

Colorado Health Benefit Plan Description Form

Rocky Mountain HMO

HMO Standard Health Benefit Plan for Colorado

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Health Maintenance Organization (HMO)
2. OUT-OF-NETWORK CARE COVERED?¹	Only for emergency and urgent care.
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado except in the following areas: Gunnison County and Baca County

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 ONLY (out of network care is not covered except as noted)
4. Deductible Type²	Calendar Year
4. ANNUAL DEDUCTIBLE^{2a} a) Individual ^{2b} b) Family ^{2c}	a) \$500 b) \$1,500 aggregate - Deductibles shall be applied to satisfy the out-of-pocket maximum. - Deductible must be satisfied before services will be covered, except as noted.
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 annual out-of-pocket maximum, unless otherwise noted. 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	Rocky Mountain HMO Network, Life Strategies (behavioral health network). See participating provider directory for a complete list of current providers.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes
8. MEDICAL OFFICE VISITS⁴ a) Primary Care Providers b) Specialists	a) \$30 per visit copayment, not subject to deductible b) \$50 per visit copayment, not subject to deductible

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<p>9. PREVENTIVE CARE <u>Preventive Services recommended by the U.S. Preventive Services Task Force, including:</u></p> <p>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>10. MATERNITY a) Prenatal care b) Delivery & inpatient well baby care⁵</p>	<p>a) Benefit level determined by type of service b) \$500 per day copayment up to \$2,000 per admission, no copayment thereafter, not subject to deductible</p>
<p>11. PRESCRIPTION DRUGS⁶ Level of coverage and restrictions on prescriptions</p> <p>a) Inpatient prescription drugs and injectables b) Outpatient prescription drugs and Insulin (including injectables, disposable and diabetic supplies and medical foods) 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) <u>Retail pharmacy:</u> Generic (Tier 1): \$15 copay per prescription for a 31-day supply Preferred (Tier 2): \$40 copay per prescription for a 31-day supply Non-Preferred (Tiers 3, 4 & 5): \$60 copay per prescription for a 31-day supply</p> <p><u>Mail order pharmacy:</u> Generic (Tier 1): \$37.50 copay per prescription for a 90-day supply Preferred (Tier 2): \$100 copay per prescription for a 90-day supply Non-Preferred (Tiers 3, 4): \$150 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>12. INPATIENT HOSPITAL</p>	<p>\$500 per day copayment up to \$2,000 per admission, no copayment thereafter, not subject to deductible</p>
<p>13. OUTPATIENT/AMBULATORY SURGERY</p>	<p>\$250 per visit copayment for outpatient surgery and invasive diagnostic tests, not subject to deductible</p>

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14. DIAGNOSTICS a) Laboratory & x-ray b) MRI, nuclear medicine, CT, CTA, MRA and PET scans	a) No copayment (100% covered) after deductible b) 20% copayment after deductible
15. EMERGENCY CARE^{7, 8}	\$150 per visit copayment, not subject to deductible, for emergency room for in- and out-of-network emergency care (waived if admitted as an inpatient)
16. AMBULANCE	20% copayment after deductible
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	\$75 per visit copayment, not subject to deductible. Out-of-network urgent care covered only if traveling or temporarily absent from the service area.
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE⁹	Coverage is no less extensive than the coverage provided for any other physical illness. Coverage is not duplicative of other mental health care.
19. OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	a) 20% copayment after deductible. Maximum Benefit Level: 45 days or 90 partial days per member per calendar year b) \$50 per visit copayment, not subject to deductible. Maximum Benefit Level: 20 visits per member per calendar year.
20. ALCOHOL & SUBSTANCE ABUSE <u>Rehabilitation:</u> a) Inpatient care b) Outpatient care <u>Detoxification:</u> c) Inpatient care d) Outpatient care	a) Not covered b) Not covered c) 50% copayment after deductible – limited to removal of toxic substances from the body. d) 50% copayment after deductible– limited to the removal of the toxic substances from the body.
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY a) Inpatient care b) Outpatient care	a) Included in inpatient hospital copayment. b) \$30 per visit copayment, not subject to deductible. Maximum Benefit Level: 20 visits per therapy per member per calendar year.
22. DURABLE MEDICAL EQUIPMENT a) Durable Medical Equipment (DME) and repairs b) Prosthetic devices (including arm and leg prostheses)	a) and b) 20% copayment after deductible
23. OXYGEN	20% copayment after deductible
24. ORGAN TRANSPLANTS a) Inpatient care b) Outpatient care	a) \$500 per day copayment up to \$2,000 per admission, no copayment thereafter, not subject to deductible b) \$250 per visit copayment, not subject to deductible
25. HOME HEALTH CARE	20% copayment after deductible
26. HOSPICE CARE	20% copayment after deductible. Maximum Benefit Level: Respite care is limited to periods of 5 days or less.
27. SKILLED NURSING FACILITY CARE	20% per day copayment after deductible. Maximum Benefit Level: 100 days per member per calendar year.
28. DENTAL CARE	Routine: Not covered. Non-Routine: Applicable copay for the type of service for repair of sound and natural teeth due to accidental injury.
29. VISION CARE	Annual Routine Vision Screening: Not covered Non Routine: Applicable copay for the type of service for treatment due to injury or disease of the eye.
30. CHIROPRACTIC CARE	Not covered

	IN-NETWORK ONLY (out of network care is not covered except as noted)
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	<p>1) <u>Spinal manipulation</u>: \$30 per visit copayment, not subject to deductible.</p> <p>2) <u>Hearing Aids (for members up to 18 years of age)</u>: Benefit level determined by place of service.</p> <p>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.</p>

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED. ¹⁰	Not applicable. Plan does not exclude coverage for pre-existing conditions.
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No.
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	Not applicable. Plan does not exclude coverage for pre-existing conditions.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	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.

PART D: USING THE PLAN

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

	IN-NETWORK
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.	Policy Form <u>HMO STD Group Plan</u> - Group - all sizes
43. Does the plan have a binding arbitration clause?	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.