. Adequate documentation of dependent status must be provided to RMHP.

Each calendar year, RMHP will mail a letter to those subscribers with dependents who are or will shortly be at the age 19 limit, requesting status and dependency. A Certification of Dependent Status form will be included with the letter and must be completed and returned to RMHP. If dependent does not meet the eligibility requirement, coverage for the dependent is terminated and the subscriber is notified.

To print a Certification of Dependent Status form from our website, click

http://www.rmhp.org/pdf/Employer%20Groups/MK531_Certificate_of_Dependent_Status.pdf

Exhibit D — Previous Health Insurance Information (Prior Creditable Coverage)

- For groups with up to 50 employees
- Does not affect the HMO Basic and Standard Health Benefit Plans for Colorado

Previous Health Insurance Information (Prior Creditable Coverage) section of the application form is to be completed by the business owner for himself or herself and dependents to be covered. If dependents waive coverage when the plan comes into effect, they must also complete this section if they apply for coverage later.

RMHP will implement a six-month pre-existing condition limitation period for all new enrollees. This period starts from the enrollment date with RMHP.

If the enrollee has had Prior Creditable Coverage within 90 days from his/her enrollment in RMHP, the pre-existing condition limitation period will be reduced and possibly eliminated. Prior Creditable Coverage includes health care coverage provided under: (a) Medicare or Medicaid; (b) an employee welfare benefit plan or group health insurance or health benefit plan; (c) an individual health benefit plan; or (d) a state health benefits risk pool (including but not limited to the Colorado Uninsurable Health Insurance Plan).

The Previous Health Insurance Information must be submitted to RMHP with the application form or Change Form, along with proof of Prior Creditable Coverage. Proof of Creditable Coverage can include (1) a Certificate of Creditable Coverage (CCC), provided by the prior carrier, or (2) premium billing statements for the past six months. If you or your dependents do not have a CCC, RMHP can assist with obtaining proof as long as the prior coverage information is listed on the form.

To print the Application — Business Group of One from our website, click

http://www.rmhp.org/pdf/Employer%20Groups/MK453_Uniform_Employee_Application.pdf

Section Three

Premium Billing

As a prepaid health plan, RMHP sends premium billings on or about the 15th of the month prior to the month for which coverage is to continue in effect. **Premium payments are due on the 1st of the month for which coverage is effective.** The next page is a sample premium billing statement.

If a new dependent is eligible for coverage but is not listed on the billing statement you received, please pay the "Total Amount Due" regardless of any needed adjustments. RMHP will make the appropriate adjustments on your next billing statement.

Please note some key information:

Account Summary

Group Name, Group Identification Number*, Invoice Number*, Due Date, Coverage Period From and Through Dates, Total Amount Due

*Please include this information with your premium payment to ensure accurate processing.

Account Detail

Benefits, Subscribers, Dependents, and Premium Billing

Miscellaneous Billing Items

Billing representative initiated adjustments

Retroactive Adjustments

Retroactive system adjustments to premium billing

Current Subscriber Details

Subscriber Name, Subscriber Social Security Number, Selected Plan Options, and Premium Billing Amount

Delinquent Premiums

BG1s whose premium payments are not received by the premium due date will be sent a delinquent notice. This letter provides notification that payment must be received by RMHP within 15 days from the date of the letter. All claims for health care services will be suspended until premium is received.

If RMHP does not receive premium payment for the month due within 15 days from the delinquent notice, group health plan coverage will terminate as of the end of that month. The BG1 will continue to be billed for delinquent premiums as well as an additional month's premium and sent to a collection agency if warranted.

A termination letter will be sent to the BG1.

Sample Premium Billing Statement



PO Box 10600, 2775 Crossroads Blvd.,
 Grand Junction, CO 81506-8758
 970-244-7760 or 800-843-0719
 Fax: 970-244-7880

PREMIUM BILLING STATEMENT

Amount Remitted: _____

Billing For: Any Group Subgroup
 2775 Crossroads Blvd
 Grand Junction, CO 81506

Due Date: 07/01/2000
 Billing Date: 06/28/2000
 Coverage Period From: 07/01/2000
 Through: 07/31/2000

Group ID:00001000
 Sub Group ID:0001

Invoice Number:001807817
 Total Due: \$800.14

Please detach and return this portion with your payment in the return envelope. Include Group I.D. on payment.

