ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

Colorado Health Benefit Plan Description Form

Rocky Mountain Health Care Options

Rocky Mountain Good Health Savings Plans

GH PPO HSA $2650/100% RX

(HSA ELIGIBLE)

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 Type[2]	Calendar Year	
4a. ANNUAL DEDUCTIBLE[2a] **a) Individual[2b]** **b) Family[2c]**	a) $2,650 - per individual – separate deductible b) $5,000 - per family – aggregate deductible If family membership is selected, individual deductibles will apply for each family member until either that individual's deductible is met or until the family aggregate deductible is met. - Deductibles shall be applied to satisfy the out-of-pocket maximum. - In-network and out-of-network deductible combined. - Deductible must be satisfied before services will be covered, except as noted.	
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] **a) Individual** **b) Family** **c) Is deductible included in the out-of-pocket maximum?**	a) $2,650 - per individual b) $5,000 – per family of 2 or more c) Deductible is included in the out-of-pocket maximum. All copayments apply toward the out-of-pocket maximum. Out-of-pocket maximum is calculated separately for in-network and out-of-network benefits.	a) $5,000 – per individual b) $10,000 – per family of 2 or more c) Deductible is included in the out-of-pocket maximum. All copayments apply toward the out-of-pocket maximum. Out-of-pocket maximum is calculated separately for in-network and out-of-network benefits.
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)	$2 million per member per lifetime (in-network and out-of-network benefits combined)
7A. COVERED PROVIDERS	In Colorado: Rocky Mountain HCO Network Outside Colorado: MultiPlan/PHCS Network Behavioral Health: 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 VISITS[4] **a) Primary Care Providers** **b) Specialists**	a) No copayment (100% covered) after deductible b) No copayment (100% covered) after deductible 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: No copayment (100% covered) after 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) 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) No copayment (100% covered), not subject to deductible.	a) Not covered b) Not covered c) Not covered d) Not covered
10. MATERNITY **a) Prenatal care (routine)** **b) Delivery & inpatient well baby care[5]** **Non-routine prenatal care will have the applicable copayment/coinsurance for the type of service.**	a) No copayment (100% covered) after deductible b) No copayment (100% covered) after deductible	a) 50% coinsurance after deductible b) 50% coinsurance after deductible

11. PRESCRIPTION DRUGS[6] **Level of coverage and restrictions on prescriptions** **a) Inpatient prescription drugs and injectables** **Prescription drugs obtained from a retail or specialty pharmacy:** **b) Outpatient prescription drugs (including Insulin) and self-administered injectables (Select Injectables)*** **c) Non-Select Injectables (excluding Insulin)** **Prescription drugs not obtained from a retail pharmacy:** **d) Outpatient prescription drugs (including Insulin) and Select Injectables*** **e) Non-Select Injectables (excluding Insulin)** ***Refer to the RMHP formulary for self-administered injectable medication on the Select Injectable List.** **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) Tiers 1 – 6: No copayment (100% covered) after deductible c) No copayment (100% covered) after deductible d) Not covered e) No copayment (100% covered) after deductible **Preventive Generic Drugs:** Certain preventive generic drugs will be covered with a $10 copay, not subject to deductible. (Refer to RMHP Good Health Formulary for a list of these drugs).	a) Included in inpatient hospital copayment b) Not covered c) Not covered d) Not covered e) 50% coinsurance after deductible
12. INPATIENT HOSPITAL	No copayment (100% covered) after deductible	50% coinsurance after deductible
13. OUTPATIENT/AMBULATORY SURGERY	No copayment (100% covered) 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) No copayment (100% covered) after deductible b) No copayment (100% covered) after deductible	a) 50% coinsurance after deductible b) 50% coinsurance after deductible
15. EMERGENCY CARE[7,8]	No copayment (100% covered) after deductible	
16. AMBULANCE	No copayment (100% covered) after deductible	

17. URGENT, NON-ROUTINE, AFTER HOURS CARE	No copayment (100% covered) after deductible	50% coinsurance after deductible
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]	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) No copayment (100% covered) after deductible. Maximum Benefit Level: 45 days or 90 partial days per member per calendar year b) No copayment (100% covered) after deductible. 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
20. ALCOHOL & SUBSTANCE ABUSE **Rehabilitation:** **a) Inpatient care** **b) Outpatient care** **Detoxification:** **c) Inpatient care** **d) Outpatient care**	a) No copayment (100% covered) after deductible. Maximum Benefit Level: 45 days or 90 partial days per member per calendar year. b) No copayment (100% covered) after deductible. 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. c) No copayment (100% covered) after deductible – limited to removal of toxic substances from the body. d) No copayment (100% covered) after deductible – limited to removal of the toxic substances from the body. 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.	a) Not covered b) Not covered c) 50% coinsurance after deductible – limited to removal of the toxic substances from the body d) 50% coinsurance after deductible – limited to removal of the toxic substances from the body
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY **a) Inpatient care** **b) Outpatient care** **Maximum Benefit Levels for in-network and out-of-network are combined.**	a) Included in inpatient hospital copayment. Maximum Benefit Level: 60 days per episode per medical condition b) No copayment (100% covered) after deductible. Maximum Benefit Level: 20 visits per member per calendar year for each type of therapy.	a) Included in inpatient hospital copayment. Maximum Benefit Level: 60 days per episode per medical condition b) 50% coinsurance after deductible – Maximum Benefit Level: 20 visits per member per calendar year for each type of therapy.

