



ROCKY MOUNTAIN
HEALTH PLANS®
Good health. That's the plan.

November 2008

Dear Valued Employer:

Thank you for your continued good health partnership with Rocky Mountain Health Plans (RMHP). The amendment for your Health Benefits Contract is enclosed. It is effective January 1, 2009, and describes changes resulting from recent legislation and other regulatory reasons. The deductible, coinsurance, limitations and exclusions of your current health care plan have not changed.

Changes to the Health Benefits Contract

- The Health Benefits Contract will now be called the Evidence of Coverage.
- Coverage for hearing screening and hearing aids for children is added.
- The eligibility criteria for the right to enroll outside of the open enrollment period in certain circumstances is updated.
- The Dispute Resolution Procedures were rewritten for consistency. There are not substantive changes to the procedures.

Please read the enclosed amendment carefully and keep it with your Evidence of Coverage, since it becomes part of the Contract. If you have a plan change on renewal, you will receive a new Evidence of Coverage and may disregard this amendment.

If you have any questions, please contact your RMHP Account Manager or the Group Management Team at 800-453-2981, option 1.

Sincerely,

Director, Sales Administration

ROCKY MOUNTAIN HEALTH PLANS
HEALTH BENEFITS CONTRACT
Underwritten by Rocky Mountain HealthCare Options, Inc.

AMENDMENT TO HEALTH BENEFITS CONTRACT

THIS AMENDMENT TO ROCKY MOUNTAIN HEALTH BENEFITS CONTRACT (Amendment) amends the Rocky Mountain HealthCare Options, Inc. Health Benefits Contract (Contract) as provided in this Amendment. This Amendment is effective January 1, 2009. All terms defined in the Contract shall have the same meaning when used in this Amendment.

I. HEALTH BENEFITS CONTRACT

The Health Benefits Contract is amended as follows:

1. In the Rocky Mountain Choice PPO, Rocky Mountain Chamber PPO, Rocky Mountain Good Health Savings PPO and the PPO Health Benefits Contracts, the subparagraph titled "Hearing Care" within subparagraph 2.B, the "Schedule of Health Care Services," is amended to provide as follows:

Hearing Care

Coverage is provided for audio testing and treatment due to Injury or Sickness.

For Members under age eighteen, coverage is provided for: (1) services and supplies including the initial assessment, fitting of hearing aids, adjustments and auditory training provided according to accepted professional standards; (2) initial hearing aids and replacement hearing aids not more frequently than every five years; and (3) a new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the Member.

2. In the Rocky Mountain Core Plus Hospital PPO Health Benefits Contract, the subparagraph titled "Hearing Care" within subparagraph 2.B, the "Schedule of Health Care Services," is amended to provide as follows:

Hearing Care

Coverage is provided for audio testing and treatment due to Injury or Sickness.

For Members under age eighteen, coverage is provided for: (1) services and supplies including the initial assessment, fitting of hearing aids, adjustments and auditory training provided according to accepted professional standards; (2) initial hearing aids and replacement hearing aids not more frequently than every five years; and (3) a new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the Member.

X *The following are not covered:*

- *Hearing exams not due to or associated with an Injury or Sickness.*
- *Hearing aids and devices, including bone anchored hearing aids and auditory osseointegrated devices or implants, and the fitting thereof, for Members age eighteen and older.*
- *Cochlear implants.*

3. In the Rocky Mountain Good Health PPO and Rocky Mountain Good Health PPO HSA Health Benefits Contracts, the subparagraph titled “Hearing Care” within subparagraph 2.B, the “Schedule of Health Care Services,” is amended to provide as follows:

Hearing Care

Coverage is provided for audio testing and treatment due to Injury or Sickness.

For Members under age eighteen, coverage is provided for: (1) services and supplies including the initial assessment, fitting of hearing aids, adjustments and auditory training provided according to accepted professional standards; (2) initial hearing aids and replacement hearing aids not more frequently than every five years; and (3) a new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the Member.

