

General Multi-Language Insert



ROCKY MOUNTAIN
HEALTH PLANS®

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-282-1420 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-282-1420 (TTY: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-282-1420 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-282-1420 (TTY: 711)。
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-282-1420 (TTY: 711)번으로 전화해 주십시오.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-282-1420 (телетайп: 711).
Amharic	ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-888-280-1420 (መስማት ለተሳናቸው: 711)።
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية متوفرة لك بالمجان. اتصل برقم 888-282-1420--1 (رقم هاتف الصم والبكم: 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-282-1420 (TTY: 711).
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-282-1420 (ATS : 711).
Nepali	ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-282-1420 (टिटिवाइ: 711) ।
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-282-1420 (TTY: 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-282-1420 (TTY:711) まで、お電話にてご連絡ください。
Cushite/Oromo	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-282-1420 (TTY: 711).
Persian	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-282-1420 (TTY: 711) تماس بگیرید.
Ibo/Igbo	Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-888-282-1420 (TTY: 711).
Kru-Bassa	Dè dè nià kè dyédé gbo: ɔ jũ ké m̄ [Bàsòò-wùdù-po-nyò] jũ ní, níí, à wuɖu kà kò dò po-poò béin m̄ gbo kpáa. Ǻá 1-888-282-1420 (TTY: 711)
Yoruba	AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-888-282-1420 (TTY: 711).

Notice of Nondiscrimination

Rocky Mountain Health Plans (RMHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. RMHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

RMHP takes reasonable steps to ensure meaningful access and effective communication is provided timely and free of charge:

- Provides free auxiliary aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters (remote interpreting service or on-site appearance)
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, such as:
 - Qualified interpreters (remote or on-site)
 - Information written in other languages

If you need these services, contact the RMHP Member Concerns Coordinator at 800-346-4643, 970-243-7050, or TTY 970-248-5019, 800-704-6370, Relay 711; para asistencia en español llame al 800-346-4643.

If you believe that RMHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: the RMHP EEO Officer at 800-346-4643, 970-244-7760, ext. 7883, or TTY 970-248-5019, 800-704-6370, Relay 711; para asistencia en español llame al 800-346-4643, or eeoofficer@rmhp.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the RMHP EEO Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

RMHP is a Medicare-approved Cost plan. Enrollment in RMHP depends on contract renewal.

1. SCHEDULE OF BENEFITS (Who Pays What)

ROCKY MOUNTAIN HEALTH PLANS
INDIVIDUAL PPO EVIDENCE OF COVERAGE
MONUMENT HEALTH GOLD 1000/2000 - TIERED NETWORK PLAN

Underwritten by Rocky Mountain Health Maintenance Organization, Inc.

COVERAGE SCHEDULE

Benefits are subject to the Cost Sharing, Yearly Out-of-Pocket Maximums, and Maximum Benefit Levels shown in this Coverage Schedule. Please see Your Contract for a description of Your Benefits, Limitations, and Exclusions. Benefits are subject to all terms of the Contract.

Providers who belong to Monument Health Network are the Preferred Network Providers for this Plan.

The following symbols are used to identify Maximum Benefit Levels, Limitations, and Exclusions:

M	Maximum Benefit Level
L	Limitation
⊗	Exclusion – Not a Benefit of the Contract

Benefits are subject to the following:

	Option 1 In-Network (Monument Health Network)	Option 2 In-Network (Other Network Providers)	Option 3 Out-of-Network (Non-Network Providers)
<p>Deductible</p> <p>a) Member (Individual)</p> <p>b) Subscriber and Dependents (Family)</p> <p>Benefits are provided to You after You meet the Individual Deductible. You do not need to meet the Family Deductible if You meet the Individual Deductible. The Deductible amounts for Options 1 and 2 will accumulate together. Some Cost Sharing for Option 2 and 3 Benefits only applies to the Option 1 Deductible. Amounts paid by You to the Deductible will apply to the Yearly Out-of-Pocket Maximum. Deductible must be met before services will be covered, except as noted. Copays and Coinsurance do not apply to the Deductible. The Deductible is calculated separately for In- and Out-of-Network Benefits.</p>	<p>a) \$1,000 per Calendar Year</p> <p>b) \$2,000 per Calendar Year</p>	<p>a) \$2,000 per Calendar Year</p> <p>b) \$4,000 per Calendar Year</p>	<p>a) \$4,000 per Calendar Year</p> <p>b) \$8,000 per Calendar Year</p>

Benefits are subject to the following:

	Option 1 In-Network (Monument Health Network)	Option 2 In-Network (Other Network Providers)	Option 3 Out-of-Network (Non-Network Providers)
<p>Yearly Out-of-Pocket Maximum</p> <p>a) Member (Individual)</p> <p>b) Subscriber and Dependents (Family)</p> <p>Benefits are provided to You without Cost Sharing after You meet the Individual Yearly Out-of-Pocket Maximum. You do not need to meet the Family Yearly Out-of-Pocket Maximum if You meet the Individual Yearly Out-of-Pocket Maximum. Yearly Out-of-Pocket Maximum amounts for Options 1 and 2 will accumulate together. Some Cost Sharing for Option 2 and 3 Benefits only applies to the Option 1 Yearly Out-of-Pocket Maximum. All Copays and Coinsurance apply to the Yearly Out-of-Pocket Maximum. The Yearly Out-of-Pocket Maximum is calculated separately for In- and Out-of-Network Benefits. If the Yearly Out-of-Pocket Maximum is met before the Deductible, all services will be covered without Copay or Coinsurance.</p>	<p>a) \$3,500 per Calendar Year</p> <p>b) \$7,000 per Calendar Year</p>	<p>a) \$6,000 per Calendar Year</p> <p>b) \$12,000 per Calendar Year</p>	<p>a) \$12,000 per Calendar Year</p> <p>b) \$24,000 per Calendar Year</p>

If You get services from non-Network Providers, You may have to pay in full for those services and send claims to Us for reimbursement. You are responsible to pay any billed amounts in excess of the Allowed Charges for Out-of-Network Care.

Benefits

The Covered Services listed below are subject to Copays or Coinsurance until the applicable Yearly Out-of-Pocket Maximum is met.

If You do not get Prior Authorization when required for Out-of-Network services, Benefits will be denied. You may go to Our website at www.rmhp.org or call customer service to find out if a service requires Prior Authorization.

Cost Sharing will not apply to Benefits if:

- You are an Indian;
- You got this Policy through the Exchange; and
- You receive Care from an Indian Health Program.

Covered Services	Option 1 In-Network (Monument Health Network)	Option 2 In-Network (Other Network Providers)	Option 3 Out-of-Network (Non-Network Providers)
Care not shown on this Coverage Schedule	After Deductible, 20% Coinsurance	After Deductible, 40% Coinsurance	After Deductible, 50% Coinsurance

Covered Services	Option 1 In-Network (Monument Health Network)	Option 2 In-Network (Other Network Providers)	Option 3 Out-of-Network (Non-Network Providers)
<p>Acupuncture and Chiropractic Care (Chiro Care)</p> <p>M - Options 1 and 2 combined: Chiro Care limited to 20 visits per Member per Calendar Year.</p> <p>M - Option 3: The Maximum Benefit Level for acupuncture and Chiro Care combined is \$500 per Member per Calendar Year. This Maximum Benefit Level will not apply to any services that are Essential Health Benefits.</p>	<p>⊗ Acupuncture not covered In-Network</p> <p>Chiro Care: \$15 Copay per visit Not subject to Deductible</p> <p>Only applies to Option 1 Yearly Out-of-Pocket Maximum</p>		<p>50% Coinsurance</p> <p>Not subject to Deductible</p>
<p>Alcohol and Substance Abuse – Detox</p> <p>L - Limited to removal of toxic substances from the body.</p> <p>a) Inpatient Care b) Outpatient Care</p>	<p>a) After Deductible, 20% Coinsurance</p> <p>b) \$15 Copay per visit</p> <p>Not subject to Deductible</p>	<p>a) After Deductible, 40% Coinsurance</p> <p>b) \$40 Copay per visit</p> <p>Not subject to Deductible</p>	<p>a) & b) After Deductible, 50% Coinsurance</p>
<p>Alcohol and Substance Abuse – Rehab</p> <p>a) Inpatient and other facility based Care b) Outpatient Care</p>	<p>a) After Deductible, 20% Coinsurance</p> <p>b) \$15 Copay per visit</p> <p>Not subject to Deductible</p>	<p>a) After Deductible, 40% Coinsurance</p> <p>b) \$40 Copay per visit</p> <p>Not subject to Deductible</p>	<p>a) & b) After Deductible, 50% Coinsurance</p>
<p>Ambulance Services</p>	<p>After Deductible, 20% Coinsurance</p> <p>The Deductible amounts for Options 1, 2 and 3 for ambulance services only apply to the Option 1 Deductible. Coinsurance amounts for Options 1, 2 and 3 for ambulance services only apply to the Option 1 Yearly Out-of-Pocket Maximum</p>		
<p>Asthma Education – outpatient</p> <p>a) PCP b) Any other provider</p> <p>Related services are subject to the applicable Cost Sharing for the type of service.</p>	<p>a) \$15 Copay per visit</p> <p>Not subject to Deductible</p> <p>b) \$50 Copay per visit</p> <p>Not subject to Deductible</p>	<p>a) \$40 Copay per visit</p> <p>Not subject to Deductible</p> <p>b) \$50 Copay per visit</p> <p>Not subject to Deductible</p>	<p>a) & b) After Deductible, 50% Coinsurance</p>
<p>Autism Spectrum Disorders (ASD)</p>	<p>Benefit level determined by place and type of service</p>	<p>Benefit level determined by place and type of service</p>	<p>Benefit level determined by place and type of service</p>

Covered Services	Option 1 In-Network (Monument Health Network)	Option 2 In-Network (Other Network Providers)	Option 3 Out-of-Network (Non-Network Providers)
Bariatric Services a) Inpatient and outpatient surgery b) All other bariatric services	a) After Deductible, 20% Coinsurance b) Subject to the applicable Cost Sharing for type of service provided	a) After Deductible, 40% Coinsurance b) Subject to the applicable Cost Sharing for type of service provided	a) After Deductible, 50% Coinsurance b) Subject to the applicable Cost Sharing for type of service provided
Blood Services – outpatient Office visit Cost Sharing may apply.	After Deductible, 20% Coinsurance	After Deductible, 40% Coinsurance	After Deductible, 50% Coinsurance
Children’s Dental Services L – Children’s Dental Services are only covered for Members up to age 19.	No Copay Not subject to Deductible	No Copay Not subject to Deductible	⊗ Not covered Out-of- Network
Colorectal Cancer Screenings – outpatient (Including screening colonoscopies and sigmoidoscopies, removal of polyps during the screening and fecal occult blood tests) Related services (anesthesia, laboratory services, medical supplies and radiology) are included in the colorectal cancer screening benefit. Cost Sharing may apply for non- preventive Care provided at the same visit.	No Copay Not subject to Deductible	No Copay Not subject to Deductible	No Copay Not subject to Deductible
Diabetic Education - outpatient a) PCP b) Any other provider Related services are subject to the applicable Cost Sharing for the type of service.	a) \$15 Copay per visit Not subject to Deductible b) \$50 Copay per visit Not subject to Deductible	a) \$40 Copay per visit Not subject to Deductible b) \$50 Copay per visit Not subject to Deductible	a) & b) After Deductible, 50% Coinsurance
Dialysis – outpatient Related services are subject to the applicable Cost Sharing for the type of service.	After Deductible, 20% Coinsurance	After Deductible, 40% Coinsurance	After Deductible, 50% Coinsurance