Please retain this portion for your records.

Group ID:00001000
 Sub Group ID:0001

Invoice Number:001807817

Account Summary

06/27/2000	Previous Total Due	1,600.28	
06/27/2000	Payment	(800.94)	
Outstanding Balance as of 06/28/2000		0.00	
	Current Invoice	800.14	
	Total Due	\$ 800.14	Please Pay This Amount

Message : 1
 TOTAL BALANCE DUE BY 1ST OF THE MONTH

Message : 2
 PLEASE RETURN TOP PORTION OF PAGE 1 WITH YOUR PAYMENT

PAGE: 1
 Form ID: LBL1

F112R00103

Sample Premium Billing Statement



PO Box 10600, 2775 Crossroads Blvd.,
Grand Junction, CO 81506-8758
970-244-7760 or 800-843-0719
Fax: 970-244-7880

Group ID:00001000
Sub Group ID:0001

Invoice Number:001807817

Account Detail

	Subscribers	Dependents	Current	Retro	Net
C1000 C1000 PLAN	2	2	700.00		700.00
DENTAL ALL DENTAL PLANS	2	2	78.50		78.50
RX29 \$10/\$15/\$25 COPAY CO	2	2	0.00		
VISION ALL VISION PLANS	2	2	21.64		21.64
			800.14	0.00	800.14
				0.00	
					\$ 800.14

PAGE: 2
Form ID: LBL1

Section Four

Colorado Continuation of Coverage Law Information

In certain circumstances, Colorado State law requires employers to offer continued coverage for a specified period for dependents who are no longer eligible for coverage.

Rocky Mountain Health Plans (RMHP) will provide administrative support to assist you with compliance of the provisions of the law. There is no charge for this service. The obligation to meet all statutory requirements of CCOC rests with you, the BG1, not RMHP.

This section will help you understand how this law affects you and the ways in which RMHP is prepared to assist you. The following documents are included:

- Colorado Continuation of Coverage Law Procedures
- Summary Description of the Colorado Continuation of Coverage Law
- RMHP Policies Regarding Employers Affected by the Colorado Continuation of Coverage Law
- Notice to RMHP of Qualifying Event for Continuation of Coverage
- Notice of Right to Elect Continuation of Coverage Under Colorado Continuation of Coverage Law
- Colorado Continuation of Coverage Election Form and CoverColorado Plan Notice Form
- Explanation and Sample Form of Certificate of Credible Coverage

If you have any questions about this information, please call your RMHP group representative or consult your legal counsel.

Colorado Continuation of Coverage Law Procedures

The following is an outline of procedures to continue coverage for eligible members under the Colorado Continuation of Coverage Law if an employer has elected to have RMHP assist with the Colorado Continuation of Coverage Law. When an RMHP member becomes eligible for continuation of health care coverage under the Colorado Continuation of Coverage Law, the BG1 should:

- Terminate the member's coverage by submitting a Change Form to RMHP. We must receive the form no later than 5:00 p.m. Mountain Time on the first business day of the month following the disenrollment effective date.
- Submit to RMHP a completed Notice to RMHP of Qualifying Event for Continuation of Coverage form as soon as possible. If member is not eligible for Continuation of Coverage (see Qualifying Events on the next page), then RMHP will in most cases send conversion information.
- Notify the member of his or her rights to continue coverage under the Colorado Continuation of Coverage Law. It is the BG1's responsibility to provide this notification to the extent required by applicable law.
- If RMHP receives a completed Notice to RMHP of Qualifying Event for Continuation of Coverage form for an eligible Colorado Continuation of Coverage member, RMHP's Member Enrollment & Billing Department will send a Colorado Continuation of Coverage Election Form to the eligible member.
- When RMHP receives from the member a completed Colorado Continuation of Coverage Election form and premium payment from the termination date through the end of the current month, the member is reinstated retroactively. All retroactive premiums must be collected and paid to RMHP before coverage can be continued without a lapse.
- Upon completion of this process, the member is reinstated and billed directly for the premium. RMHP will send the BG1 a monthly premium statement billing and a list of persons covered under the Colorado Continuation of Coverage option.