✘ *The following are not covered:*

- *Hearing exams not due to or associated with an Injury or Sickness.*
- *Hearing aids and devices, including bone anchored hearing aids and auditory osseointegrated devices or implants, and the fitting thereof, for Members age eighteen and older.*
- *Cochlear implants for Members over age 12.*

4. The subparagraph titled either “Medical Foods,” “Inherited Enzymatic Disorders” or “Nutrition” (whichever is present) within subparagraph 2.B, the “Schedule of Health Care Services,” is amended by addition of the following new subparagraph:

Total Parenteral Nutrition – Outpatient: Outpatient total parenteral (intravenous) nutrition is covered when received in a Member’s home if the Member cannot maintain weight and strength matching the Member’s normal healthy physical condition because of a medical condition of the digestive tract which does not allow absorption of sufficient nutrients or if the Member is unable to swallow food.

— **Limitation:** *See the Coverage Schedule for any Maximum Benefit Level applicable to this Health Care Service.*

5. The specific exclusion within subparagraph 2.C(3) currently stating “hearing aids and the fitting of hearing aids” is amended to provide as follows:

Hearing aids and devices, including bone anchored hearing aids and auditory osseointegrated devices or implants, and the fitting thereof, for Members age eighteen and older.

6. If not already present, subparagraph 4.B, titled “Report Out of Service Area Medical Emergencies and Out of Service Area Urgent Care Services,” is amended by addition of the following sentence at the end of the paragraph:

Reasonable exceptions to this time limit are permitted when documentation of incapacitation is provided to RMHCO.

7. Paragraph 6, titled “Eligibility,” is amended by addition of the following new subparagraph 6.H:

Request for Certificate of Creditable Coverage

A Member may request a certificate of Creditable Coverage at any time by calling a RMHCO customer service representative at 970-243-7050 or 800-346-4643.

8. Subparagraph 7.B(3)(a), within subparagraph 7.B, titled “Other Dependents Except Late Enrollees,” is replaced with the following:

(3) Eligible Employees and Other Dependents Except Late Enrollees: Eligible Employees and other Dependents who are not Late Enrollees may enroll as Members after the initial enrollment period, provided that any such person meets the General Eligibility Requirements of subparagraph 6.A and:

(a) The Eligible Employee or Dependent:

(i) was covered under other Creditable Coverage at the time of the initial enrollment period and, if required by RMHCO, stated at the time of such initial enrollment period that this was the reason for declining enrollment;

(ii) lost coverage under the other Creditable Coverage as a result of:

- loss of eligibility for the Creditable Coverage, including as a result of legal separation, divorce, death, termination or reduction in the number of hours of employment (voluntary or involuntary, with or without election of COBRA coverage), cessation of dependent status (such as by attaining the maximum age to be a dependent child) or by moving out of the other Creditable Coverage’s service area; or
- involuntary termination of the Creditable Coverage; or
- termination of employer contributions toward the Creditable Coverage; or
- exhaustion of COBRA coverage; or
- incurring a claim that meets or exceeds a lifetime limit on all benefits under the coverage; and

(iii) the Subscriber or Eligible Employee requests enrollment within thirty (30) days after termination of the other Creditable Coverage, or in the event of meeting or exceeding a lifetime limit under the other Creditable Coverage, within

thirty (30) days after a claim is denied due to the operation of the lifetime limit on all benefits.

(b) A court has ordered that coverage be provided for the Dependent under this Contract and the request for enrollment is made within thirty (30) days after issuance of such court order;

(c) The Dependent is a Dependent Child nineteen (19) years of age or older and the request for enrollment of the Dependent Child is made within thirty (30) days after becoming eligible to enroll; otherwise, the Dependent Child must enroll as a Late Enrollee (the Eligible Employee must have previously enrolled as the Subscriber for this provision to apply);

(d) A person becomes a Dependent through marriage, birth, adoption or placement for adoption and enrollment is requested no later than thirty (30) days after the person becomes a Dependent; or

(e) A parent or legal guardian of the Dependent has disenrolled the Dependent from CHP+, and requests enrollment of the Dependent no later than 90 days after the disenrollment.