Covered Services	Option 1 In-Network (Monument Health Network)	Option 2 In-Network (Other Network Providers)	Option 3 Out-of-Network (Non-Network Providers)
<p>Disposable Medical Supplies</p> <p>a) Picked up from a pharmacy and listed on the RMHP Formulary</p> <p>L - Subject to quantity limits noted in the RMHP Formulary.</p> <p>b) All other Disposable Medical Supplies</p> <p>Office visit Cost Sharing may apply.</p> <p>See the RMHP Formulary at www.rmhp.org.</p>	<p>a) & b) After Deductible, 20% Coinsurance</p>	<p>a) After Deductible, 20% Coinsurance</p> <p>Only applies to Option 1 Deductible and Yearly Out-of-Pocket Maximum</p> <p>b) After Deductible, 40% Coinsurance</p>	<p>a) ⊗ Not covered Out-of-Network</p> <p>b) After Deductible, 50% Coinsurance</p>
<p>Durable Medical Equipment (DME) and Repairs (Rehabilitative and Habilitative)</p> <p>a) Picked up from a pharmacy and listed on the RMHP Formulary on Tier 1 – Tier 5</p> <p>b) Picked up from a pharmacy and listed on the RMHP Formulary on Tier 6</p> <p>c) Breast pumps and supplies</p> <p>L – Covered with the birth of a child.</p> <p>L – Rental or purchase is covered up to the cost of the RMHP Preferred Model.</p> <p>d) All other Durable Medical Equipment</p> <p>Office visit Cost Sharing may apply.</p> <p>See the RMHP Formulary at www.rmhp.org.</p>	<p>a) See Outpatient Prescription Drug section on this Coverage Schedule</p> <p>b) After Deductible, 20% Coinsurance</p> <p>c) Rental or purchase: No Copay</p> <p>Not subject to Deductible</p> <p>d) After Deductible, 20% Coinsurance</p>	<p>a) See Outpatient Prescription Drug section on this Coverage Schedule</p> <p>b) After Deductible, 20% Coinsurance</p> <p>Only applies to Option 1 Deductible and Yearly Out-of-Pocket Maximum</p> <p>c) Rental or purchase: No Copay</p> <p>Not subject to Deductible</p> <p>d) After Deductible, 40% Coinsurance</p>	<p>a & b) ⊗ Not covered Out-of-Network</p> <p>c) Purchase: No Copay</p> <p>Not subject to Deductible</p> <p>⊗ Rental: Not covered Out-of-Network</p> <p>d) After Deductible, 50% Coinsurance</p>
<p>Early Intervention Services (EIS)</p> <p>M - Options 1, 2 and 3 combined: 45 therapeutic visits per Member per Calendar Year.</p> <p>Any therapy Benefits received as part of EIS are not subject to and will not apply to the Maximum Benefit Levels for other therapy services under this Contract</p> <p>L - EIS are only a Benefit for Members who are under age 3.</p>	<p>No Copay</p> <p>Not subject to Deductible</p>		

Covered Services	Option 1 In-Network (Monument Health Network)	Option 2 In-Network (Other Network Providers)	Option 3 Out-of-Network (Non-Network Providers)
<p>Emergency Room Care</p> <p>Copay waived if You are admitted to a hospital.</p> <p>a) Before Your Deductible is met b) After Your Deductible is met</p>	<p>a) \$150 Copay per visit, not subject to Deductible, then balance of Allowed Charges for visit subject to Deductible</p> <p>b) \$150 Copay per visit, then 20% Coinsurance</p> <p>The Deductible amounts for Options 1, 2 and 3 for emergency room Care only apply to the Option 1 Deductible. Copay and Coinsurance amounts for Options 1, 2 and 3 for emergency room Care only apply to the Option 1 Yearly Out-of-Pocket Maximum</p>		
<p>Enteral Nutrition</p> <p>L - Covered for Members up to age 3.</p> <p>a) Picked up from a pharmacy b) Not picked up from a pharmacy</p> <p>Office visit Cost Sharing may apply.</p> <p>See the RMHP Formulary at www.rmhp.org.</p>	<p>a) After Deductible, 20% Coinsurance up to a 31-day supply</p> <p>b) After Deductible, 20% Coinsurance</p>	<p>a) After Deductible, 20% Coinsurance up to a 31-day supply</p> <p>Only applies to Option 1 Deductible and Yearly Out-of-Pocket Maximum</p> <p>b) After Deductible, 40% Coinsurance</p>	<p>a) <input type="checkbox"/> Not covered Out-of-Network</p> <p>b) After Deductible, 50% Coinsurance</p>
<p>Eye Care</p> <p>a) Vision screening</p> <p>M - One per Member per Calendar Year.</p> <p>b) Eyeglasses, lenses and contact lenses</p> <p>Related services are subject to the applicable Cost Sharing for the type of service.</p> <p>L – Vision screenings are only covered for children up to age 19.</p> <p>L – Eyeglasses, lenses and contact lenses are only covered for children up to age 19, or after covered eye surgery, or with a diagnosis of keratoconus.</p> <p>L – Replacement eyeglasses, lenses and contact lenses are limited to one pair or set every two (2) years for children up to age 19.</p>	<p>a) No Copay</p> <p>Not subject to Deductible</p> <p>b) After Deductible, 20% Coinsurance</p> <p>Only applies to Option 1 Deductible and Yearly Out-of-Pocket Maximum</p>		<p>a) After Deductible, 50% Coinsurance</p> <p>b) <input type="checkbox"/> Not covered Out-of-Network</p>

Covered Services	Option 1 In-Network (Monument Health Network)	Option 2 In-Network (Other Network Providers)	Option 3 Out-of-Network (Non-Network Providers)
<p>Family Planning and Sterilization</p> <p>a) Any medically acceptable device or procedure used to prevent pregnancy not listed below</p> <p>b) Counseling and information on birth control</p> <p>Birth control for women</p> <p>We cover at least one form of contraceptive in each method identified by the FDA without Cost Sharing. The FDA has currently identified 18 methods of contraception.</p> <p>c) Diaphragms</p> <p>d) IUDs and subdermal implants</p> <p>e) Hormone injections</p> <p>f) Surgical sterilization for women</p> <p>g) Prescription drugs and devices picked up from a pharmacy</p> <p>Birth control for men</p> <p>h) Surgical sterilization for men</p> <p>⊗ Over-the-counter contraceptive drugs or devices which do not require a prescription, except those listed as included in the RMHP Formulary.</p> <p>See the RMHP Formulary at www.rmhp.org.</p>	<p>a) Subject to the applicable Cost Sharing for type of service provided</p> <p>b) – f) No Copay</p> <p>Not subject to Deductible</p> <p>g) See the Outpatient Prescription Drug section of this Coverage Schedule</p> <p>h) Subject to the applicable Cost Sharing for type of service provided</p>	<p>a) Subject to the applicable Cost Sharing for type of service provided</p> <p>b) – f) No Copay</p> <p>Not subject to Deductible</p> <p>g) See the Outpatient Prescription Drug section of this Coverage Schedule</p> <p>h) Subject to the applicable Cost Sharing for type of service provided</p>	<p>a) Subject to the applicable Cost Sharing for type of service provided</p> <p>b) – f) Subject to the applicable Cost Sharing for type of service provided</p> <p>g) ⊗ Not covered Out-of Network</p> <p>h) Subject to the applicable Cost Sharing for type of service provided</p>
<p>Hearing Exams and Hearing Aids</p> <p>a) Hearing exams and tests</p> <p>b) Hearing aids</p> <p>L - Hearing aids are only covered for Members up to age 18.</p> <p>L - Replacement hearing aids are limited to 1 pair every 5 years, unless changes to the current hearing aid cannot meet the needs of the Member.</p>	<p>a) \$15 Copay per visit</p> <p>Not subject to Deductible</p> <p>b) After Deductible, 20% Coinsurance</p>	<p>a) \$40 Copay per visit</p> <p>Not subject to Deductible</p> <p>b) After Deductible, 40% Coinsurance</p>	<p>a & b) After Deductible, 50% Coinsurance</p>
<p>Home Health Services</p>	<p>After Deductible, 20% Coinsurance</p>	<p>After Deductible, 40% Coinsurance</p>	<p>After Deductible, 50% Coinsurance</p>
<p>Hospice Services – inpatient and outpatient</p>	<p>After Deductible, 20% Coinsurance</p>	<p>After Deductible, 40% Coinsurance</p>	<p>After Deductible, 50% Coinsurance</p>

Covered Services	Option 1 In-Network (Monument Health Network)	Option 2 In-Network (Other Network Providers)	Option 3 Out-of-Network (Non-Network Providers)
Hospital – inpatient and outpatient (Applies to all Hospital Care unless otherwise provided in this Coverage Schedule)	After Deductible, 20% Coinsurance	After Deductible, 40% Coinsurance	After Deductible, 50% Coinsurance
Infertility Care – outpatient a) PCP b) Any other provider c) Artificial insemination Related services are subject to the Cost Sharing for the type of service.	a) \$15 Copay per visit Not subject to Deductible b) \$50 Copay per visit Not subject to Deductible c) After Deductible, 20% Coinsurance	a) \$40 Copay per visit Not subject to Deductible b) \$50 Copay per visit Not subject to Deductible c) After Deductible, 40% Coinsurance	a) - c) After Deductible, 50% Coinsurance
Injectable Drugs (Self-Administered) a) Obtained from a pharmacy b) Received in a Physician’s office or outpatient facility See the RMHP Formulary at www.rmhp.org .	a) See the Outpatient Prescription Drug section of this Coverage Schedule b) ⊗ Not covered	a) See the Outpatient Prescription Drug section of this Coverage Schedule b) ⊗ Not covered	a & b) ⊗ Not covered Out-of-Network
Injectable Drugs, including allergy injections (Non Self-Administered) and Infusion Drugs a) Obtained from a pharmacy b) Not obtained from a pharmacy Office visit Cost Sharing may apply. See the RMHP Formulary at www.rmhp.org .	a) & b) After Deductible, 20% Coinsurance	a) After Deductible, 20% Coinsurance Only applies to Option 1 Deductible and Yearly Out-of-Pocket Maximum b) After Deductible, 40% Coinsurance	a) ⊗ Not covered Out-of-Network b) After Deductible, 50% Coinsurance
Laboratory Services – outpatient Office visits and related services are subject to the applicable Cost Sharing for the type of service.	\$15 Copay per visit Not subject to Deductible	After Deductible, 40% Coinsurance	After Deductible, 50% Coinsurance

Covered Services	Option 1 In-Network (Monument Health Network)	Option 2 In-Network (Other Network Providers)	Option 3 Out-of-Network (Non-Network Providers)
<p>Maternity Care</p> <p>a) Routine prenatal office visits b) Other routine prenatal Care c) Delivery and inpatient well-baby Care</p> <p>Non-routine maternity services are subject to the applicable Cost Sharing for the type of service.</p>	<p>a) & b) No Copay</p> <p>Not subject to Deductible</p> <p>c) After Deductible, 20% Coinsurance</p>	<p>a) & b) No Copay</p> <p>Not subject to Deductible</p> <p>c) After Deductible, 40% Coinsurance</p>	<p>a) - c) After Deductible, 50% Coinsurance</p>
<p>Medical Foods and Therapeutic Formulas</p> <p>a) Picked up from a pharmacy b) Not picked up from a pharmacy</p> <p>Office visit Cost Sharing may apply.</p> <p>See the RMHP Formulary at www.rmhp.org.</p>	<p>a) After Deductible, 20% Coinsurance up to a 31-day supply</p> <p>b) After Deductible, 20% Coinsurance</p>	<p>a) After Deductible, 20% Coinsurance up to a 31-day supply</p> <p>Only applies to Option 1 Deductible and Yearly Out-of-Pocket Maximum</p> <p>b) After Deductible, 40% Coinsurance</p>	<p>a) ⊗ Not covered Out-of-Network</p> <p>b) After Deductible, 50% Coinsurance</p>
<p>Mental Health Services Mental Illness and Mental Disorders</p> <p>a) Inpatient Care b) Outpatient Care</p>	<p>a) After Deductible, 20% Coinsurance</p> <p>b) \$15 Copay per visit</p> <p>Not subject to Deductible</p>	<p>a) After Deductible, 40% Coinsurance</p> <p>b) \$40 Copay per visit</p> <p>Not subject to Deductible</p>	<p>a) & b) After Deductible, 50% Coinsurance</p>
<p>Office Visits (Applies to all office visit Care unless otherwise provided in this Coverage Schedule)</p> <p>a) PCP b) Any other provider</p> <p>Related services are subject to the Cost Sharing for the type of service.</p> <p>Visits at an outpatient facility will be subject to the applicable Cost Sharing in addition to any applicable office visit Cost Sharing.</p>	<p>a) \$15 Copay per visit</p> <p>Not subject to Deductible</p> <p>b) \$50 Copay per visit</p> <p>Not subject to Deductible</p>	<p>a) \$40 Copay per visit</p> <p>Not subject to Deductible</p> <p>b) \$50 Copay per visit</p> <p>Not subject to Deductible</p>	<p>a) & b) After Deductible, 50% Coinsurance</p>

