Rocky Mountain Health Plans®
We understand Colorado. We understand you.

Colorado Health Benefit Plan Description Form

Rocky Mountain HMO

HMO Basic Limited Mandate Health Benefit Plan for Colorado
(Includes additional optional rider coverage for prostate screenings)

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 Type[2]	No Annual Deductible. See below for prescription drug deductible.
4. ANNUAL DEDUCTIBLE[2a] **a) Individual[2b]** **b) Family[2c]**	No Annual Deductible. See below for prescription drug deductible.
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] **a) Individual** **b) Family** **c) Is deductible included in the out-of-pocket maximum?**	a) $8,000 b) $16,000 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. Prescription drug deductible does not apply to out-of-pocket maximum.
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 VISITS[4] **a) Primary Care Providers** **b) Specialists**	 a) $40 per visit copayment b) $60 per visit copayment

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9. PREVENTIVE CARE **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, alcohol misuse screening and behavioral counseling, tobacco use screening and cessation intervention and cholesterol screening for lipid disorders)** **e) Routine prostate screenings**	a) $40 per visit copayment b) $40 per visit copayment c) $40 per office visit copayment; $500 per outpatient/ambulatory surgery procedure copayment. d) $40 per visit copayment, except vaccination for cervical cancer will be covered in full with no copayment. e) No copayment (100% covered) Included as an optional rider. Copayments apply toward annual out-of-pocket maximum.
10. MATERNITY **a) Prenatal care** **b) Delivery & inpatient well baby care[5]**	a) Benefit level determined by type of service b) $1,000 per day copayment up to $4,000 per admission, no copayment thereafter
11. PRESCRIPTION DRUGS[6] **Level of coverage and restrictions on prescriptions** **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** **Injectable medication (excluding Insulin) is limited to a 31-day supply when obtained from a mail-order pharmacy.** - 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.	a) Included in inpatient hospital copayment b) **Deductible:** $150 per person per calendar year for outpatient prescription drugs, disposable medical supplies and medical foods **Retail pharmacy:** Generic (Tier 1): **$20** copay per prescription for a 31-day supply Preferred (Tier 2): **$50** copay per prescription for a 31-day supply Non-Preferred (Tiers 3, 4 & 5): **$70** copay per prescription for a 31-day supply **Mail order pharmacy:** Generic (Tier 1): **$50** copay per prescription for a 90-day supply Preferred (Tier 2): **$125** copay per prescription for a 90-day supply Non-Preferred (Tiers 3, 4): **$175** copay per prescription for a 90-day supply *Tier 5 is limited to certain injectables which are only available in a 31-day supply.* **Deductible and copayments for outpatient prescription drugs, disposable medical supplies and medical foods do not apply toward the out-of-pocket maximum.** c) No copayment (100% covered) in addition to the office visit copayment.
12. INPATIENT HOSPITAL	$1,000 per day copayment up to $4,000 per admission, no copayment thereafter
13. OUTPATIENT/AMBULATORY SURGERY	$500 per visit copayment for outpatient surgery and invasive diagnostic tests
14. DIAGNOSTICS **a) Laboratory & x-ray** **b) MRI, nuclear medicine, CT, CTA, MRA and PET scans**	a) No copayment (100% covered) b) $300 per visit copayment

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15. EMERGENCY CARE[7],[8]	$250 per visit copayment for emergency room for in- and out-of-network emergency care (waived if admitted as an inpatient)
16. AMBULANCE	30% 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.
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]	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 **Rehabilitation:** **a) Inpatient care** **b) Outpatient care** **Detoxification:** **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) **Prosthetic devices (including arm and leg prostheses)**	a) 30% copayment b) 30% copayment, except for arm and leg prosthetics which have a 20% copayment. Maximum Benefit Level: $1,500 per member per calendar year paid by plan for DME, and Oxygen combined.
23. OXYGEN	30% copayment. Maximum Benefit Level: $1,500 per member per calendar year paid by plan for DME and Oxygen combined.
24. ORGAN TRANSPLANTS **a) Inpatient care** **b) Outpatient care**	a) $1,000 per day copayment up to $4,000 per admission, no copayment thereafter b) $500 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	30% 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 of 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

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31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	1) Hearing Aids (for members up to 18 years of age): • Benefit level determined by place of service. 2) Treatment for Autism Spectrum Disorders (ASD): 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.

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**
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 HMOBSC_P Group Plan - Group - all sizes

	IN-NETWORK
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.