The Eligible Employee must enroll or have previously enrolled for any Dependent to enroll under this provision. The effective date of coverage when a person becomes a Dependent through birth, adoption or placement for adoption shall be the date the person becomes a Dependent. In all other cases, the effective date of coverage shall be no later than the first day of the month following the request for enrollment.

9. Paragraph 10, titled either “Mandatory Complaint Procedures” or “Dispute Resolution Procedures,” is deleted and replaced with the following:

DISPUTE RESOLUTION PROCEDURES

We want You to be satisfied with the care You receive and the services We provide. We offer You several different ways to bring to Our attention any questions, concerns or complaints that You may have. We describe each of these different procedures below.

If You need help with the dispute resolution procedures, You may name a “Designated Representative.” A Designated Representative is someone You choose to represent You with respect to the dispute resolution procedures of this Contract. You must notify Us in writing if You have named a Designated Representative. If a health care professional with knowledge of Your medical condition has submitted an expedited review request to which We apply expedited review timelines, We will assume that such health care professional acts as Your Designated Representative.

For purposes of this paragraph 10, the definitions of the terms “You,” “Your” and “Member” will include you (the Member) or a Designated

Representative chosen by you to act on your behalf. For purposes of this paragraph 10, the definitions of the terms “We,” “Our,” “Us” or “Rocky Mountain” shall refer to RMHCO.

A. Informal Resolution Procedure

If You have questions or concerns, You may call the Rocky Mountain customer service department and discuss Your questions or concerns with one of our representatives. You may also express Your questions or concerns in writing and mail, deliver or fax them to Rocky Mountain. We strive to resolve Your concerns through the informal process when You contact Us. If Our customer service department does not resolve Your questions or concerns, You must follow the dispute resolution procedures below.

B. Review Procedure

The review procedure includes:

- a First Level Review process;
- an optional Second Level Review, and
- an optional external review process that is only available in certain circumstances, as described in this Contract.

There are two types of reviews which apply to the First Level and optional external review procedures listed above: (1) a standard review, and (2) an expedited review. You can request that Your appeal be considered under expedited review timelines if the standard review timelines would:

- seriously jeopardize Your life or health;
- jeopardize Your ability to regain maximum function; or
- if You have a disability, would create an imminent and substantial limitation of Your existing ability to live independently.

You can also request that Your appeal be expedited if You have received emergency services and have not been discharged from a facility. An expedited review request will result in an “Expedited Decision.” A Rocky Mountain Medical Director will make the determination whether to accept Your expedited review request or to apply the standard review timeline. If Rocky Mountain decides to apply the standard review timeline, You will be notified of the decision within seventy-two (72) hours after Your request for expedited review is received. An Expedited Decision will be made within seventy-two (72) hours after the request is received (with written confirmation within three (3) working days if the initial notification of the Expedited Decision is made by telephone).

The review procedures are as follows:

(1) **Filing a Complaint:** If You:

- disagree with a decision made by Rocky Mountain and desire to appeal the decision; or
- claim that Rocky Mountain is responsible for the adequacy or competency of Health Care Services provided to You, and You claim You were harmed when those Health Care Services were provided; or
- claim that Rocky Mountain failed to provide services or failed to perform duties owed to You,

You must use the review procedures described below. Complaints regarding the privacy of Your medical and insurance information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) are governed by a separate procedure described below. Complaints regarding the quality of care You receive are also governed by a separate procedure described below.

To start the review procedures, You must submit a claim in *writing* by mail, hand delivery, e-mail or facsimile to:

Rocky Mountain Health Plans
Attention: Member Appeals
2775 Crossroads Boulevard
Post Office Box 60007
Grand Junction, Colorado 81506
Fax: (970) 244-7828
email: customer_service@rmhp.org

With respect to a request for an expedited review, a complaint may be submitted by telephone to 970-243-7050 in Mesa County or 800-346-4643 toll-free.