Covered Services	Option 1 In-Network (Monument Health Network)	Option 2 In-Network (Other Network Providers)	Option 3 Out-of-Network (Non-Network Providers)		
<p>Outpatient Prescription Drugs</p> <p>L - Retail Pharmacy and Mail Order Pharmacy – up to a 90-day supply. Specialty Pharmacy – up to a 31-day supply. Drugs on Tier 5 are limited to a 31-day supply.</p> <p>Outpatient Prescription Drugs include:</p> <ul style="list-style-type: none"> • self-administered injectable drugs; and • DME received from a Network Pharmacy. <p>Benefits are subject to the Limitations and Exclusions in the RMHP Formulary and Your Contract.</p> <p>There is no Cost Sharing for contraceptive drugs and devices noted as “Women’s Preventive Healthcare” on any tier of the RMHP Formulary.</p> <p>See the RMHP Formulary at www.rmhp.org.</p>	<p>All Outpatient Prescription Drug Cost Sharing only applies to Option 1 Yearly Out-of-Pocket Maximum</p> <p>See chart below</p>		<p>⊗ Not covered Out-of-Network</p>		
<p>In Network Outpatient Prescription Drug Benefit</p>	<p>Tier 1 drugs: Not subject to Deductible</p>	<p>Tier 2 drugs: Not subject to Deductible</p>	<p>Tier 3 drugs: Not subject to Deductible</p>	<p>Tier 4 drugs: Not subject to Deductible</p>	<p>Tier 5 drugs: Not subject to Deductible</p>
<p>Up to 31 day supply at all Network Pharmacies</p>	<p>\$15.00 Copay</p>	<p>\$40.00 Copay</p>	<p>\$65.00 Copay</p>	<p>\$175.00 Copay</p>	<p>\$250.00 Copay</p>
<p>32 to 60 day supply at a Retail Pharmacy & Mail Order Pharmacy</p>	<p>\$30.00 Copay</p>	<p>\$80.00 Copay</p>	<p>\$130.00 Copay</p>	<p>\$350.00 Copay</p>	<p>Limited to 31 day supply</p>
<p>61 to 90 day supply at a Retail Pharmacy & Mail Order Pharmacy</p>	<p>\$37.50 Copay</p>	<p>\$100.00 Copay</p>	<p>\$162.50 Copay</p>	<p>\$437.50 Copay</p>	<p>Limited to 31 day supply</p>
<p>Oxygen Service – outpatient</p>	<p>After Deductible, 20% Coinsurance</p>	<p>After Deductible, 40% Coinsurance</p>	<p>After Deductible, 50% Coinsurance</p>		
<p>Physician Services</p> <p>Physician’s office and outpatient facility Care.</p> <p>Office visit Cost Sharing may apply.</p>	<p>After Deductible, 20% Coinsurance</p>	<p>After Deductible, 40% Coinsurance</p>	<p>After Deductible, 50% Coinsurance</p>		

Covered Services	Option 1 In-Network (Monument Health Network)	Option 2 In-Network (Other Network Providers)	Option 3 Out-of-Network (Non-Network Providers)
<p>Preventive Cancer Screenings – outpatient</p> <p>M - Options 1, 2 and 3 combined: One per type of service per Member per Calendar Year.</p> <p>Cost Sharing may apply for non-preventive Care provided at the same visit.</p> <p>a) Mammograms (preventive or diagnostic)</p> <p>b) Prostate screenings</p> <p>c) Routine pap smears (cervical cancer screenings)</p>	<p>a - c) No Copay</p> <p>Not subject to Deductible</p>	<p>a - c) No Copay</p> <p>Not subject to Deductible</p>	<p>a - c) No Copay</p> <p>Not subject to Deductible</p>

Covered Services	Option 1 In-Network (Monument Health Network)	Option 2 In-Network (Other Network Providers)	Option 3 Out-of-Network (Non-Network Providers)
<p>Preventive Services – outpatient Cost Sharing may apply for non-preventive Care provided at the same visit.</p> <p>a) Adult physical exams and routine gynecological exams</p> <p>M - Options 1, 2 and 3 combined: One per type of service per Member per Calendar Year, except for additional preventive services recommended by a Physician.</p> <p>b) Well baby Care, well child Care and child health supervision services, not including immunizations</p> <p>L - Well child services as age appropriate.</p> <p>c) Immunizations - Adult and child immunizations, vaccination for cervical cancer, and influenza and pneumococcal immunizations as recommended by ACIP</p> <p>⊗ - Travel immunizations</p> <p>d) Alcohol misuse screening and behavioral counseling interventions for adults per the “A” or “B” recommendations of the USPSTF</p> <p>e) Tobacco use screening for adults by any primary care provider per the “A” or “B” recommendations of the USPSTF. Tobacco cessation interventions for adults per the “A” or “B” recommendations of the USPSTF.</p> <p>f) Cholesterol screening for lipid disorders</p> <p>g) Chlamydia screening, for female Members within the ages of the USPSTF recommendation</p> <p>h) Type 2 diabetes screening</p> <p>i) Any preventive service not listed above included:</p> <ul style="list-style-type: none"> • as an “A” or “B” recommendation by the USPSTF; • in the women’s preventive care and screening guidelines supported by HRSA; or • in the infants, children, and adolescents preventive care and screenings guidelines supported by HRSA. 	<p>a - i) No Copay</p> <p>Not subject to Deductible</p>	<p>a - i) No Copay</p> <p>Not subject to Deductible</p>	<p>a) ⊗ Not covered Out-of-Network</p> <p>b) No Copay</p> <p>Not subject to Deductible</p> <p>c) 50% Coinsurance for adult immunizations, except influenza and pneumococcal;</p> <p>Child immunizations, vaccination for cervical cancer and influenza and pneumococcal immunizations:</p> <p>No Copay</p> <p>Not subject to Deductible</p> <p>d - f) No Copay</p> <p>Not subject to Deductible</p> <p>g & h) ⊗ Not covered Out-of-Network</p> <p>i) Subject to the applicable Cost Sharing for type of service provided</p> <p>Not subject to Deductible</p>

Covered Services	Option 1 In-Network (Monument Health Network)	Option 2 In-Network (Other Network Providers)	Option 3 Out-of-Network (Non-Network Providers)
Prosthetic Devices (PD) and Orthotic Devices (OD) (Including repairs) Office visit Cost Sharing may apply.	After Deductible, 20% Coinsurance	After Deductible, 40% Coinsurance	After Deductible, 50% Coinsurance
Radiation Therapy	After Deductible, 20% Coinsurance	After Deductible, 40% Coinsurance	After Deductible, 50% Coinsurance
Skilled Nursing Facility Services M - Options 1, 2 and 3 combined: 100 days per Member per Calendar Year.	After Deductible, 20% Coinsurance	After Deductible, 40% Coinsurance	After Deductible, 50% Coinsurance
Surgery (Applies to all surgery Care and services unless otherwise provided in this Coverage Schedule) a) Inpatient Care b) Outpatient surgery and invasive diagnostic testing	a) & b) After Deductible, 20% Coinsurance	a) & b) After Deductible, 40% Coinsurance	a) & b) After Deductible, 50% Coinsurance
Therapy Services – inpatient physical, speech, occupational therapy, pulmonary and cardiac rehabilitation M - Options 1, 2 and 3 combined: Rehabilitative and Habilitative physical, occupational and speech therapies (combined) are limited to 2 months per Episode per medical condition.	After Deductible, 20% Coinsurance	After Deductible, 40% Coinsurance	After Deductible, 50% Coinsurance

Covered Services	Option 1 In-Network (Monument Health Network)	Option 2 In-Network (Other Network Providers)	Option 3 Out-of-Network (Non-Network Providers)
<p>Therapy Services – outpatient physical, speech, occupational therapy, pulmonary and cardiac rehabilitation</p> <p>M - Options 1, 2 and 3 combined: Physical, occupational and speech therapies for rehabilitative purposes are limited to 20 visits per Member per therapy per Calendar Year.</p> <p>M - Options 1, 2 and 3 combined: Physical, occupational and speech therapies for rehabilitative purposes for congenital defects and birth abnormalities (for Members up to 6 years of age) are limited to 20 visits per Member per therapy per Calendar Year.</p> <p>M - Options 1, 2 and 3 combined: Physical, occupational and speech therapies for Habilitative purposes are limited to 20 visits per Member per therapy per Calendar Year.</p>	<p>\$25 Copay per visit</p> <p>Not subject to Deductible</p>	<p>After Deductible, 40% Coinsurance</p>	<p>After Deductible, 50% Coinsurance</p>
<p>Total Parenteral Nutrition (TPN) – outpatient</p> <p>Office visit Cost Sharing may apply.</p>	<p>After Deductible, 20% Coinsurance</p>	<p>After Deductible, 40% Coinsurance</p>	<p>After Deductible, 50% Coinsurance</p>
<p>Transplants – inpatient and outpatient</p>	<p>After Deductible, 20% Coinsurance</p>	<p>After Deductible, 40% Coinsurance</p>	<p>After Deductible, 50% Coinsurance</p>
<p>Urgent Care Services – outpatient</p> <p>Related services are subject to the applicable Cost Sharing for the type of service.</p>	<p>\$50 Copay per visit</p> <p>Not subject to Deductible</p> <p>Copay amounts for Options 1 and 2 for urgent care services only apply to the Option 1 Yearly Out-of-Pocket Maximum</p>		<p>After Deductible, 50% Coinsurance</p>
<p>X-ray and Other Imaging Services – outpatient</p> <p>a) X-rays and other imaging</p> <p>b) MRI, PET and CT scans</p> <p>Office visits and related services are subject to the applicable Cost Sharing for the type of service.</p>	<p>a) \$30 Copay per visit</p> <p>Not subject to Deductible</p> <p>b) After Deductible, 20% Coinsurance</p>	<p>a) & b) After Deductible, 40% Coinsurance</p>	<p>a) & b) After Deductible, 50% Coinsurance</p>

2. TITLE PAGE (Cover Page)

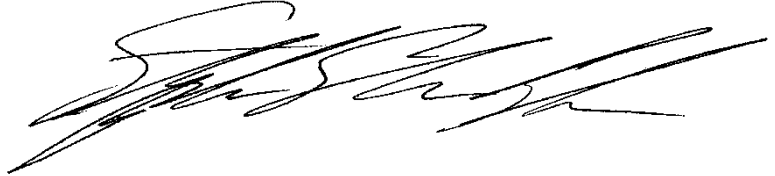
ROCKY MOUNTAIN HEALTH PLANS
ROCKY MOUNTAIN INDIVIDUAL PREFERRED PROVIDER ORGANIZATION
EVIDENCE OF COVERAGE
UNDERWRITTEN BY ROCKY MOUNTAIN HEALTH MAINTENANCE ORGANIZATION, INC.