Summary Description of the Colorado Continuation of Coverage Law

What is the Colorado Continuation of Coverage Law?

The Colorado Continuation of Coverage Law addresses continuation of coverage benefits for dependents who would otherwise lose group health insurance coverage.

Employers Affected

The Colorado Continuation of Coverage Law affects all Colorado employers offering group health plan coverage. (Employers with 20 or more employees must comply with the Federal Consolidated Budget Reconciliation Act [COBRA], which requires continuation coverage for qualified individuals.)

Plan Participants Affected

In Business Groups of One, the Colorado Continuation of Coverage Law applies to covered dependents.

Qualifying Events

A Qualifying Event for continued coverage under the Colorado Continuation of Coverage Law occurs if:

- A dependent's eligibility to receive health coverage has ended due to the death or change in marital status of the business owner.

In addition, the following requirements must be met:

- Premiums or contributions required from or on behalf of an dependent must have been paid to the termination of coverage date.

Duration of Coverage

The continuation of coverage period under the Colorado Continuation of Coverage Law extends for 18 months following loss of coverage or until the dependent becomes eligible for other group coverage, whichever occurs first.

Election Period

If the BG1 is independently administering Colorado Continuation of Coverage, the covered dependent has 30 days from the date of termination to elect and pay premium for continued coverage under the Colorado Continuation of Coverage Law if the BG1 properly notifies the dependent of the right to continue coverage. If the BG1 does not properly notify the dependent of his/her right to continue coverage, the dependent shall have 60 days from the date of termination to elect and pay premium for coverage under the Colorado Continuation of Coverage Law.

If RMHP is authorized to assist the BG1 in administering Colorado Continuation of Coverage, the covered dependent has 60 days from the date of termination to elect and pay premium for continued coverage under the Colorado Continuation of Coverage Law if the BG1 properly notifies RMHP of the dependent's right to continue coverage.

Cost

The premium payable by the covered dependent under the Colorado Continuation of Coverage Law equals 100% of the applicable group premium rate.

This is only a brief summary of the Colorado Continuation of Coverage Law. You should read applicable statutes and regulations and/or contact your legal counsel for complete details.

RMHP Policies Regarding BG1s Affected by Colorado Continuation of Coverage Law

BG1 shall notify all covered dependents in writing of their rights to continuation of coverage benefits in accordance with the Colorado Continuation of Coverage Law requirements at the time such dependents first become covered under the group health plan. Such notice shall include the rights and obligations of eligible dependents under the law, including but not limited to:

- The amount the dependent must pay monthly to retain coverage, which payment shall include the BG1's contribution for such dependent in addition to the dependent's own contribution;
- The manner in which and the office of the carrier to which payments must be made;
- The time by which payment must be made to retain coverage; and
- The fact that loss of coverage will result if timely payment is not made.

As required by law, RMHP Health Benefits Contracts provide for continuation of coverage to RMHP group members who become eligible under this law. However, RMHP will not conduct billing, election notification, or other administrative procedures for any BG1 unless the BG1 has requested such assistance from RMHP under the terms contained in this policy statement.

The following are the terms of RMHP providing assistance to BG1s:

- BG1 shall notify RMHP in writing at the time of a dependent's eligibility for continuation of coverage, and in no event later than 10 days after the date of such eligibility. Such written notice from BG1 to RMHP shall be in the format as provided to BG1s by RMHP in the Notice to RMHP of Qualifying Event for Continuation of Coverage and shall include all information requested in such notice.
- BG1 is responsible for the accuracy of all information provided to RMHP, including the accuracy of current addresses, names, and the date of Qualifying Event related to dependent's rights to elect continuation of coverage.
- BG1 agrees to and shall hold RMHP harmless from any costs, expenses, penalties, forfeitures, or any other claims or damages resulting to RMHP as a result of any inaccuracy of information, the failure to give any notice to RMHP regarding a dependent, and from any dispute arising from failure to comply with the provisions of the Colorado Continuation of Coverage Law or the BG1's interpretation or administration of that law. Said indemnity shall include penalties, court costs, and attorney's fees, and any fines imposed under the Colorado Continuation of Coverage law or as otherwise provided by law.
- RMHP shall send a Notice of Right to Elect Continuation of Coverage under Colorado Continuation of Coverage Law to the eligible dependents. Such notice will be sent by RMHP within 14 days of RMHP's receipt of the Notice to RMHP of Qualifying Event for Continuation of Coverage from the employer. (NOTE: Eligible dependents have **30 days** from the date of the Qualifying Event within which to elect continuation of coverage under the Colorado Continuation of Coverage Law.)
- RMHP shall directly bill eligible dependents who elect to continue coverage.
- Failure on the part of the eligible dependent to pay the premium within the payment period established will result in termination of coverage. RMHP will notify the BG1 and the eligible dependent of such termination.
- RMHP shall monitor the length of the continuation of coverage period and shall notify eligible dependents who elect continuation of coverage of their right to a conversion policy upon exhaustion of continuation coverage.