We must receive Your complaint within one hundred eighty (180) days of the first of the following to occur:

- the date of notice to You of the Rocky Mountain decision;
- the denial of Benefits, or failure to provide services or perform duties owed to You; or
- the date on which You have knowledge, or with reasonable diligence should have had knowledge, of the event giving rise to Your claim regarding adequacy or competency of Health Care Services.

(2) **First Level Review (Mandatory):** Your First Level Review complaint will be reviewed and the decision made by someone not involved in the initial decision. If Your complaint involves a decision regarding:

- whether a treatment or service is Medically Necessary;
- whether a treatment or service is experimental or investigational, or
- whether there is a reasonable medical basis that a contractual exclusion does not apply to a requested treatment or service,

a health care professional will make the decision after consulting with an appropriate clinical peer (or peers) in the same or similar specialty as would typically manage Your case. You must present evidence from a medical professional to support a claim that there is a reasonable medical basis that a contractual exclusion does not apply to a requested treatment or service.

Rocky Mountain will issue a written decision to You on standard review decisions within thirty (30) days of receiving Your request for the First Level Review, unless expedited review timelines apply.

The decision will be final and binding on You and Rocky Mountain unless:

- We receive a timely request for a Second Level Review;
- We receive a timely request for an independent external review (if such request is available to You);
- We receive a timely request for arbitration (if the Employee Retirement Income Security Act of 1974, known as ERISA, does not apply to Your claim for Benefits); or
- You timely assert a claim in court under section 502(a) of ERISA.

- (3) **Second Level Review (Voluntary):** If You disagree with the First Level Review decision, You may request a Second Level Review. Second Level Review is voluntary on Your part.

If You wish to request a Second Level Review, You must submit the request in writing by mail, hand delivery, e-mail or facsimile to Rocky Mountain at the addresses stated above within thirty (30) days of the date Rocky Mountain gives You notice of the First Level Review decision.

The Second Level Review will be conducted by an internal review committee (the “Member Appeals Committee”) of at least three (3) people within sixty (60) days after Rocky Mountain receives a request for a Second Level Review. You will be notified in writing at least twenty (20) days in advance of the Second Level Review hearing. Rocky Mountain will not unreasonably deny Your request for postponement of such hearing. Anyone involved in the First Level Review decision or initial decision can provide information to the Member Appeals Committee but may not vote as part of the Member Appeals Committee. For review of decisions involving:

- whether a treatment or service is Medically Necessary;

- whether a treatment or service is experimental or investigational; or
- whether there is a reasonable medical basis that a contractual exclusion does not apply to a requested treatment or service,

the Member Appeals Committee will be comprised of health care professionals with appropriate expertise in relation to the appeal. No Member Appeals Committee member will have a direct financial interest in the appeal or its outcome.

You and Your counsel, advocates, health care professionals and other witnesses may attend the Second Level Review hearing in person or by telephone or by using other communications technology, if such technology is available and not unduly costly for Rocky Mountain to use. At the Second Level Review hearing, You and Rocky Mountain will:

- have the opportunity to bring counsel, advocates and health care professionals to the hearing;
- have the opportunity to present materials for consideration. You and Rocky Mountain must provide a copy of the materials intended to be presented at the hearing at least five (5) days prior to the hearing. If new information is developed after the five (5) days advance deadline, such material may be presented at the hearing if feasible; and
- have the opportunity to make an audio or visual recording of the Second Level Review hearing. If a recording is made, You may have a copy, and a copy will be provided to any independent external review entity to which You choose to appeal the Second Level Review decision, if independent external review is available to You.

The Member Appeals Committee will issue a written decision to You within seven (7) days of completing the Second Level Review hearing, and provide notice of the decision to any health care providers You previously designated.

The Second Level Review decision will be final and binding on You and Rocky Mountain unless:

- We receive a timely request for an independent external review (if such review is available to You); or
- We receive a timely request for arbitration (if ERISA does not apply to Your claim for Benefits); or
- You timely assert a claim in court under section 502(a) of ERISA.