By enrolling with and/or obtaining Benefits from Us, each Subscriber and Member agrees to all terms of this Contract.

This Contract is effective for use beginning January 1, 2017.

This Contract does not provide any dental benefits to individuals age 19 or older. This Contract is being offered so the purchaser will have pediatric dental coverage as required by the Affordable Care Act. If You want adult dental benefits, You will need to buy a plan that has adult dental benefits. This Contract will not pay for any adult dental care, so You will have to pay the full price of any care you receive.

ROCKY MOUNTAIN HEALTH
MAINTENANCE ORGANIZATION, INC.



By _____
Stephen K. ErkenBrack, President and CEO

3. CONTACT US

Customer Service	
Address:	Rocky Mountain Health Plans 2775 Crossroads Blvd. PO Box 10600 Grand Junction, CO 81502-5600
Hours:	8:00 A.M. – 5:00 P.M. Monday – Friday
Phone Number:	970-243-7050 or 800-346-4643 Para asistencia en español llame al 970-243-7050 or 800-346-4643
TTY Number:	If you are hearing impaired and use TTY equipment, call 711.
Fax:	Fax: 970-244-7880
Email Address:	customer_service@rmhp.org
Interpretation Services:	Help is available for callers who speak other languages. Please call Us at the phone numbers above.
Other Important Contacts	
Complaints About the Care You Get	Rocky Mountain Health Plans Attention: Member Appeals 2775 Crossroads Blvd. PO Box 10600 Grand Junction, CO 81502-5600 Fax: 970-244-7828
Privacy Complaints	Rocky Mountain Health Plans Attention: Privacy Complaint 2775 Crossroads Blvd. PO Box 10600 Grand Junction, CO 81502-5600

4. TABLE OF CONTENTS

- 1. SCHEDULE OF BENEFITS (Who Pays What)..... 1
- 2. TITLE PAGE (Cover Page) i
- 3. CONTACT US ii
- 4. TABLE OF CONTENTS iii
- 5. ELIGIBILITY..... 1
 - A. General Eligibility Rules..... 1
 - B. Eligibility of Subscriber 1
 - C. Eligibility of Dependent Spouse 1
 - D. Eligibility of a Dependent Child 1
 - E. Eligibility of Same-Sex Domestic Partner 1
 - F. Eligibility of a Designated Beneficiary 2
 - G. Adding a Dependent 2
 - H. Yearly Open Enrollment Period..... 3
 - I. Special Enrollment Periods 3
 - J. Native Americans/Alaskan Natives 5
 - K. Member ID Card 5
 - L. False Statements..... 5
- 6. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS 6
 - A. Getting Care 6
 - (1) Network or Non-Network Providers 6
 - (2) In-Network Benefits 6
 - (3) Out-of-Network Benefits 7
 - (4) Network Specialist and Other Provider Visits: 7
 - (5) PCP Visits..... 7
 - B. Payment for Non-Covered Services..... 7
 - C. Choosing a PCP 7
 - D. Changing Your PCP 8
 - E. Your Member ID Card..... 8
 - F. Emergency Care..... 8
 - G. Prior Authorization 8
 - H. Access Plan 9
 - I. Non-Discrimination 9
- 7. BENEFITS/COVERAGE (What is Covered) 10
 - A. Benefits 10
 - B. Covered Benefits..... 11
 - (1) Alcohol and Substance Abuse Treatment..... 11
 - (2) Allergy Testing 11
 - (3) Ambulance Services 11
 - (4) Autism Spectrum Disorders 12
 - (5) Bariatric Services..... 12
 - (6) Blood Services..... 13
 - (7) Chemotherapy (chemo) and Radiation 13
 - (8) Chiropractic Care (Chiro Care) 13
 - (9) Cleft Lip and Palate Services 15
 - (10) Clinical Trials 15
 - (11) Dental Services and Oral Surgery 16

(12)	Diabetic Services	18
(13)	Dialysis	19
(14)	Early Intervention Services (EIS).....	19
(15)	Education Services	19
(16)	Emergency Care and Urgent Care.....	20
(17)	Eye Care	20
(18)	Habilitative Care.....	21
(19)	Hearing Care.....	21
(20)	Home Health Services	22
(21)	Hospice Services	23
(22)	Hospital Services	24
(23)	Implanted Devices	25
(24)	Infertility Services	25
(25)	Intractable Pain.....	26
(26)	Mastectomy Services.....	26
(27)	Maternity Care and Family Planning	26
(28)	Medical Equipment, Supplies, Orthotic Devices (OD), Prosthetic Devices (PD) and Repairs and Oxygen	28
(29)	Mental Health Services.....	30
(30)	Nutrition	31
(31)	Outpatient Injectable and Infusion Drugs.....	32
(32)	Physician Services and Preventive Services.....	32
(33)	Podiatry Services	34
(34)	Prescribed Drugs and Immunizations.....	35
(35)	Reconstructive Surgery	36
(36)	Skilled Nursing Facility (SNF) Services	37
(37)	Therapy Services	38
(38)	Transplants	39
C.	Pilot Programs.....	41
D.	Double Coverage and Coordination of Benefits (COB)	41
(1)	Medicare COB.....	41
(2)	Auto Insurance Benefits COB	41
(3)	Prior Coverage.....	42
(4)	Pursuit of Coverage	42
(5)	No Double Recovery	43
(6)	Insurance With Other Insurers.....	43
8.	LIMITATIONS/EXCLUSIONS (What is Not Covered)	43
A.	Limitations:	43
B.	General Exclusions	44
C.	Specific Exclusions	46
9.	MEMBER PAYMENT RESPONSIBILITY	55
A.	Payment.....	55
B.	Assessments	56
C.	Yearly Out-of-Pocket Maximum	56
D.	Change of Health Care Plans	56
E.	Incentives	56
F.	Third Party Liability	57
(1)	Applicability	57
(2)	Subrogation	57

	(3)	Reimbursement of Proceeds	57
	(4)	Settlement of Third-Party Liability Claims	58
	G.	Interest.....	58
10.		CLAIMS PROCEDURE (How to File a Claim).....	58
	A.	Filing Claims.....	58
	(1)	Time Limit.....	58
	(2)	Required Information	59
	(3)	Manner of Payment	60
	(4)	Minor or Incompetency	60
	B.	Time Lines for Our Decisions.....	60
	C.	RMHP Formulary Exception Requests.....	62
	(1)	Standard Review.....	62
	(2)	Expedited Review.....	62
	(3)	External Review	63
11.		GENERAL POLICY PROVISIONS	63
	A.	Reporting Rules for Subscribers and Members	63
	(1)	Double Coverage.....	63
	(2)	Tell Us if You are Admitted to a Non-Network Hospital	63
	(3)	Report Third-Party Claims	63
	(4)	If Your Eligibility Changes	63
	(5)	Tell Us if Your Address Changes.....	64
	B.	Duration	64
	C.	Application and Effective Date.....	64
	D.	Confidentiality of Records	64
	E.	Relationship with Providers.....	65
	F.	Controlling Costs	65
	G.	Notice.....	65
	H.	Assignment	66
	I.	Enforcement.....	66
	J.	Offset.....	66
	K.	Binding Effect.....	66
	L.	Headings	66
	M.	Unexpected or Uncontrollable Events	66
	N.	Entire Agreement	67
	O.	Interpretation.....	67
12.		TERMINATION/NON-RENEWAL/CONTINUATION	67
	A.	Termination for Cause	67
	B.	Procedure to Terminate for Cause	68
	C.	Other Terminations	68
	D.	Reinstatement of Contract.....	70
	E.	Requests for Retroactive Termination	70
	F.	Effect of Ending Subscriber's Coverage.....	70
	G.	Termination for Any Reason	70
	H.	Renewability of this Contract	70
	I.	Continued Inpatient Care	71
	J.	Continuation of Coverage.....	71
13.		APPEALS AND COMPLAINTS.....	71
	A.	Informal Procedure	72
	B.	Review Time Lines	72

	(1)	Fast Review	72
	(2)	Fast External Review.....	72
C.		Review Procedure	73
	(1)	Filing a Complaint.....	73
	(2)	Internal Review	74
	(3)	External Review:	76
D.		Arbitration.....	78
E.		De Novo Review.....	79
F.		Jurisdiction and Venue.....	80
G.		Time is of the Essence	80
H.		Contact the Insurance Commissioner	80
I.		HIPAA Privacy Complaints.....	80
J.		Quality of Care Concerns.....	81
K.		Release of Records.....	81
L.		Changes to the Complaint Process.....	81
14.		INFORMATION ON POLICY AND RATE CHANGES	81
	A.	Amendment.....	81
	B.	Premium Changes	81
15.		DEFINITIONS	82
	A.	Definitions.....	82

5. ELIGIBILITY

A. General Eligibility Rules

You must meet all of the “General Eligibility Rules” below to enroll with Us, unless the rules are not allowed by law:

- The Subscriber must live in one of the following counties in the Service Area:
 - Mesa;This rule does not apply to Subscribers as allowed by Us in writing under Our rules;
- You must meet the rules of this Contract;
- We must get Your accurate and complete application and other requested information;
- A Network Provider, a Non-Network Provider or anyone affiliated with a Network Provider or Non-Network Provider who has provided or intends to provide You Care may not pay Your Premium. This will not apply if We are required by law to accept such payment; and
- Dependents must meet the eligibility rules in this Contract.

We will not refuse to enroll You solely because You are a medical assistance recipient and coverage is sought per section 25.5-4-210, C.R.S.

B. Eligibility of Subscriber

A Subscriber may enroll if he or she meets all the General Eligibility Rules.

C. Eligibility of Dependent Spouse

A Dependent Spouse may enroll if he or she meets the General Eligibility Rules.

D. Eligibility of a Dependent Child

A Dependent Child must meet the General Eligibility Rules and one of the following rules to be eligible to enroll:

- Be under 26 years old. (Eligibility ends the last day of the month when the child becomes 26 years old.)
- Be medically certified as disabled and dependent on the Subscriber, Dependent Spouse or Domestic Partner. A disabled Dependent Child can be any age. The Subscriber must give Us proof of the disability and dependency each Calendar Year. This requirement may be waived by Us in writing.

E. Eligibility of Same-Sex Domestic Partner

A Same-Sex Domestic Partner (“Domestic Partner”) may enroll if the Domestic Partner meets the General Eligibility Rules.

F. **Eligibility of a Designated Beneficiary**

A Designated Beneficiary (DB) may enroll if the DB:

- meets the General Eligibility Rules; and
- has a Designated Beneficiary Agreement (DBA) per Colorado law.

G. **Adding a Dependent**

If You got this Policy on the Exchange, You must tell the Exchange when You are adding a Dependent. If You did not get this Policy on the Exchange, You must tell Us when You are adding a Dependent.

- (1) **Newborns:** A newborn Dependent Child is covered under this Contract for 31 days after birth. Coverage will continue after the first 31 days unless the Subscriber asks Us to disenroll the newborn. The request to disenroll must be made within 30 days of the birth. Any Premium changes will start the 32nd day after the birth. All Care is subject to applicable Cost Sharing.
- (2) **New Dependents Due to Adoption or Placement for Adoption (Adoption):** A person who becomes a Dependent by Adoption may enroll if he or she meets the General Eligibility Rules. The request to enroll must be made within 60 days after the Adoption. The effective date of coverage will be the date of the Adoption. Premiums will change on the effective date of coverage.
- (3) **New Dependents Due to Placement in Foster Care:** A person who becomes a Dependent due to placement in foster care may enroll if he or she meets the General Eligibility Rules. The request to enroll must be made within 60 days after the placement in foster care. The effective date of coverage will be the date of the placement in foster care. Premiums will change on the effective date of coverage.
- (4) **New Dependents Due to Marriage:** A person who becomes a Dependent by marriage or Civil Union after the Effective Date may enroll if he or she meets the General Eligibility Rules. The request to enroll must be made within 60 days after the marriage or Civil Union. Coverage will begin on the date of the marriage or Civil Union if We get the request to enroll before that date. If not, coverage begins the first day of the month after the date of the marriage or the Civil Union. If Premiums change, they will change on:
 - the first day of the month the coverage began if the Effective Date is the 1st through the 15th day of the month, or
 - the first day of the month after the Effective Date if the coverage began after the 15th day of the month.
- (5) **New Dependents Who Are Designated Beneficiaries (DB):** A person who becomes a DB after the Effective Date may enroll if the DB meets the General Eligibility Rules.