Notice of Right to Elect Colorado Continuation of Coverage

March 23, 2010

«FirstName» «LastName»
«Address1»
«Address2»
«City», «State» «PostalCode»

SAMPLE

Rocky Mountain Health Plans (RMHP) has recently been notified of the termination of your group health plan coverage. This letter is to inform you that under the provisions of the Colorado Continuation of Coverage Law, you have the option to retain your RMHP group health plan for a period of 18 months. If you reside outside the service area at any time during your continuation of coverage period, you will not be eligible for any benefits, including urgent and emergency care. Please see the enclosed Election Form for premium amounts and the effective date of continued coverage.

Continuation of coverage may terminate early if:

- The required premium payment is not paid when due.
- You or your spouse or dependent child(ren), if any, become eligible for coverage under another group health plan that does not contain any exclusion or limitation for any of your pre-existing conditions.
- You or your spouse or dependent child(ren), if any, become covered by Medicare or Medicaid.
- All of the company's group health plans are terminated.

If you become eligible for coverage by another group insurance plan, you may continue RMHP coverage through the 18-month period only if there is a pre-existing condition that is excluded by the other plan. If the new group plan does not exclude a pre-existing condition, the RMHP coverage must be terminated.

Whether or not you choose continuation of coverage, please complete and return the Election Form in the enclosed envelope for our records. If you wish to choose continuation of coverage, the enclosed Election Form must be completed, and payment of the required premium must be made within 60 days from the date of termination of coverage. Thereafter, you will receive a monthly billing.

During the continuation of coverage period, you will be responsible for paying the monthly premiums. The amount payable to RMHP is 100% of the monthly rate charged by RMHP to the employer that previously offered your group coverage. This rate will change if the employer's rates change. If your group plan is "age rated," rates will be based on the age of the subscriber. If the subscriber's birthday results in a change to a new age category, the premium will increase on the first day of the month following that birthday.

RMHP has been pleased to provide you with comprehensive health plan coverage and looks forward to continuing your membership should you so choose. If you have any questions, please contact «BillingRep» in the RMHP Member Enrollment & Billing Department at 970-«PhoneNumber» or 800-843-0719 ext.«Extension».

Continuation coverage is provided subject to your eligibility. RMHP reserves the right to terminate your continuation coverage retroactively if you are determined to be ineligible for coverage. To be sure that you, your spouse, and your dependent child(ren), if any, receive the necessary information concerning your rights, you should keep your employer and RMHP informed of any address changes. This notice is a summary of your continuation coverage rights. For answers to specific questions, please contact RMHP at the telephone number listed above.

You may be eligible for the CoverColorado plan if the CoverColorado premium is less than the continuation of coverage plan premium. Please see the CoverColorado Plan Notice included with this letter.

March 23, 2010

2B

«FirstName» «LastName»
Billing Representative: «BillingRep»

ID#: «AccountNumber»

SAMPLE

Colorado Continuation of Coverage Election Form

Your continuation period is for 18 months and your monthly continuation premium is \$«PremMedDenVisChiro».

To reactivate RMHP coverage effective «EffectiveDate», **please remit premium** for the month(s) of «PremiumMonths», totaling \$«TotalPremiumDue», as soon as possible. Once you have elected coverage, we will bill you monthly. **Please include payment with this form.**

I have read this form and the Notice of Right to Elect Colorado Continuation of Coverage. I understand my rights to elect continuation of coverage and would like to take the action indicated below. I understand that if I elect continuation of coverage and I fail to pay any premium payment on time, this coverage will terminate. I also agree to notify RMHP if I or any member of my family become(s) eligible for coverage under another group health plan or covered by Medicare or Medicaid. **I understand that my continuation of coverage through RMHP is contingent on my previous employer's continued participation with RMHP.**

Please check ONE only:

- I elect to continue family coverage (including__ excluding__ myself) with RMHP. (Only to be checked by those Qualified Beneficiaries who had family coverage before the Qualifying Event.)