22. DURABLE MEDICAL EQUIPMENT **a) Durable Medical Equipment (DME) and repairs** **b) Disposable Medical Supplies (DMS)** **c) Orthotics and Prosthetics** **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.**	a) No copayment (100% covered) after deductible b) No copayment (100% covered) after deductible c) No copayment (100% covered) after deductible. Orthotics covered only for diabetes. Arm, leg, and breast prosthetics and mastectomy bras are not subject to the annual limit. Certain items obtained from a pharmacy (as designated on the Rocky Mountain Formulary) are not subject to the Maximum Benefit Level.	a) Not covered (except for Glucometers are covered at 50% after deductible). b) 50% coinsurance after deductible when not picked up at a pharmacy. c) Not covered, except arm, leg, and breast prosthetics and mastectomy bras covered as required by law.
23. OXYGEN **Maximum Benefit Level: $2,500 per member per calendar year paid by health benefit plan for DME, Repairs, DMS, Oxygen and Orthotics/Prosthetics combined.**	No copayment (100% covered) after deductible.	Not covered
24. ORGAN TRANSPLANTS **a) Inpatient care** **b) Outpatient care**	a) No copayment (100% covered) after deductible b) No copayment (100% covered) after deductible	a) Not covered b) Not covered
25. HOME HEALTH CARE **Maximum Benefit Levels for in-network and out-of-network are combined.**	No copayment (100% covered) after deductible Maximum Benefit Level: 60 visits per member per calendar year.	50% coinsurance after deductible Maximum Benefit Level: 60 visits per member per calendar year.
26. HOSPICE CARE	No copayment (100% covered) after deductible Maximum Benefit Level: Respite care is limited to periods of 5 days or less.	50% coinsurance after deductible Maximum Benefit Level: Respite care is limited to periods of 5 days or less.
27. SKILLED NURSING FACILITY CARE **Maximum Benefit Levels for in-network and out-of-network are combined.**	No copayment (100% covered) after deductible. Maximum Benefit Level: 60 days per member per calendar year.	50% coinsurance after deductible Maximum Benefit Level: 60 days per member per calendar year.
28. DENTAL CARE	**Routine:** Not covered. **Non-Routine:** No copayment (100% covered) after deductible - For repair to sound and natural teeth due to accidental injury. Additional coverage may be obtained as an optional benefit.	**Routine:** Not covered **Non-Routine:** 50% coinsurance after deductible for repair to sound and natural teeth due to accidental injury.
29. VISION CARE	**Annual Routine Vision Screening:** No copayment (100% covered) after deductible **Non Routine:** No copayment (100% covered) after deductible - For treatment due to injury or disease of the eye. Additional coverage may be obtained as an optional benefit.	**Annual Routine Vision Screening:** Not covered **Non-Routine:** 50% coinsurance after deductible for treatment due to injury or disease of the eye
30. CHIROPRACTIC CARE	Not covered	Not covered

31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	1) Additional Preventive Exams: 20% coinsurance, not subject to deductible, for Type 2 Diabetes Screenings, Lipid Screenings, and Eye Exams for children under age 5. 2) Accident-related medical services: Up to $500 covered per member per accident. The first $500 is not subject to deductible or copayment/coinsurance. (Benefit available when purchased at employer group level). 3) Cancer Screening Coverages and Parameters: 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: • Breast – Mammogram • Cervical – PAP test • Colorectal – Colonoscopy, Sigmoidoscopy, Fecal Occult Blood • Ovarian – CA125 • Prostate – PSA Coverage for these cancer screening tests are subject to the following parameters: a) the test must be ordered by your physician, and b) you must comply with plan procedures 4) Medically Necessary Eyeglasses and Contacts: No copayment (100% covered) after deductible (when required as a result of eye surgery or with a diagnosis of keratoconus).	1) Additional Preventive Exams: Not covered. 2) Accident-related medical services: Up to $500 covered per member per accident. The first $500 is not subject to deductible or copayment/coinsurance. (Benefit available when purchased at employer group level). 3) Cancer Screening Coverages and Parameters: 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: • Breast – Mammogram • Cervical – PAP test • Colorectal – Colonoscopy, Sigmoidoscopy, Fecal Occult Blood • Ovarian – CA125 • Prostate – PSA Coverage for these cancer screening tests are subject to the following parameters: a) the test must be ordered by your physician, and b) you must comply with plan procedures 4) Medically Necessary Eyeglasses and Contacts: 50% coinsurance after deductible (when required as a result of eye surgery or with a diagnosis of keratoconus).

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.[10]	**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. **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. **For large groups** (with 51 or more employees): 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"?	**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. **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. **For large groups:** 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	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 GH PPO HSA 2650/100 Group Plan - 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 my 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 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 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.