The request to enroll must be made within 60 days after the DBA is recorded. If We get the request to enroll before the DBA is recorded, coverage begins on the date the DBA is recorded. Changes in Premium for the addition of a new Dependent will occur on the effective date of coverage.

If You got this Policy on the Exchange, the effective date of coverage will be the date the Exchange specifies. If You didn't get this Policy on the Exchange, the effective date of coverage will be the date We approve the Dependent's application. Changes in Premium for the addition of a new Dependent will occur on the effective date of coverage.

H. Yearly Open Enrollment Period

During the Yearly Open Enrollment Period, You may change Policies or add Dependents to Your coverage under this Contract. The effective date of any changes will be the January 1 following the Yearly Open Enrollment Period.

I. Special Enrollment Periods

You may enroll outside of the Yearly Open Enrollment Period if the General Eligibility Rules are met and if the request to enroll is made within 60 days after any of the following events:

- You gain a Dependent through marriage, birth, adoption, placement for adoption, placement in foster care, or by entering into a Civil Union;
- if You got this Policy on the Exchange and the Subscriber or Dependent, who was not previously a citizen, national, or lawfully present individual gains such status;
- Your enrollment or non-enrollment in a QHP or other health benefit plan is unintentional, inadvertent, or a mistake and is the result of the mistake, misrepresentation, or inaction of a carrier, producer or an officer, employee, or agent of the Exchange or the U.S. Department of Health and Human Services (HHS);
- You show the Exchange or the Colorado Division of Insurance that Your QHP or other health benefit plan substantially violated a material provision of its contract with You;
- You gain access to new QHPs or other Creditable Coverage due to a permanent move;
- if You got this Policy on the Exchange, You show the Exchange, per HHS guidelines, that You meet other exceptional circumstances as the Exchange may provide;
- The Exchange determines that You:

- were not enrolled in a QHP,
- were not enrolled in the QHP You chose, or
- are eligible but are not getting advance payments of the premium tax credit or cost-sharing reductions

because of misconduct by a non-Exchange entity helping with enrollment. For purposes of this section, misconduct means the failure of the non-Exchange entity to follow the standards of:

- the ACA, or
- other applicable Federal or State laws

as determined by the Exchange;

- the Exchange determines the Subscriber or Dependent to be newly eligible or newly ineligible for the federal advance payment tax credit or cost sharing reductions available through the Exchange under federal law;
- the Subscriber or Dependent's Medicaid or CHP+ coverage ends due to a loss of eligibility; or
- if You got this Policy on the Exchange, the Subscriber or Dependent becomes eligible for Medicaid or CHP+ premium assistance, including under any waiver or demonstration project.

You may enroll outside of the Yearly Open Enrollment Period if the General Eligibility Rules are met and the request to enroll is made within 60 days before or after any of the following events, unless otherwise noted below:

You or Your Dependents:

- lose minimum essential coverage or existing Creditable Coverage for any reason other than Fraud or failure to pay a Premium. The date of the loss of coverage is the last day You would have coverage under Your previous plan or coverage;
- enrolled in any non-calendar year health insurance policy that will expire. This is even if You have the option to renew the expiring non-calendar year individual health insurance policy. The date of the loss of coverage is the date of the expiration of the non-calendar year policy;
- lose pregnancy-related coverage described in the Social Security Act. The date of the loss of coverage is the last day You have pregnancy-related coverage;
- lose medically needy coverage as described in the Social Security Act only once per calendar year. The date of the loss of coverage is the last day You would have medically needy coverage;
- who are enrolled in an eligible employer-sponsored plan are determined newly eligible for advance payments of the premium tax credit. This is based in part on

a finding that You are ineligible for qualifying coverage in an eligible-employer sponsored plan, including as a result of Your employer discontinuing or changing available coverage within the next 60 days, provided that You are allowed to terminate existing coverage; or

- You gain access to new QHPs as a result of a permanent move. For calendar year 2016, You must tell Us within 60 days after the move. Beginning in calendar year 2017, You must tell Us within 60 days before or after the move.

If You timely request to enroll, the effective date of coverage will be:

- the first day of the month following the marriage, Civil Union, or loss of Creditable Coverage. However, if You request to enroll before the event, the effective date of coverage will be the date of the event;
- the date of the birth, Adoption, or placement in foster care; or
- for all other events:
 - the date of the event if coverage is requested prior to the event;
 - the first day of the following month if coverage is purchased between the 1st and the 15th day of the month; or
 - the first day of the second following month if coverage is purchased after the 15th day of the month.

The Exchange may permit the Subscriber to choose other coverage effective dates.

J. Native Americans/Alaskan Natives

If the Subscriber or Dependent is an Indian, then he or she may enroll in a QHP or change from one QHP to another one time per month.

K. Member ID Card

We will send You a Member ID Card when You enroll with Us. The Member ID Card does not prove eligibility or that You will get Benefits. You cannot get Benefits under this Contract if:

- You are no longer eligible; or
- the Contract ends.

L. False Statements

Any Fraud by You with regard to a Member's eligibility (included in an application or request to enroll, or in any additional information needed by Us), may cause the Subscriber's and the Member's enrollment to be Rescinded. We will give the Subscriber and each Member notice at least 30 days before enrollment is Rescinded. If the Contract between the Subscriber and Us is Rescinded for Fraud, the Subscriber

will pay Us for Benefits paid or costs incurred by Us on behalf of the Subscriber and Dependents.

6. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

A. Getting Care

(1) Network or Non-Network Providers

You may choose to get Care from Network Providers or Non-Network Providers. Some of Our Policies include an option to get Care from Preferred Network Providers. Referrals are not required. Network Providers and Preferred Network Providers, if applicable, are listed on Our Provider Directory. You may get a printed Provider Directory by calling Us, or You may get one from Our website at www.rmhp.org. We will not deny or restrict In-Network Benefits to You solely because You obtained treatment from a Non-Network Provider.

(2) In-Network Benefits

In most cases, You must get Care from Network Providers for the Care to be covered as In-Network Benefits. In-Network Benefits are provided at a higher level than Out-of-Network Benefits. If available, Benefits provided by Preferred Network Providers are provided at a higher level than regular In-Network Benefits. Cost Sharing for In-Network Benefits provided by Network Providers and Preferred Network Providers, if applicable, is shown on the Coverage Schedule. If You need Care that You cannot get from a Network Provider, We will arrange for Care from a Non-Network Provider. The Care will not cost You more than if the Care was from a Network Provider.

You do not need a referral to get specialty services from any Network Provider that is qualified to provide the Care.

If We terminate a Network Provider without cause and do not provide notice of the termination to Members as required by Colorado law, We will allow Members to continue Care from the provider for 60 days from the date of termination.

Care provided at a Network Provider facility, including ancillary Care provided by a Non-Network Provider, will not cost more than if You received the Care from a Network Provider. But if You seek care on purpose from a Non-Network Provider, this care is considered out-of-network Care and will be a Benefit only under limited circumstances. This rule applies even if You got the care at a Network Provider facility.

(3) **Out-of-Network Benefits**

Care from Non-Network Providers is covered as Out-of-Network Benefits unless approved by Us in writing. Cost Sharing for Out-of-Network Benefits is shown on the Coverage Schedule. Some Care from Non-Network Providers is not covered (see the Coverage Schedule).

(4) **Network Specialist and Other Provider Visits:**

You may see a Network Specialist or a Network Provider for Care. You do not need a referral from Your PCP. In most cases, Your Cost Sharing for Network Specialist visits will be more than for PCP visits.

You do not need approval from Us or Your PCP to get Care from a Network Provider who is an OB, GYN, CNM or eye care provider. The provider may need to follow certain procedures. This includes getting Prior Authorization for some services, following a pre-approved treatment plan, and making referrals. For a list of Network Providers who are OBs, GYNs, CNMs or eye care providers, call Us or review the Provider Directory on our website, www.rmhp.org.

(5) **PCP Visits**

You should see a PCP for routine Care. In most cases, Cost Sharing will be lower when You get Care from Your PCP or another PCP.

B. Payment for Non-Covered Services

We will not cover, and You must pay for, all health services or supplies which:

- are not Benefits under this Contract; or
- You get in violation of this Contract.

You agree to pay Us back any amounts paid by Us for non-covered services and supplies.

C. Choosing a PCP

You may choose a PCP who is a Network Provider. Each Member may pick a different PCP. Before choosing a PCP, You should check with the new PCP to be sure that they are accepting new patients. For help choosing a PCP, and for a list of PCPs, review the Provider Directory on our website, www.rmhp.org, or call Us.

You may choose a pediatrician as the PCP for Your child.

Women may choose an obstetrician (OB), gynecologist (GYN), or a certified nurse midwife (CNM) provider as their PCP. For a list of OBs, GYNs or CNMs who are Network Providers, review the Provider Directory on our website, www.rmhp.org, or call Us.

In most cases, Your Cost Sharing will be lower when You get Care from a PCP instead of from a Network Specialist or other Network Provider.

D. Changing Your PCP

You may change Your PCP by calling Us or by going to www.rmhp.org. Please call Us before getting Care from Your new PCP. If Your PCP is no longer a PCP in Our network, You may choose a new PCP. Before changing Your PCP, You should check with the new PCP to be sure they are accepting new patients. You should have Your health records sent to Your new PCP as soon as possible.

E. Your Member ID Card

When You enroll with Us, You will get a Member ID Card. You must show the Member ID Card to the provider each time You get Care. We will send You a new Member ID Card if information on the card changes.

F. Emergency Care

An Emergency occurs when You have a life- or limb-threatening emergency. A “life- or limb-threatening emergency” means any event that a prudent layperson would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health. You do not need to call a PCP before getting Emergency Care.

In an Emergency, You have the option to:

- call the local pre-hospital emergency medical service system by dialing the emergency telephone access number 9-1-1 or its local equivalent whenever You are confronted with a life- or limb-threatening emergency;
- call the local emergency number; or
- go to an emergency room.

If You go to an emergency room and You do not have an Emergency, You will have to pay for Care You get.

G. Prior Authorization

We require Prior Authorization for some Care before You get it. All requests for Prior Authorization must be:

- sent to Us in writing; and
- approved by Us before You get the services.

You may go to www.rmhp.org or call Us to find out if a service needs Prior Authorization. Some examples of services which may need Prior Authorization are:

- admission to a Hospital or inpatient rehab facility;
- DME, prosthetic devices (PD), orthotic devices (OD) and oxygen;

- treatment of TMJ;
- diagnostic imaging;
- surgery;
- transplants; and
- high dose chemo.

A Network Provider is responsible for getting any Prior Authorizations.

You are responsible for obtaining any required Prior Authorization for care provided by a Non-Network Provider. If You are in the National Network which allows access to Care outside of Colorado, the National Network providers are responsible for getting the Prior Authorization for services You get from National Network providers.

We will send You or Your Network Provider a written notice when We make a Prior Authorization decision. If We deny Prior Authorization, You or Your provider may ask that We review and reconsider Our decision. If the Prior Authorization request is denied (and not overturned), and You still get the care:

- benefits will be denied; and
- You must pay for the care.

If We Prior Authorized Care in writing, We cannot deny the Benefit after You get the Care. This does not apply in cases of fraud or abuse by the Subscriber or Member. If We give Prior Authorization for Care that is a not a Benefit, We will pay for the Care as Prior Authorized with no penalty to You.

