

Colorado Health Benefit Plan Description Form

Rocky Mountain Health Care Options

Rocky Mountain Vista PPO

500/70 Plan

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Preferred Provider Plan
2. OUT-OF-NETWORK CARE COVERED?¹	Yes, but patient pays more for out-of-network care.
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado.

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	OUT-OF-NETWORK
4. Deductible Type²	Calendar Year	
4a. ANNUAL DEDUCTIBLE^{2a} a) Individual ^{2b} b) Family ^{2c}	a) \$500 b) \$1,000 aggregate - In-network and out-of-network deductible combined - Deductibles shall not 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) \$3,000 b) \$6,000 c) Deductible is excluded from the out-of-pocket maximum. All copayments apply toward the out-of-pocket maximum, unless otherwise noted. Out-of-pocket maximum is calculated separately for in-network and out-of-network benefits. 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.	a) \$6,000 b) \$12,000 c) Deductible is excluded from the out-of-pocket maximum. All copayments apply toward the out-of-pocket maximum, unless otherwise noted. Out-of-pocket maximum is calculated separately for in-network and out-of-network benefits. 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	\$2 million per member per lifetime (in-network and out-of-network benefits combined)	
7A. COVERED PROVIDERS	<u>In Colorado:</u> Rocky Mountain HCO Network <u>Outside Colorado:</u> MultiPlan/PHCS Network <u>Behavioral Health:</u> Life Strategies See participating provider directory for a complete list of current providers.	All providers licensed or certified to provide covered benefits

7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes – some network providers are available outside of Colorado.	Not applicable
8. MEDICAL OFFICE VISITS⁴ a) Primary Care Providers b) Specialists	a) \$35 per visit copayment, not subject to deductible - for visits to designated PCP b) \$35 per visit copayment, not subject to deductible - for visits to any other participating provider Copayments do not apply toward annual out-of-pocket maximum. Lab/X-rays part of the office visit will have the applicable copay for the type of service. Physician fees for surgical and medical services when part of the office visit: No copayment (100% covered), not subject to deductible	a) 50% coinsurance after deductible b) 50% coinsurance after deductible
9. PREVENTIVE CARE a) Children’s services (well-child services as age appropriate) b) Adults’ services (routine physical and gynecological exam – 1 per member per calendar year) c) Routine screening mammograms, pap smears, prostate screenings d) Colorectal cancer screenings e) Immunizations (excluding Travel)	a) No copayment (100% covered), not subject to deductible. Lab/X-ray services will have the applicable copayment for the type of service b) No copayment (100% covered), not subject to deductible. Lab/X-ray services will have the applicable copayment for the type of service. c) No copayment (100% covered), not subject to deductible d) 30% coinsurance, not subject to deductible e) No copayment (100% covered), not subject to deductible	a) Not covered b) Not covered c) Not covered, except mammograms and prostate screenings are covered at 50%, not subject to deductible. Maximum Benefit Level: \$115 payable by plan for mammograms and \$65 payable by plan for prostate screenings or such other amounts as may be required by Colorado law. d) 50% coinsurance, not subject to deductible e) Not covered
10. MATERNITY a) Prenatal care (routine) b) Delivery & inpatient well baby care⁵ Non-routine prenatal care will have the applicable copayment/coinsurance for the type of service.	a) 30% coinsurance after deductible b) 30% coinsurance after deductible	a) 50% coinsurance after deductible b) 50% coinsurance after deductible