List dependents to be covered:

Names	Relationship	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____

- I elect to continue single coverage with RMHP.

Name	Relationship (if dependent or spouse)	Date of Birth
_____	_____	_____

- I have read this form and the Notice to Elect Colorado Continuation of Coverage. I am waiving my right to continuation of coverage under the plan.

Signed: _____ Date: _____

Name (please print): _____

Anniversary Date: «AnniversaryMonth»
(Rate change may occur on the first of this month.)

Social Security Number: _____

Date of Birth: _____

ADDRESS CORRECTION REQUESTED:

Current Address: _____

City, State, Zip: _____

Telephone: _____

IF PREMIUM PAYMENT IS NOT RECEIVED ON TIME, COVERAGE WILL TERMINATE AND MAY NOT BE REINSTATED

Certificate of Creditable Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes nationwide standards on all group health plans. National HIPAA rules generally apply to all employer plans covering two or more employees, but Colorado laws apply HIPAA requirements to Business Groups of One.

One of the many requirements of HIPAA involves providing a Certificate of Creditable Coverage (CCC) to anyone losing coverage under a group health plan. The certificate is used by individuals who lose such group coverage to obtain "credit" toward any pre-existing limitation of group plans and to obtain individual plan coverage.

The law and regulations describe three events that will trigger CCCs. A CCC must be provided when any of the following occurs:

- Automatically upon a loss of coverage, for any reason, under a plan (including due to a COBRA or Colorado Continuation of Coverage (CCOC) Qualifying Event).
- Automatically upon the loss or exhaustion of COBRA or CCOC.
- At any time upon an individual's request within 24 months after coverage under the plan ends.

Rocky Mountain Health Plans will assist BG1s in meeting their HIPAA and Colorado law requirements by issuing CCCs for all plans. There is no charge to BG1s for this assistance. Under HIPAA rules, BG1s are not required to issue duplicate certificates if another entity provides them to dependents.

However, in order for RMHP to meet the requirements established by HIPAA, it is imperative that each BG1 provides timely and accurate termination information on all dependents to RMHP.

Upon receipt of termination information from the BG1, RMHP will generate a Certificate of Creditable Coverage, providing the information required by HIPAA and Colorado law. A copy of a sample certificate is on the next page.

«DATE»

SAMPLE

«SUBNAME»

«ADDR1»

«ADDR2»

«ADDR3»

***IMPORTANT* – KEEP THIS CERTIFICATE as a permanent record. You may need it to obtain future coverage.**

Certificate of Group Health Plan Coverage

Employer Name: «GROUPNAME»

Name Identification Number Waiting Period Coverage Period

«SUBHDR»

«MEM1»

«DEPHDR»

«MEM2»

«MEM3»

«MEM4»

«MEM5»

«MEM6»

«MEM7»

«MEM8»

«MEM9»

STATEMENT OF HIPAA PORTABILITY RIGHTS

This certificate is evidence of your coverage under this plan. Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems.

Preexisting condition exclusions. Some group health plans restrict coverage for medical conditions that existed before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." Preexisting condition exclusions can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months (or 12 months for Business Groups of One) before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, preexisting condition exclusions cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage; COBRA continuation coverage; coverage under an individual health policy, Medicare, Medicaid, or State Children's Health Insurance Program (SCHIP); and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 90 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 90-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in another plan.

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to individual health coverage. Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 90 days or more;
- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status as a result of a 90-day break.

State flexibility. This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For more information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) at 866-444-3272 (for free HIPAA publications ask for publications concerning changes in your health care laws). You may also contact the Centers for Medicare & Medicaid Services (CMS) publication hotline at 800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at <http://www.dol.gov/ebsa>; the DOL's interactive web pages, Health Elaws; or <http://www.cms.hhs.gov/hipaa1>

For further information, please call 970-244-7760 or 800-843-0719