All Benefits, including Care which needs Prior Authorization, are subject to the terms and conditions of this Contract.

H. Access Plan

You have the right to request a copy of Our access plan(s). You can also review a copy at any of Our offices.

I. Non-Discrimination

We will not discriminate:

- with respect to participation under this Contract; or
- coverage

against any provider who is acting within the scope of his or her license or certification.

7. BENEFITS/COVERAGE (What is Covered)

A. Benefits

In-Network Benefits are the services and supplies described in the Covered Benefits section. Out-of-Network Benefits are payment of Allowed Charges subject to the terms of this Contract, after You pay any required Deductible. Benefits are subject to:

- the Limitations and Exclusions in this section; and
- any Cost Sharing and Maximum Benefit Levels listed on the Coverage Schedule.

Allowed Charges will not exceed any:

- Maximum Benefit Level; or
- Maximum Benefit Allowance.

You must pay any billed amounts over the Allowed Charges for Care from Non-Network Providers.

If You obtained this Policy through the Exchange, You are an Indian and You receive Care from an Indian Health Program, Cost Sharing will not apply.

This section uses the following symbols to identify Maximum Benefit Levels, Limitations and Exclusions:

M	Maximum Benefit Level may apply - see Coverage Schedule
L	Limitation may apply
⊗	Exclusion – Not a Benefit of the Contract

Benefits are covered only when these conditions are met:

- the services are Medically Necessary;
- You comply with the Primary Care Procedures to get the services;
- the Premium is paid, except for:
 - automatic coverage of Dependent newborns for 31 days (see subsection 5.F);
 - continued coverage for inpatients (see subsection 12.I); and
 - coverage during any 31 day Grace Period or the first month of any 3 month Grace Period (see subsection 12.A).
- the services are provided within the Service Area, except for:
 - Emergency Care;

- Urgent Care;
- Care received from providers in Our National Network;
- Benefits for a Dependent Child who lives outside the Service Area are limited to services for:
 - Emergency Care;
 - Urgent Care;
 - follow-up treatment; and
 - Care received from providers in Our National Network.

Deductibles, if applicable, are shown in the Coverage Schedule. Required Deductibles must be satisfied before You can get Benefits. Some services are not subject to a Deductible. Deductibles are applied to the Yearly Out-of-Pocket Maximums. If You have coverage under an HDHP with the minimum Deductible allowed by Internal Revenue Code (IRC) provisions applicable to HDHPs and You add or drop a Dependent, Deductibles and Yearly Out-of-Pocket Maximums under Your HDHP will change. Deductibles are subject to annual adjustments in accordance with federal law.

B. Covered Benefits

(1) Alcohol and Substance Abuse Treatment

- **Detoxification (detox).** Coverage is provided for inpatient (at a Residential Treatment Facility or a Hospital) and outpatient detox services.

L *Limited to removal of toxic substances from the system.*

- **Rehabilitation (rehab).** Coverage is provided for inpatient (at a Residential Treatment Facility or a Hospital) and outpatient rehab services for the treatment of alcohol and substance abuse.

⊗ *Court ordered treatment that would not otherwise be covered.*

(2) Allergy Testing

Allergy injections and diagnostic testing performed with an allergy work-up are covered.

⊗ *If not set forth on the RMHP Formulary, injectable drugs, medications and adult immunizations.*

(3) Ambulance Services

Coverage is provided for transportation by licensed or certified ground or air ambulance when needed to bring You to the Hospital or other facility for:

- an Emergency; or
- Non-emergency transport.

L *Non-emergency transport is provided only when transport by other means would put Your life or health in danger.*

L *Air ambulance service is provided only when:*

- *Ordered by an emergency responder because of an Emergency;*
- *Ground ambulance transport would put Your life or health in danger; or*
- *The cost of air ambulance transport would be less than the cost of ground ambulance transport.*

⊗ *Transportation that serves only as a convenience for You or Your family.*

(4) **Autism Spectrum Disorders**

Coverage is provided for treatment for ASD when ordered by a Physician or licensed psychologist and includes the following:

- evaluation and assessment;
- behavior training, behavior management and ABA, including consultations, direct care, supervision, treatment, or any combination, for ASD provided by Autism Services Providers;
- Habilitative or rehabilitative care, including occupational therapy, physical therapy, speech therapy, or any combination;
- supplies and medicine from a pharmacy;
- psychiatric care;
- psychological care, including family counseling; and
- therapeutic care.

(5) **Bariatric Services**

Bariatric surgery is covered according to Our clinical guidelines. All bariatric surgery is subject to Prior Authorization.

⊗ *Panniculectomy for cosmetic reasons.*

⊗ *Gastric balloon.*

⊗ *Intestinal bypass.*

- ⊗ *Reversal of obesity services.*
- ⊗ *Cosmetic surgery related to bariatric services.*
- ⊗ *Vagal stimulation.*

(6) **Blood Services**

Coverage is provided for the following services related to blood:

- processing;
- handling;
- transportation; and
- administration.

- ⊗ *Blood and blood products that are not provided as part of a service covered under this Contract.*

(7) **Chemotherapy (chemo) and Radiation**

Coverage is provided for chemo, oral anti-cancer drugs and radiation, subject to Our policies.

L *High dose chemo along with bone marrow transplant, including peripheral stem cell removal and reintroduction, is provided only for the diagnoses in the subsection in this Covered Benefits section entitled “Transplants” for autologous or allogeneic human bone marrow or peripheral stem cells.*

(8) **Chiropractic Care (Chiro Care)**

The following services are covered for diagnosis and treatment of Neuromusculoskeletal Disorders related to Injury or Sickness. These services are referred to herein as “Chiro Care”:

- evaluations, manipulations and adjustments; and
- lab and x-ray services.

M *See Coverage Schedule*

- ⊗ *Chiro Care for children 3 years of age and younger.*

- ⊗ *Chiro Care provided in excess of what is necessary for maximum improvement. This is the point at which the patient shows little or no improvement with additional therapy.*
- ⊗ *Chiro Care provided on an inpatient basis.*
- ⊗ *Chiro Care which is maintenance care. Maintenance care is defined as a treatment program designed to maintain optimal health in the absence of symptoms.*
- ⊗ *Neuromusculoskeletal manipulation under anesthesia.*
- ⊗ *Clinical laboratory services and any associated procedures related to Chiro Care involved in the collection and/or testing of biological or lab specimens.*
- ⊗ *Preventive care, educational programs, therapies, nonmedical self-care, self-help training and any related diagnostic testing, except that which occurs during the normal course of providing Chiro Care.*
- ⊗ *Vocational or long-term rehab related to Chiro Care.*
- ⊗ *Advanced diagnostic testing and imaging performed as part of Chiro Care, including:*
 - *MRI, CT or bone scans;*
 - *diagnostic ultrasound;*
 - *videoflourosopy;*
 - *thermography;*
 - *electrodiagnostic testing, such as nerve conduction velocity (NCV); and*
 - *electromyography (EMG) or evoked potentials.*
- ⊗ *Radiological procedures related to Chiro Care performed on equipment not certified, registered or licensed by the state where the services are performed.*
- ⊗ *Radiological procedures that We determine cannot be safely utilized in diagnosis or treatment.*

⊗ *Chiro Care for or related to diagnosis and treatment of jaw joint problems, including TMJ or craniomandibular disorders.*

⊗ *Technique-specific radiographs exposed to support such techniques.*

⊗ *Transportation costs related to Chiro Care, including ambulance charges.*

(9) **Cleft Lip and Palate Services**

Coverage is provided if You were born with a cleft lip and/or cleft palate. Benefits are provided regardless of age. Services include:

- oral and facial surgery, surgical management and follow-up care;
- prosthetic devices, such as speech and feeding appliances;
- orthodontic treatment;
- prosthodontic treatment;
- speech therapy;
- otolaryngology treatment; and
- hearing assessments and treatment.

(10) **Clinical Trials**

Coverage is provided for services included in this Covered Benefits section when You are part of a Clinical Trial if:

- You have a disabling, progressive or life-threatening condition that will be treated in the Clinical Trial;
- Your Physician recommends taking part in the Clinical Trial for therapeutic health benefits;
- the Clinical Trial is: approved under the Medicare National Coverage Decision regarding Clinical Trials; federally-funded; a study or investigation conducted under an investigational new drug application reviewed by the FDA or a drug trial that is exempt from this type of application;
- Your care is provided by a certified, registered or licensed health care provider practicing within the scope of his/her practice with the experience and training to provide the treatment in a competent way; and
- You have signed a statement of consent.

⊗ *Any part of a Clinical Trial that is paid for by a government or biotechnical, pharmaceutical or medical industry.*

- ⊗ *Any drug or device used in a Clinical Trial that is paid for by the manufacturer, distributor or provider of the drug or device.*
- ⊗ *Extraneous expenses related to taking part in a Clinical Trial, including travel, housing and other expenses that You, or a person traveling with You, may incur.*
- ⊗ *Any items or care provided as part of a Clinical Trial only to satisfy a need for data collection or analysis that are not directly part of Your clinical management.*
- ⊗ *Costs for the management of research relating to a Clinical Trial.*
- ⊗ *Care that, except for the fact that it is being provided in a Clinical Trial, is otherwise specifically excluded from coverage.*

(11) **Dental Services and Oral Surgery**

General Anesthesia for Dental Procedures for Dependent Children:

Coverage is provided for general anesthesia provided in a Hospital, an outpatient surgical facility or other facility for dental care provided to a Dependent Child if:

- the child has a physical, mental or medically compromising condition; or
- local anesthesia is not working due to acute infection, anatomic variations or allergy; or
- the child is extremely uncooperative, anxious, or uncommunicative and the dental care cannot be delayed; or
- the child has sustained extensive orofacial and dental Injury.

Coverage includes associated Hospital or facility charges for dental care provided to a Dependent Child.

L *Anesthesia services do not include treatment provided for TMJ.*

Injuries to Sound and Natural Teeth: Coverage is provided for basic restorative services and supplies (fillings and root canals), and orthodontic care needed to quickly repair Sound and Natural Teeth damaged or removed as a result of an accidental Injury.

L *Treatment must begin within 60 days of the accident. Services must be completed within 24 months of the accident.*

L *Services must be provided while You are entitled to Benefits under this Contract.*

Children's Dental Services: Coverage is provided for Children's Dental Services for Members up to age 19. "Children's Dental Services" means the following, each of which is covered per Calendar Year, unless otherwise noted below:

- 2 oral exams and evaluations;
- 2 fluoride applications;
- 1 set of x-rays (intra-oral or bitewing);
- 1 set of x-rays (panoramic or full mouth) – once every 5 years;
- 2 routine cleanings;
- 1 space maintainer;
- sealants; and
- palliative care.

Any two of the services from the following list are also covered per Calendar Year as part of Children's Dental Services:

- amalgam, resin, composite or sedative fillings;
- extractions;
- root canal therapy; and
- surgical periodontal services.

Any one of the services from the following list are also covered per Calendar Year as part of Children's Dental Services:

- crowns; and
- pin retention.

Oral Surgery: Coverage is provided for oral and maxillofacial surgery for:

- treatment of the temporomandibular joint due to congenital defect or Injury of such joint by an illness;
- removal of tumors and cysts; and
- treatment of fractures.

