

Colorado Health Benefit Plan Description Form

Rocky Mountain HMO

HMO Basic Limited Mandate 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	No Deductibles
4. ANNUAL DEDUCTIBLE^{2a} a) Individual ^{2b} b) Family ^{2c}	No Deductibles
5. OUT-OF-POCKET ANNUAL MAXIMUM³ a) Individual b) Family c) Is deductible included in the out-of-pocket maximum?	a) \$6,000 b) \$12,000 c) No deductibles 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) \$40 per visit copayment for visits to designated PCP b) \$60 per visit copayment for visits to any other participating provider

	IN-NETWORK ONLY (out of network care is not covered except as noted)
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 and prostate screenings d) PAP smears and colorectal cancer screenings e) Routine child immunizations and travel immunizations	a) \$40 per visit copayment – for exam office visit only. Associated services will have the applicable copayment for the type of service. b) \$40 per visit copayment – for exam office visit only. Associated services will have the applicable copayment for the type of service. Associated services will have the applicable copayment for the type of service. c) Not covered d) No copayment (100% covered) – office visit copayment may apply e) No copayment (100% covered) – office visit copayment may apply
10. MATERNITY a) Prenatal care b) Delivery & inpatient well baby care ⁵	a) \$40 copayment per pregnancy b) \$500 per day copayment up to \$2,000 per admission, no copayment thereafter
11. PRESCRIPTION DRUGS⁶ Level of coverage and restrictions on prescriptions a) Inpatient prescription drugs and injectables b) Outpatient prescription drugs and Insulin (including injectables) c) Outpatient injectable medication (except Insulin) – administered in a physician's office or outpatient facility	a) Included in inpatient hospital copayment b) Deductible: \$100 per person per calendar year Retail pharmacy: <u>Generic drugs:</u> \$20 copay per prescription for a 31-day supply <u>Preferred brand-name drugs:</u> \$50 copay per prescription for a 31-day supply <u>Non-preferred brand name drugs:</u> \$70 copay per prescription for a 31-day supply Mail order pharmacy: <u>Generic drugs:</u> \$50 copay per prescription for a 90-day supply <u>Preferred brand-name drugs:</u> \$125 copay per prescription for a 90-day supply <u>Non-preferred brand name drugs:</u> \$175 copay per prescription for a 90-day supply Deductible and copayments for pharmacy do not apply toward the medical plan. c) No copayment (100% covered) in addition to the office visit copayment. - Some medications and devices are not covered, including but not limited to medications for which a prescription is not required, medications for which there is a therapeutic equivalent available over the counter, medications used for non-medical reasons, such as to treat wrinkles. - Access to participating pharmacies is available nationwide. Members can obtain prescription medication at pharmacies throughout the U.S. and pay the applicable copayment. - To locate participating pharmacies or for more information about drugs on our approved list, contact RMHP Customer Service at 800-346-4643.
12. INPATIENT HOSPITAL	\$500 per day copayment up to \$2,000 per admission, no copayment thereafter
13. OUTPATIENT/AMBULATORY SURGERY	\$300 per visit copayment for outpatient surgery and invasive diagnostic tests
14. DIAGNOSTICS a) Laboratory & x-ray b) MRI, nuclear medicine, and other high-tech services	a) No copayment (100% covered) b) \$300 per visit copayment
15. EMERGENCY CARE^{7, 8}	\$250 per visit copayment for emergency room for in- and out-of-network emergency care (waived if admitted)
16. AMBULANCE	\$100 per trip copayment
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	\$100 per visit copayment. Out-of-network urgent care covered only if traveling or temporarily absent from the service area.

	IN-NETWORK ONLY (out of network care is not covered except as noted)
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE⁹	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) Not covered b) Not covered
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) Not covered d) Not covered
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY a) Inpatient care b) Outpatient care	a) Included in inpatient hospital copayment. b) \$40 per visit copayment. Maximum Benefit Level: 25 visits per member per therapy per calendar year.
22. DURABLE MEDICAL EQUIPMENT a) Durable Medical Equipment (DME) and repairs b) Disposable Medical Supplies (DMS) c) Prosthetic devices (including arm and leg prostheses)	a) 30% copayment b) 20% copayment Maximum Benefit Level: \$1,000 per member per calendar year paid by plan for DME, DMS, and Oxygen combined. Disposable Medical Supplies obtained from a pharmacy are covered under the pharmacy benefit. c) 20% copayment
23. OXYGEN	30% copayment. Maximum Benefit Level: \$1,000 per member per calendar year paid by plan for DME, DMS, and Oxygen combined.
24. ORGAN TRANSPLANTS a) Inpatient care b) Outpatient care	a) \$500 per day copayment up to \$2,000 per admission, no copayment thereafter b) \$300 per visit copayment
25. HOME HEALTH CARE	\$20 per visit copayment. Maximum Benefit Level: 60 visits per member per calendar year.
26. HOSPICE CARE a) Inpatient b) Outpatient	a) \$50 per diem copayment b) \$20 per diem copayment
27. SKILLED NURSING FACILITY CARE	\$50 per day copayment. Maximum Benefit Level: 100 days per member per calendar year.
28. DENTAL CARE	Routine: Not covered. Non-Routine: \$40 per visit copayment/PCP \$60 per visit copayment/Any other participating provider For repair to sound and natural teeth due to accidental injury.
29. VISION CARE	Annual Routine Vision Screening: Not covered Non Routine: \$40 per visit copayment/PCP \$60 per visit copayment/Any other participating provider 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>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 b) you must comply with plan procedures</p> <p>2) <u>Hearing Aids (for members up to 18 years of age):</u></p> <ul style="list-style-type: none"> • Benefit level determined by place of service.

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.¹⁰	Not applicable; plan does not impose limitation periods 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 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

	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>HMOBSC 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.