(4) **Independent External Review Process (Optional):** You may, but are not required to, submit the First Level Review decision or the Second Level Review decision concerning:

- whether a treatment or service is Medically Necessary;

- whether a treatment or service is experimental or investigational; or
- whether there is a reasonable medical basis that a contractual exclusion does not apply to a requested treatment or service,

to an independent external review (“IER”) entity. However, complaints or appeals that do not involve these types of decisions may not be submitted to an IER entity. If You choose to appeal a First Level Review decision to an IER entity, You are not entitled to a Second Level Review decision.

The IER will be conducted by an IER entity certified by the Colorado Division of Insurance. The IER will be conducted in accordance with applicable Colorado law.

You or a provider acting on Your behalf must submit a request for a standard or an expedited IER in writing by mail, hand delivery, e-mail or facsimile to Rocky Mountain at the address stated above within sixty (60) days of the date You receive notice of the First Level Review decision or Second Level Review decision. If You are requesting an expedited IER, Your request must be accompanied by a certification from a Physician that Your circumstances meet the criteria for an expedited review, as set forth above.

Rocky Mountain will pay the cost of the IER. The decision of the IER entity will be final and binding upon You and Rocky Mountain unless:

- either You or Rocky Mountain appeal the decision by timely submitting the decision to arbitration (if ERISA does not apply to Your claim for Benefits); or
- You timely assert a claim in court under section 502(a) of ERISA.

C. Arbitration

- (1) You may submit a First Level Review decision, a Second Level Review decision or the decision of the IER entity, except for claims under section 502(a) of ERISA, to arbitration by requesting arbitration within thirty (30) days of the decision being submitted to arbitration. Rocky Mountain may submit a decision of the IER entity to arbitration by requesting arbitration within thirty (30) days of the decision being submitted to arbitration. You or Rocky Mountain must request the arbitration by personal service of a demand for arbitration on the other party within such thirty (30) day period or by giving notice of the demand for arbitration to the other party in accordance with subparagraph 16.B, within such thirty (30) day period, provided that any mailing of the demand for arbitration is made by certified mail, return receipt requested.

If You request arbitration of a First Level Review decision, You may not request a Second Level Review decision. Except for claims brought under section 502(a) of ERISA, any claims that You may assert against Rocky

Mountain are subject to arbitration under this Contract. Any arbitration under this Contract will be governed by the Colorado Uniform Arbitration Act, section 13-22-201, et seq., C.R.S., except as otherwise stated in this paragraph 10. Consolidation of arbitration proceedings and/or class action arbitrations are not be permitted under this Contract.

- (2) The arbitration will be decided by an arbitrator or arbitrators selected as follows:
 - (a) If the amount at issue in the arbitration is less than One Hundred Thousand Dollars (\$100,000.00), as determined by Rocky Mountain, the arbitration will be before a neutral arbitrator who will be selected by agreement of You and Rocky Mountain. If You and Rocky Mountain are unable to agree to a neutral arbitrator, the neutral arbitrator will be selected in accordance with the Colorado Uniform Arbitration Act.
 - (b) If the amount at issue in the arbitration is One Hundred Thousand Dollars (\$100,000.00) or more, as determined by Rocky Mountain, the arbitration will be held before three (3) arbitrators. One arbitrator will be selected by Rocky Mountain, one arbitrator will be selected by You, and the third arbitrator will be a neutral arbitrator selected by the first two arbitrators chosen. If the two arbitrators are unable to agree to a third neutral arbitrator, the third neutral arbitrator will be selected in accordance with the Colorado Uniform Arbitration Act.
 - (c) The arbitrator or arbitrators will be referred to as the Arbitration Panel.
- (3) You and Rocky Mountain must make disclosures as set forth in Colorado Rule of Civil Procedure (C.R.C.P.) 26(a)(1) within ten (10) days after a date is selected for the arbitration hearing. You and Rocky Mountain must also disclose to each other expert testimony as set forth in C.R.C.P. 26(a)(2)(A) and 26(a)(2)(B) at least ten (10) days prior to the date of the arbitration hearing.
- (4) The arbitration will be conducted in Mesa County, Colorado, or in the county where You reside, if You reside in Colorado. If the parties are unable to agree on venue, the Arbitration Panel will decide whether the arbitration will be held in Mesa County or in the county where You reside in Colorado. If You reside outside of Colorado, venue for the arbitration will be in Mesa County, Colorado.
- (5) The Arbitration Panel will follow Colorado law in making an award. The Arbitration Panel will issue written findings of fact and conclusions of law. The Arbitration Panel's fees and expenses will be paid by Rocky Mountain. You will be responsible for Your expenses, including, but not limited to, travel, food, lodging and other expenses for You and the fees and expenses for Your attorney and witnesses, if any, unless, under Colorado law, the claim