⊗ *Dental splints, implants or prostheses.*

⊗ *Treatment for periodontal disease.*

⊗ *Dental treatment or services on or to the teeth, gums or jaws. This Exclusion does not apply to treatment for Injuries to Sound and Natural Teeth or to Children's Dental Services.*

- ⊗ *Treatment for pain or infection known or thought to be due to a dental cause and near the teeth or jaw, unless not treating such an infection may result in a systemic illness.*
- ⊗ *Surgical correction of malocclusion, services, supplies or appliances provided to alter, correct, fix, improve, remove, replace, reposition, restore or treat the jaw, or any jaw implant. This Exclusion does not apply to services for cleft lip and cleft palate and reconstructive surgery services. (See section 7.B.(9))*
- ⊗ *Maxillofacial and/or mandibular orthognathic surgery, oral surgery and orthodontia treatment including all outpatient and related costs, if the services are related to a dental condition.*
- ⊗ *Treatment of craniomandibular joint disorders and TMJ by use of orthodontic appliances and treatment, crowns, bridges or dentures.*
- ⊗ *Removal of a tooth, except for treatment for Injuries to Sound and Natural Teeth.*
- ⊗ *Treatment for Injury to Sound and Natural Teeth caused by biting or chewing.*
- ⊗ *Alveoplasty when performed with an excluded service.*
- ⊗ *Care provided with non-covered dental services, except for general anesthesia for dental procedures for Dependent Children.*
- ⊗ *Dental cleaning, in-mouth scaling, planing, or scraping, except for Children's Dental Services.*
- ⊗ *Myofunctional Therapy.*
- ⊗ *Services, including related orthodontic treatment, to repair or replace teeth.*

(12) **Diabetic Services**

Coverage is provided for treatment of diabetes, including:

- disposable medical equipment;
- Disposable Medical Supplies;

- DME;
- eye care;
- podiatry services;
- outpatient training and education on managing Your diabetes; and
- health nutrition therapy when prescribed by a Physician or other provider.

(13) **Dialysis**

Coverage is provided for dialysis services for chronic renal disease.

(14) **Early Intervention Services (EIS)**

Coverage is provided for EIS for a qualified Dependent Child under age 3 with a written individualized family service plan who:

- (a) has major delays in development;
- (b) has been diagnosed with a physical or mental condition that has a high probability of resulting in a major delay in development, or
- (c) is a child with a developmental delay as defined by the Colorado Department of Human Services.

Examples of EIS include:

- audiology;
- developmental intervention;
- nutrition;
- occupational therapy;
- speech therapy; and
- vision.

M *See Coverage Schedule*

⊗ *Non-emergency transport, Respite Care, service coordination, and assistive technology (unless otherwise covered under the Covered Benefits section).*

⊗ *EIS services for children age 3 and older.*

(15) **Education Services**

Coverage is provided for the following education services:

- asthma education for Members with asthma;

- basic health education through newsletters from Us and services from Network Providers;
- specialized health education such as health risk profiles, workshops, physical fitness programs, and CPR classes which may be offered to You. These services are arranged by Us and provided by Our staff or providers.

(16) **Emergency Care and Urgent Care**

Coverage is provided for Emergency Care 24 hours a day, 7 days a week.

Coverage is provided for Urgent Care when needed to avoid a serious decline of Your health before You are able to get Care during a routine office visit. Extra services, including labs, x-rays and diagnostic testing, are covered and may be subject to additional Cost Sharing.

⊗ *Follow-up Care You get in an emergency room.*

See section 11.A for rules on reporting admissions for out of Service Area Care.

(17) **Eye Care**

Coverage is provided for:

- eye exams for children under age 19;
- eyeglasses, lenses and contact lenses for children under age 19;
- eyeglasses, contacts and the fitting of contacts after covered eye surgery or with a diagnosis of keratoconus;
- treatment needed for an eye Injury or Sickness; and
- eye surgery due to Injury or Sickness (for example, cornea transplants and cataract extractions).

The eyeglasses and lenses benefit is designed to cover visual needs. We will pay the cost of the basic lenses and basic frames. You will be responsible for the additional cost for these options:

- anti-reflective coating;
- color coating;
- mirror coating;
- scratch coating;
- blended lenses;
- high index lenses;
- cosmetic lenses;
- laminated lenses;
- oversize lenses;
- photochromic lenses;
- tinted lenses except Pink #1 and Pink #2;

- progressive multifocal lenses;
- UV (ultraviolet) protected lenses; or
- designer frames.

M *See Coverage Schedule*

L *Coverage of frames and lenses is limited to the most cost effective medically acceptable choices.*

L *Replacement eyeglasses, lenses and contact lenses are limited to one pair or set every two (2) years for children under age 19.*

⊗ *Eyeglasses, contacts and the fitting of contacts, except:*

- for children under age 19,
- after covered eye surgery, or
- with a diagnosis of keratoconus.

⊗ *Replacement of lost or broken lenses or frames.*

⊗ *Vision therapy, including the use of lenses and/or prisms for the treatment of a traumatic brain Injury, learning disabilities, and dyslexia.*

⊗ *Refractive keratoplasty, including radial and laser keratotomy (Lasik surgery), and any procedure to fix a refractive defect.*

(18) **Habilitative Care**

Inpatient and outpatient Habilitative Care is covered.

M *See Coverage Schedule*

(19) **Hearing Care**

Coverage is provided for:

- hearing exams and tests to determine the need for hearing correction;
- audio testing and treatment due to Injury or Sickness;
- hearing aid services and supplies for Members under age 18, including:
 - i. the initial assessment, fitting and adjustments;
 - ii. auditory training;
 - iii. initial hearing aids;

- iv. replacement hearing aids; and
- v. new hearing aids when changes to the current hearing aid cannot meet the needs of the Member.

L *Replacement hearing aids are limited to 1 pair every 5 years. This does not apply if changes to the current hearing aid cannot meet the needs of the Member.*

⊗ *Hearing aids and devices, including bone anchored hearing aids and auditory devices or implants attached to the bone, and fitting for Members age 18 and older.*

⊗ *Cochlear implants and equipment and devices related to cochlear implants. This includes:*

- *internal receivers/stimulators,*
- *transmitters, and*
- *speech processors.*

(20) **Home Health Services**

Home Health Services must be provided by a Home Health Agency and ordered by a Physician. Care must be provided under a Home Health Care Plan established by the Physician and the Home Health Agency. Coverage is provided for:

- part-time or intermittent home nursing care for:
 - skilled nursing care under the supervision of a Registered Nurse (RN),
 - home health aide services under the supervision of an RN or therapist,
 - certified nurse aide services,
 - medical social services under the supervision of an RN;
- infusion services;
- physical, occupational, pulmonary, and speech therapies;
- Nutritional counseling by a nutritionist or dietitian;
- audiology services; and
- medical supplies and lab services that would be covered if You were an inpatient at a Hospital.

⊗ *Private Duty Nursing, unless determined to be Medically Necessary by a Physician.*

⊗ *Custodial Care.*

⊗ *Housekeeping, homemaker and meal services.*

(21) **Hospice Services**

Coverage is provided:

- if You are terminally ill with a life expectancy of 6 months or less as certified by a Physician; and
- for Your Immediate Family, primary caregiver and people close to You.

If You live beyond the 6 month period, Benefits will continue for an extra 3 months. After 9 months, Rocky Mountain, Your attending Physician and the Hospice will decide if You need to continue hospice services.

Benefits are actively managed and coordinated by a Hospice and must be provided by a Hospice Care Team under the terms of a Hospice Care Program regardless of location. You may get hospice services at home or at a facility. Benefits will be provided for:

- intermittent and 24-hour on-call professional nursing services by or under the supervision of an RN;
- intermittent and 24-hour on-call counseling, and social services;
- certified nurse aid services; or nursing services delegated as allowed by law;
- part-time or intermittent home health aide services under the supervision of an RN or therapist;
- physical, occupational, pulmonary (respiratory or breathing), and speech therapies;
- hearing services;
- nutritional counseling;
- Respite Care;
- medical supplies;
- prostheses and orthopedic appliances;
- drugs and biologicals;
- oxygen and respiratory supplies;
- DME;
- transportation;
- Physician services;
- diagnostic testing;
- short-term inpatient hospice care or continuous home care for a period of crisis; and
- grief support services for Your Immediate Family, primary caregiver and people close to You during the twelve-month period after death.

Care that is not related to the reason You are getting hospice care is subject to the coverage provisions of this Contract.

⊗ *Private Duty Nursing, unless determined to be Medically Necessary by a Physician.*

⊗ *Grief support services, except as provided above.*

(22) **Hospital Services**

Coverage is provided for:

Inpatient Hospital services:

- semi-private room and board;
- nursing care;
- services and supplies;
- use of operating room, recovery room, private room when Medically Necessary, intensive care;
- special diet, including enteral and parenteral nutrition;
- prescribed drugs;
- x-rays;
- anesthesia;
- Private Duty Nursing; and
- labs.

⊗ *Personal comfort or convenience items.*

⊗ *Private room unless it is Medically Necessary.*

⊗ *Care for complications that arise after You leave a Hospital against medical advice.*

Outpatient Hospital services:

- outpatient surgery facilities;
- x-rays and other imaging services;
- diagnostic tests;
- radiation therapy;
- labs;
- anesthesia; and
- services You get in an emergency room – see **Emergency Care**.

⊗ *Surgical treatment for obesity or conditions related to obesity except for covered bariatric services.*

⊗ *Reversal of obesity services.*

- ⊗ *Treatment of any complications caused by obesity treatment except for covered bariatric services.*
- ⊗ *Services and supplies related to any care that is not covered. This includes services and supplies that are an integral part of a non-covered benefit.*
- ⊗ *Clinical pathology services unless the services are within the scope of practice of the individual providing the services and are either rendered personally by the pathologist or are performed under the pathologist's direct supervision.*

(23) **Implanted Devices**

Coverage is provided for cardiac pacemakers and internally implanted prosthetic devices.

- ⊗ *Cochlear implants and equipment and devices related to cochlear implants. This includes:*
 - *internal receivers/stimulators,*
 - *transmitters, and*
 - *speech processors.*
- ⊗ *Equipment, supplies and drugs not approved by the Food and Drug Administration for medical use.*
- ⊗ *Hair transplants or implants.*
- ⊗ *Dental splints, implants or prostheses.*

(24) **Infertility Services**

We cover the following infertility services:

- (a) services for diagnosis and treatment of involuntary infertility;
 - (b) artificial insemination; and
 - (c) related x-ray and laboratory procedures.
- ⊗ *Reversal of voluntary sterilization.*
 - ⊗ *The following treatments for infertility or to cause pregnancy for both fertile and infertile couples:*

- *prescription drugs;*
- *donor eggs and semen;*
- *procurement and storage of donor eggs and semen;*
- *in vitro fertilization (IVF);*
- *gamete intrafallopian transfer (GIFT);*
- *ovum transplants;*
- *zygote intrafallopian transfer (ZIFT); and*
- *embryo transplants.*

(25) **Intractable Pain**

Coverage is provided for Covered Services listed in this Contract for treatment for Intractable Pain.

⊗ *Pain clinic services.*

(26) **Mastectomy Services**

Coverage is provided for:

- mastectomy services;
- treatment for physical complications in all stages of mastectomy, including lymphedemas;
- reconstructive surgery following a mastectomy, including:
 - reconstruction of the breast that was removed;
 - surgery or reduction on the other breast to produce a symmetrical appearance; and
- prostheses and mastectomy bras.

(27) **Maternity Care and Family Planning**

Maternity Care

Coverage is provided for:

- pre-natal care;
- delivery, including special procedures such as cesarean section (C-section);
- post-natal care;
- imaging;
- labs;
- Physician services; and
- Hospital care for a newborn and mother.

The minimum length of stay for a newborn and mother are:

- not less than 48 hours after a normal vaginal delivery. If 48 hours after delivery falls after 8:00 P.M., coverage will continue until 8:00 A.M. the next morning.
- not less than 96 hours after a C-section. If 96 hours after the C-section falls after 8:00 p.m., coverage will continue until 8:00 A.M. the next morning.

A mother and newborn may be discharged before the minimum lengths of stay described above if the decision is made by an attending Physician and the mother agrees.

Complications of Pregnancy are covered the same way as any other Sickness or Injury.