<p>11. PRESCRIPTION DRUGS⁶ Level of coverage and restrictions on prescriptions</p> <p>a) Inpatient prescription drugs and injectables</p> <p><u>Prescription drugs obtained from a retail or specialty pharmacy:</u></p> <p>b) Outpatient prescription drugs (including Insulin) and self-administered injectables (Select Injectables)*</p> <p>c) Non-Select Injectables (excluding Insulin)</p> <p><u>Prescription drugs not obtained from a retail pharmacy:</u></p> <p>d) Outpatient prescription drugs (including Insulin) and Select Injectables*</p> <p>e) Non-Select Injectables (excluding Insulin)</p> <p>*Refer to the RMHP formulary for self-administered injectable medication on the Select Injectable List.</p> <p>Injectable medication (excluding Insulin) is limited to a 31-day supply when obtained from a mail-order pharmacy.</p> <p>- Prescription drugs are covered only through participating retail and mail order pharmacies. See the Participating Provider Directory for a list of participating pharmacies.</p> <p>- 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>	<p>a) Included in inpatient hospital copayment</p> <p>b) <u>\$15/\$40/\$55 Option</u></p> <p><u>Retail Pharmacy: (31-day supply):</u> <u>Tier 1:</u> \$15 copayment per fill <u>Tier 2:</u> \$40 copayment per fill <u>Tier 3:</u> \$55 copayment per fill <u>Tier 4:</u> 20% coinsurance up to maximum member copayment of \$150 <u>Tier 5:</u> 30% coinsurance up to maximum member copayment of \$250</p> <p><i>Tiers 2, 3, and 4 cover oral and Select injectable drugs. Tier 5 is limited to coverage for certain Select injectables only.</i></p> <p><u>Mail-order Pharmacy: (90-day supply):</u> <u>Tier 1:</u> \$37.50 copayment per fill <u>Tier 2:</u> \$100 copayment per fill <u>Tier 3:</u> \$137.50 copayment per fill <u>Tier 4:</u> 20% coinsurance up to maximum member copayment of \$375 <u>Tier 5:</u> Not applicable</p> <p><i>Tier 5 is limited to certain Select injectables which are only available in a 31-day supply.</i></p> <p><u>\$15 Generic Select Option</u></p> <p><u>Retail Pharmacy: (31-day supply)</u> <u>Tier 1:</u> \$15 copayment per fill</p> <p><i>Tiers 2, 3, 4, and 5 are for Select injectables only. Oral drugs not covered may be purchased from participating retail pharmacies at 100% of the Rocky Mountain Health Plan rate.</i></p> <p><u>Tier 2 (Select Injectables Only):</u> \$60 copayment per fill <u>Tier 3 (Select Injectables Only):</u> \$75 copayment per fill <u>Tier 4 (Select Injectables Only):</u> 20% coinsurance up to maximum member copayment of \$150 <u>Tier 5 (Select Injectables Only):</u> 30% coinsurance up to maximum member copayment of \$250</p> <p><u>Mail-Order Pharmacy: (90-day supply)</u> <u>Tier 1:</u> \$37.50 copayment per fill</p> <p><i>Tiers 2, 3, 4, and 5 are for Select Injectables and are limited to a 31-day supply – refer to copayments for Retail Pharmacy above.</i></p> <p>c) 30% coinsurance after deductible</p> <p>d) Not covered</p> <p>e) 30% coinsurance after deductible</p>	<p>a) 50% coinsurance after deductible</p> <p>b) Not covered</p> <p>c) Not covered</p> <p>d) Not covered</p> <p>e) 50% coinsurance after deductible</p>
<p>12. INPATIENT HOSPITAL</p>	<p>30% coinsurance after deductible</p>	<p>50% coinsurance after deductible</p>

12A. PHYSICIAN FEES FOR SURGICAL AND MEDICAL SERVICES	30% coinsurance after deductible	50% coinsurance after deductible
13. OUTPATIENT/AMBULATORY SURGERY	30% coinsurance after deductible for outpatient surgery and invasive diagnostic tests	50% coinsurance after deductible for outpatient surgery and invasive diagnostic tests
14. DIAGNOSTICS a) Laboratory & x-ray b) MRI, nuclear medicine, and other high-tech services	a) Lab: \$15 per visit copayment, not subject to deductible X-ray: \$30 per visit copayment, not subject to deductible Copayments for lab and x-ray services do not apply toward annual out-of-pocket maximum. b) 30% coinsurance after deductible	a) 50% coinsurance after deductible b) 50% coinsurance after deductible
15. EMERGENCY CARE^{7, 8}	30% coinsurance after \$150 per visit copayment, not subject to deductible (copayment is waived if admitted)	
16. AMBULANCE	30% coinsurance after in-network deductible	
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	\$50 per visit copayment, not subject to deductible Copayments do not apply toward annual out-of-pocket maximum. Lab/X-rays part of the visit will have the applicable copay for the type of service. Physician fees for surgical and medical services when part of the urgent care visit: No copayment (100% covered), not subject to deductible	50% coinsurance after deductible
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE⁹	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.
19. OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	a) 30% coinsurance after deductible. Coinsurance does not apply toward annual out-of-pocket maximum. Maximum Benefit Level: 45 days or 90 partial days per member per calendar year b) \$35 per visit copayment, not subject to deductible - Copayments do not apply toward annual out-of-pocket maximum. Maximum Benefit Level: 20 visits or \$1,000 payable by health benefit plan per member per calendar year, whichever is greater, except that for groups over 50 employees are limited to 20 visits and the \$1,000 limit does not apply. For groups with over 50 employees, services for Mental Disorders are not subject to the annual limits. Refer to Health Benefits Contract for more information.	a) Not covered b) Not covered