or claims in arbitration allow for an award of attorneys' fees and costs, in which case the Arbitration Panel may award attorneys' fees and costs consistent with such law.

The decision or award of the Arbitration Panel will be final and binding upon the parties to the same extent as if the matter had been decided by a court of competent jurisdiction, except as provided in subparagraph 10.D. The party in whose favor any award will be made may file the award with the Clerk of the Mesa County, Colorado District Court or the clerk of the district court in the county in which the arbitration is held, which may enter judgment. If the award requires the payment of money, the clerk may issue execution on the judgment.

D. De Novo Review

After You have exhausted Your remedies under this Contract, through and including arbitration, You are entitled to have a claim for Benefits (other than a claim governed by ERISA, which is subject to paragraph 10.E) reviewed de novo by any court with jurisdiction. In addition, You are entitled to a trial by jury with respect to such review. However, any other claims subject to this paragraph 10 are not subject to de novo review or trial by jury.

E. ERISA Claims

Claims under section 502(a) of ERISA are not subject to arbitration, if ERISA applies to Your claim for Benefits. However, You must arbitrate any other claims against Us that are not claims under section 502(a) of ERISA. Please see paragraph 15 of this Contract for a description of ERISA.

F. Jurisdiction and Venue

No court shall have subject matter jurisdiction of any disagreement or dispute referred to in this paragraph 10, including, but not limited to, any disagreements, disputes or claims that are or may be the subject of a class action, other than as expressly provided in this paragraph 10. The dispute resolution procedures are the exclusive and mandatory dispute resolution procedures under this Contract for disagreements and disputes subject to this paragraph 10. In the event any disagreement or dispute referred to in this paragraph 10, other than de novo review as provided in subparagraph 10.D, is attempted to be resolved in any court by either party, the venue of the matter shall only be in Mesa County, Colorado. This paragraph 10 shall not apply to claims by Rocky Mountain for amounts You may owe to Rocky Mountain.

G. Time is of the Essence

All time periods to take or request action provided or required under this paragraph 10 will be strictly construed and will be of the essence of this Contract.

H. Referral to Insurance Commissioner

You have the right to contact the Colorado Division of Insurance regarding any complaint, controversy, dispute or disagreement at any time at the following address or phone number:

Colorado Division of Insurance
Department of Regulatory Affairs
1560 Broadway, Suite 850
Denver, CO 80202
1-800-930-3745

I. HIPAA Privacy Complaints

If You have a complaint governed by Rocky Mountain's HIPAA Notice of Privacy Practices, You must follow the procedures described in the Notice and as described below in this subparagraph. If You desire to file an expression of dissatisfaction concerning Rocky Mountain's or any Participating Provider's privacy practices under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (a "HIPAA Complaint"), You must submit the HIPAA Complaint in writing, by mail, delivery or facsimile to:

Rocky Mountain Health Plans
Attention: Privacy – HIPAA
2775 Crossroads Boulevard
Post Office Box 10600
Grand Junction, Colorado 81502-5600
Fax: 970-244-7880

Rocky Mountain will investigate the HIPAA Complaint and respond in writing to You within thirty (30) calendar days of Rocky Mountain's date of receipt. You will not be entitled to any further review of HIPAA Complaints after We make our written response to You. You may make a HIPAA Complaint to the Office of Civil Rights of the United States Department of Health and Human Services at any time.