<p>20. ALCOHOL & SUBSTANCE ABUSE</p> <p><u>Rehabilitation:</u></p> <p>a) Inpatient care b) Outpatient care</p> <p><u>Detoxification:</u></p> <p>c) Inpatient care d) Outpatient care</p>	<p>a) 50% coinsurance after deductible - Coinsurance does not apply toward annual out-of-pocket maximum. Maximum Benefit Level: 45 days or 90 partial days per member per calendar year.</p> <p>b) 50% coinsurance after deductible - Coinsurance does not apply toward annual out-of-pocket maximum. Maximum Benefit Level: \$500 payable by health benefit plan per member per calendar year for alcohol and \$500 paid by health benefit plan per member per calendar year for substance abuse.</p> <p>c) 30% coinsurance after deductible – limited to removal of toxic substances from the body.</p> <p>d) \$35 per visit copayment, not subject to deductible – limited to removal of the toxic substances from the body. Copayments do not apply toward the annual out-of-pocket maximum.</p> <p>For groups with over 50 employees, services for Alcohol and Substance Abuse which are Mental Disorders are not subject to the annual limits. Refer to Health Benefits Contract for more information.</p>	<p>a) Not covered</p> <p>b) Not covered</p> <p>c) 50% coinsurance after deductible – limited to removal of the toxic substances from the body</p> <p>d) 50% coinsurance after deductible – limited to removal of the toxic substances from the body</p>
<p>21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY</p> <p>a) Inpatient care b) Outpatient care</p> <p>Maximum Benefit Levels for in-network and out-of-network are combined.</p>	<p>a) Included in inpatient hospital copayment. Maximum Benefit Level: 60 days per episode per medical condition</p> <p>b) \$35 per visit copayment, not subject to deductible. Copayments do not apply toward annual out-of-pocket maximum. Maximum Benefit Level: 20 visits per member per calendar year for each type of therapy.</p>	<p>a) 50% coinsurance after deductible – Maximum Benefit Level: 60 days per episode per medical condition</p> <p>b) 50% coinsurance after deductible – Maximum Benefit Level: 20 visits per member per calendar year for each type of therapy.</p>

<p>22. DURABLE MEDICAL EQUIPMENT</p> <p>a) Durable Medical Equipment (DME) and repairs</p> <p>b) Durable Medical Equipment (DME) and repairs - <i>obtained from a pharmacy and listed on the Rocky Mountain Formulary</i></p> <p>c) Disposable Medical Supplies (DMS) – <i>obtained from a pharmacy and listed on the Rocky Mountain Formulary</i></p> <p>d) Disposable Medical Supplies (DMS) – <i>not obtained from a pharmacy</i></p> <p>e) Orthotics and Prosthetics</p> <p>Maximum Benefit Level: \$2,500 per member per calendar year paid by health benefit plan for DME, Repairs, DMS, Oxygen, and Orthotics/Prosthetics combined. Diabetic and injectable supplies are not subject to the annual limit.</p>	<p>a) 30% coinsurance after deductible</p> <p>b) 30% coinsurance, not subject to deductible up to maximum member copayment of \$150</p> <p>c) 30% coinsurance, not subject to deductible up to maximum member copayment of \$150</p> <p>d) 30% coinsurance after deductible</p> <p>e) 30% coinsurance after deductible</p> <p>Orthotics covered only for diabetes. Arm, leg, and breast prosthetics and mastectomy bras are not subject to the annual limit</p> <p>Coinsurance does not apply toward annual out-of-pocket maximum.</p> <p>Certain items obtained from a pharmacy (as designated on the Rocky Mountain Formulary) are not subject to the Maximum Benefit Level.</p>	<p>a) Not covered (except for Glucometers covered at 50% after deductible)</p> <p>b) Not covered</p> <p>c) Not covered</p> <p>d) 50% coinsurance after deductible</p> <p>e) Not covered, except arm, leg, and breast prosthetics and mastectomy bras covered as required by law.</p> <p>Coinsurance does not apply toward annual out-of-pocket maximum.</p>
<p>23. OXYGEN</p> <p>Maximum Benefit Level: \$2,500 per member per calendar year paid by health benefit plan for DME, Repairs, DMS, Oxygen, and Orthotics/Prosthetics combined.</p>	<p>30% coinsurance after deductible</p> <p>Coinsurance does not apply toward annual out-of-pocket maximum.</p>	<p>Not covered</p>
<p>24. ORGAN TRANSPLANTS</p> <p>a) Inpatient care</p> <p>b) Outpatient care</p>	<p>a) 30% coinsurance after deductible</p> <p>b) 30% coinsurance after deductible</p>	<p>a) Not covered</p> <p>b) Not covered</p>
<p>25. HOME HEALTH CARE</p> <p>Maximum Benefit Levels for in-network and out-of-network are combined.</p>	<p>30% coinsurance after deductible.</p> <p>Maximum Benefit Level: 60 visits per member per calendar year.</p>	<p>50% coinsurance after deductible</p> <p>Maximum Benefit Level: 60 visits per member per calendar year.</p>
<p>26. HOSPICE CARE</p>	<p>30% coinsurance, not subject to deductible</p> <p>Maximum Benefit Level: Respite care is limited to periods of 5 days or less.</p>	<p>50% coinsurance after deductible</p> <p>Maximum Benefit Level: Respite care is limited to periods of 5 days or less.</p>
<p>27. SKILLED NURSING FACILITY CARE</p> <p>Maximum Benefit Levels for in-network and out-of-network are combined.</p>	<p>30% coinsurance after deductible.</p> <p>Maximum Benefit Level: 60 days per member per calendar year.</p>	<p>50% coinsurance after deductible</p> <p>Maximum Benefit Level: 60 days per member per calendar year.</p>
<p>28. DENTAL CARE</p>	<p>Routine: Not covered.</p> <p>Non-Routine: 30% coinsurance after deductible for repair to sound and natural teeth due to accidental injury.</p> <p>Additional coverage may be obtained as an optional benefit.</p>	<p>Routine: Not covered</p> <p>Non-Routine: 50% coinsurance after deductible for repair to sound and natural teeth due to accidental injury.</p>