J. Quality of Care Concerns

If You express concern to Rocky Mountain about the quality of care Your providers render, Our Quality Improvement Department may investigate Your concern. The matter may be referred to a medical practice review committee. The records of such committee are confidential under Colorado law.

K. Release of Records

By submitting a complaint, You authorize Rocky Mountain to obtain and review all necessary medical records and similar documents and information related to the complaint, and to release the medical records, documents and information to the Member Appeals Committee and to the IER entity.

L. Changes to the Dispute Resolution Procedures

Rocky Mountain reserves the right to modify the dispute resolution procedures at any time by amending this Contract in accordance with the terms of this Contract.

10. The following sentence is added at the end of the second unnumbered subparagraph of paragraph 15, titled "ERISA":

The preceding sentence does not reserve discretion to RMHCO as a Group Benefit Plan administrator or claim administrator to interpret the terms of this Contract or to determine eligibility for Benefits to the extent this discretion is prohibited by Colorado law that is not preempted by ERISA.

11. The definition of "Late Enrollee" within subparagraph 17.A, titled "Definitions," is amended to provide as follows:

"Late Enrollee" means an Eligible Employee or Dependent who requests enrollment under this Contract following the initial enrollment period for which such individual is entitled to enroll under the terms of an Employer Entity Health Care Plan, if such initial enrollment period is a period of at least thirty (30) days. An Eligible Employee or Dependent shall not be considered a Late Enrollee if:

(a) The individual:

- was covered under other Creditable Coverage at the time of the initial enrollment period and, if required by RMHCO, stated at the time of such initial enrollment period that this was the reason for declining enrollment;
- lost coverage under the other Creditable Coverage as a result of:
 - loss of eligibility for the Creditable Coverage, including as a result of legal separation, divorce, death, termination or reduction in the number of hours of employment (voluntary or involuntary, with or without election of COBRA coverage), cessation of dependent status (such as by attaining the maximum age to be a dependent child) or by moving out of the other Creditable Coverage's service area; or
 - involuntary termination of the Creditable Coverage; or
 - termination of employer contributions toward the Creditable Coverage; or
 - exhaustion of COBRA coverage; or

- incurring a claim that meets or exceeds a lifetime limit on all benefits under the coverage; and
 - The Subscriber or Eligible Employee requests enrollment within thirty (30) days after termination of the other Creditable Coverage, or in the event of meeting or exceeding a lifetime limit under the other Creditable Coverage, within thirty (30) days after a claim is denied due to the operation of the lifetime limit on all benefits;
- (b) The Eligible Employee is employed by an employer that offers multiple health benefit plans and elects a different plan during the Annual Open Enrollment Period;
- (c) A court has ordered that coverage be provided for the Dependent under the Eligible Employee’s health benefit plan and the request for enrollment is made within thirty (30) days after issuance of such court order;
- (d) A person becomes a Dependent through marriage, birth, adoption or placement for adoption and enrollment is requested no later than thirty (30) days after the person becomes a Dependent; or
- (e) A parent or legal guardian of the Dependent has disenrolled the Dependent from CHP+, and requests enrollment of the Dependent no later than 90 days after the disenrollment.

12. If present, the following definitions are deleted from subparagraph 17.A, titled “Definitions”: Administrative Complaint, Adverse Determination, Adverse Determination Complaint and Member Appeals Decision Maker.

13. If not already present, the following definition is added to subparagraph 17.A, titled “Definitions”:

“Evidence of Coverage” has the same meaning as “Contract.”

If not already present, the term “Evidence of Coverage” is added to the title of the Contract.

II. COVERAGE SCHEDULE

No changes are made to the Coverage Schedule.

III. PRESCRIPTION DRUG SUPPLEMENT

No changes are made to the Prescription Drug Supplement.

Except as amended herein, the Health Benefits Contract, including Coverage Schedules and Prescription Drug Supplements, shall continue in full force and effect.

ROCKY MOUNTAIN
HEALTHCARE OPTIONS, INC.

By  _____
John Hopkins, CEO