<p>29. VISION CARE</p>	<p>Annual Routine Vision Screening: \$35 copayment, not subject to deductible. Copayments do not apply toward annual out-of-pocket maximum.</p> <p>Non Routine: Applicable copayment/coinsurance based on type of service for treatment due to injury or disease of the eye. Additional coverage may be obtained as an optional benefit.</p>	<p>Annual Routine Vision Screening: Not covered</p> <p>Non-Routine: 50% coinsurance after deductible for treatment due to injury or disease of the eye</p>
<p>30. CHIROPRACTIC CARE</p>	<p>Coverage may be obtained as an optional benefit.</p>	<p>Not covered</p>
<p>31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)</p>	<p>1) <u>Cancer Screening Coverages and Parameters:</u> Subject to the parameters set forth below, cancer screening tests for the following items are covered subject to any applicable plan deductibles, copayments/ coinsurance, and maximum benefit levels:</p> <ul style="list-style-type: none"> • Breast – Mammogram • Cervical – PAP test • Colorectal – Colonoscopy, Sigmoidoscopy, Fecal Occult Blood • Ovarian – CA125 • Prostate – PSA <p>Coverage for these cancer screening tests are subject to the following parameters:</p> <p>a) the test must be ordered by your physician, and</p> <p>b) you must comply with plan procedures</p> <p>2) <u>Medically Necessary Eyeglasses and Contacts:</u> 30% coinsurance after deductible (when required as a result of eye surgery or with a diagnosis of keratoconus).</p>	<p>1) <u>Cancer Screening Coverages and Parameters:</u> Subject to the parameters set forth below, cancer screening tests for the following items are covered subject to any applicable plan deductibles, copayments/ coinsurance, and maximum benefit levels:</p> <ul style="list-style-type: none"> • Breast – Mammogram • Cervical – PAP test • Colorectal – Colonoscopy, Sigmoidoscopy, Fecal Occult Blood • Ovarian – CA125 • Prostate – PSA <p>Coverage for these cancer screening tests are subject to the following parameters:</p> <p>a) the test must be ordered by your physician, and</p> <p>b) you must comply with plan procedures</p> <p>2) <u>Medically Necessary Eyeglasses and Contacts:</u> 50% coinsurance after deductible (when required as a result of eye surgery or with a diagnosis of keratoconus).</p>

PART C: LIMITATIONS AND EXCLUSIONS

<p>32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.¹⁰</p>	<p>For Business Groups of One: Twelve months for all pre-existing conditions (18 months for late enrollees) unless the covered person is a HIPAA-eligible individual as defined under federal and state law, in which case there are no pre-existing condition exclusions.</p> <p>For small groups (with less than 51 employees): Six months for all pre-existing conditions (18 months for late enrollees) unless the covered person is a HIPAA-eligible individual as defined under federal and state law, in which case there are no pre-existing condition exclusions.</p> <p>For large groups (with 51 or more employees): Not applicable; plan does not impose limitation periods for pre-existing conditions.</p>
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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"?	<p>For Business Groups of One: A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last twelve months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.</p> <p>For small groups: A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last six months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.</p> <p>For large groups: Not applicable. Plan does not exclude coverage for pre-existing conditions.</p>
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	OUT-OF-NETWORK
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	No
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes	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	Yes
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 60007 Grand Junction, CO 81506-8758	
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	
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>RM Vista PPO 500/70 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.

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.