A newborn Dependent Child is covered under this Contract for 31 days after birth. Medically Necessary Care and treatment of medically diagnosed congenital defects and birth abnormalities are included in this coverage, regardless of any Limitations and Exclusions with respect to other Care under this Contract.

⊗ *Amniocentesis to find out if the baby is a boy or a girl.*

⊗ *Services performed by a direct-entry or lay midwife.*

Family Planning and Sterilization Procedures

Coverage is provided for:

- counseling;
- information on birth control;
- intrauterine contraceptive devices (IUD) and subdermal implants;
- insertion, management and removal of IUDs and subdermal implants;
- diaphragms;
- fitting of diaphragms;
- birth control pills;
- Emergency Contraception prescribed by a health care provider;
- hormone injections, vaginal rings, and patches for contraception;
- surgical sterilization;
- any other medically acceptable drug, device or procedure used to prevent pregnancy; and
- screening and treatment for sexually transmitted diseases.

⊗ *Over-the-counter contraceptive drugs or devices which do not require a prescription, except those included in the RMHP Formulary.*

⊗ *Abortifacient drugs.*

- ⊗ *Reversal of voluntary sterilization.*
- ⊗ *Services and procedures to verify the success of reversal of voluntary sterilization.*
- ⊗ *The following treatments for infertility or to cause pregnancy for both fertile and infertile couples:*
 - *prescription drugs;*
 - *donor eggs and semen;*
 - *procurement and storage of donor eggs and semen;*
 - *artificial insemination;*
 - *in vitro fertilization (IVF);*
 - *gamete intrafallopian transfer (GIFT);*
 - *ovum transplants;*
 - *zygote intrafallopian transfer (ZIFT); and*
 - *embryo transplants.*

Abortion Services

Coverage is provided for abortions in cases of rape or incest, or when the life of the woman would be endangered.

- ⊗ *Elective abortions.*

(28) Medical Equipment, Supplies, Orthotic Devices (OD), Prosthetic Devices (PD) and Repairs and Oxygen

Coverage is provided for the following equipment and supplies, subject to Medicare local coverage guidelines:

- Disposable Medical Supplies;
- Durable Medical Equipment (DME); and
- Breast pumps and breast pump supplies.

L *Coverage is limited to the most cost effective medically acceptable choices. We will compare the expected medical benefits to the cost of such choices.*

L *We determine if the equipment will be rented or purchased based on how long You will need it and the cost of the equipment. If the equipment is purchased, You will own the equipment after paying any Cost Sharing.*

L *If You choose more costly DME than We have approved, You must pay any extra charges.*

⊗ *Costs to operate DME, OD and PD.*

⊗ *Air filters, purifiers and/or humidifiers.*

⊗ *Changes made to Your home or vehicles to make them handicap accessible.*

⊗ *Home modification equipment.*

⊗ *Wigs or hairpieces.*

⊗ *Home exercise equipment.*

⊗ *Convenience items per Medicare local coverage guidelines. Examples include, cold therapy units, over the bed tables, chair and patient lifts.*

- The following OD:
 - braces;
 - splints;
 - collars;
 - custom orthopedic shoes;
 - custom foot orthoses; and
 - dental OD.

L *Dental OD are only covered if You have symptomatic sleep apnea.*

- Home oxygen service and equipment.
- The following PD:
 - artificial eyes;
 - breast prosthetics and mastectomy bras - see **Mastectomy Services**; and
 - arm and leg PD.

L *Arm and leg PD are limited to the most appropriate model that adequately meets Your medical needs, as determined by a Physician.*

⊗ *Bionic prostheses.*

⊗ *Power enhancements or controls for prosthetic limbs and terminal devices.*

⊗ *Myoelectric prostheses.*

⊗ *Peripheral nerve stimulators.*

- Repairs to DME, OD and PD due to normal wear and tear. You can get replacement equipment for up to 1 month while the repairs are being made.

⊗ *Repairs and replacements of DME, OD and PD due to Your misuse or loss.*

(29) **Mental Health Services**

- **Inpatient Mental Health Services**

Coverage is provided for inpatient treatment at a Residential Treatment Facility or a Hospital if You have a mental or behavioral disorder or require crisis intervention.

- **Outpatient Mental Health Services**

Coverage is provided for:

- evaluation;
- crisis intervention and treatment;
- treatment for Mental Disorders;
- individual and group psychotherapy sessions; and
- family counseling.

Biologically-Based Mental Illness and Mental Disorders are covered the same as any physical illness.

L *Coverage for mental health services will apply only if You have a mental or behavioral disorder or require crisis intervention.*

⊗ *Behavior modification, such as weight loss programs.*

⊗ *Court ordered treatment that would not otherwise be covered.*

(30) **Nutrition**

Enteral Nutrition

Coverage is provided for outpatient specialized formulas for enteral nutrition under certain conditions.

L *Limited to children up to age 3 for treatment of a severe gastrointestinal disorder, malabsorption syndrome or other physical condition when:*

- *normal absorption of nutrition is not possible;*
- *an abnormal growth pattern is diagnosed; and*
- *the child does not respond to other dietary formulas.*

Medical Foods and Treatment for Inherited Enzymatic Disorders

Coverage is provided for Medical Foods for treatment of Inherited Enzymatic Disorders.

L *For treatment of PKU the maximum age is 21 years for males and 35 years for females.*

⊗ *Medical Foods are not covered for Members with cystic fibrosis or for Members who are lactose- or soy-intolerant.*

Nutritional Counseling

Coverage is provided for nutritional counseling services provided by a Physician, a dietitian or a nutritionist.

L *Provided only for members who have a medical diagnosis of, or risk factors for, cardiovascular or diet related chronic disease.*

Total Parenteral Nutrition – Outpatient (TPN)

Coverage is provided for TPN when provided in a Member’s home if the Member cannot maintain weight and strength because of a condition of the digestive tract that does not allow absorption of nutrients or if the Member cannot swallow food.

⊗ *Outpatient nutrition products, including Medical Foods, TPN and therapeutic formulas, except as provided in the “Nutrition” subparagraph.*

⊗ *Weight loss programs and services.*

(31) **Outpatient Injectable and Infusion Drugs**

Injectables on the RMHP Formulary are covered, including IV infusion, self administerable drugs, and drugs given by a Provider.

M *See Coverage Schedule*

(32) **Physician Services and Preventive Services**

Coverage is provided for:

- Office visits for treatment of Injury or Sickness including:
 - exams;
 - consultations; and
 - surgical procedures, including anesthesia.

Other services, including diagnostic testing, x-rays, labs and electrocardiograms, are covered subject to any Cost Sharing.

- Physician services are covered at an inpatient or outpatient facility.
- Second opinions can be requested by You, Your Physician or Us. (If We request a second opinion there will be no cost to You.)

L *Second opinions requested by You or Your Physician are limited to one second opinion per medical condition.*

Preventive Services

Coverage is provided for the following:

- (a) All preventive services with an “A” or “B” rating by the U.S. Preventive Services Task Force (USPSTF), and as recommended in the preventive care and screening guidelines for women, infants,

children, and adolescents by the Health Resources and Services Administration (HRSA) and the Advisory Committee on Immunization Practices to the Centers for Disease Control and Prevention (ACIP). Services may be limited to people of a certain age or sex or who meet other conditions.

We cover at least one form of contraceptive in each method identified by the FDA without Cost Sharing. The FDA has currently identified 18 methods of contraception.

The recommendations are updated regularly. Visit Our website or call customer service for the most up to date recommendations.

Examples of covered preventive services include:

- *Adult routine physical exams;*
- *Alcohol misuse screening and behavioral counseling interventions for adults;*
- *Breast cancer screening (mammograms), minimum of one per calendar year;*
- *Cervical cancer screening (pap smears);*
- *Colorectal cancer screenings;*
- *Immunizations and vaccinations;*
- *Cervical cancer vaccination;*
- *Outpatient well-child care;*
- *Screening for lipid disorders; and*
- *Tobacco use counseling and cessation interventions for adults.*

Mammography screenings will include, at a minimum, the following:

- either a preventive or a diagnostic mammogram per calendar year which is covered in full; and
- further mammograms during a calendar year which are covered the same as any other x-ray.

Prostate screenings are covered and will include, at a minimum, the following:

- A prostate-specific antigen (PSA) blood test and a digital rectal examination.
- One prostate screening per Calendar Year for:
 - men 50 years of age or older; or
 - men between 40 and 50 years of age who are at increased risk of developing prostate cancer as determined by a Physician.

- (b) Other tests or exams provided during a preventive service visit (Cost Sharing may apply).

M *See Coverage Schedule*

- ⊗ *Charges for visits to a health care provider that are not kept.*
- ⊗ *Third party testing, such as lab and x-rays that are not part of suggested screening or routine physicals.*
- ⊗ *Costs for health reports, including presentations and preparation.*
- ⊗ *Third party physical and/or psychological exams for employment, licensing, insurance, adoption or any other non-health reasons.*
- ⊗ *Screening tests that are done in multiple phases.*
- ⊗ *Checkups not associated with any Injury or Sickness, except as stated in the Covered Benefits section.*
- ⊗ *Clinical ecology services and services for treatment of multiple chemical sensitivity and idiopathic environmental illness.*
- ⊗ *Services and supplies related to any care that is not covered. This includes services and supplies that are an integral part of a non-covered service.*
- ⊗ *Genetic testing, except for:*
 - *diagnosing You with a condition or illness that will affect Your health;*
 - *treating a condition or illness that will affect Your health; or*
 - *preventive care recommended by the USPSTF or HRSA, including, for example, BRCA testing and counseling.*

(33) **Podiatry Services**

Coverage is provided for non-routine foot care provided by a podiatrist.

- ⊗ *Routine foot care.*

⊗ *Trimming of corns and calluses.*

⊗ *Treatment of flat feet.*

⊗ *Partial dislocations in the feet.*

(34) **Prescribed Drugs and Immunizations**

- Inpatient prescription drugs approved by the United States Food & Drug Administration (FDA) are covered when You are in a Hospital or SNF.
- Outpatient Prescription Drugs are covered subject to the RMHP Formulary, and as follows.
 - Outpatient Prescription Drugs are designated as Tier 1, Tier 2, Tier 3, Tier 4 and Tier 5 in the RMHP Formulary.
 - Drugs not listed in the RMHP Formulary are not provided as Benefits.
 - Only Outpatient Prescription Drugs related to Emergency Care or Urgent Care may be received from non-Network Pharmacies.
 - We will repay You for the cost of an Outpatient Prescription Drug purchased through a non-Network Pharmacy in an amount not to exceed the Allowed Charge, less the applicable Cost Sharing set forth on the Coverage Schedule.
 - Outpatient Prescription Drugs from a Network Pharmacy will be provided subject to the Cost Sharing set forth on the Coverage Schedule.
 - Contraceptive drugs and devices noted as “Women’s Preventive Healthcare” on the RMHP Formulary are covered with no Cost Sharing, regardless of tier.
 - Adult immunizations listed on the RMHP Formulary are covered.
 - Child immunizations that are supported by ACIP and the Child Health Immunization Bulletin issued from time to time by the Colorado Division of Insurance are covered.
 - Drugs approved by the FDA for use in treatment of cancer will not be excluded or restricted if the drug:
 - is prescribed for treatment of cancer that is not an FDA approved use; and
 - is recognized for treatment of that cancer by an authoritative listing of drugs as identified by the U.S. Department of Health and Human Services; and
 - will be used to treat a covered condition.

M *See Coverage Schedule*

L *We reserve the right to limit the maximum amount of an Outpatient Prescription Drug covered per Copay for specific Outpatient Prescription Drugs.*

L *Brand name contraceptive drugs are covered with no Cost Sharing only if:*

- *the generic drug is not medically safe and effective for the Member; or*
- *no generic drug is available.*

⊗ *Drugs and injectables excluded from, or not included in, the RMHP Formulary. We reserve the right to exclude any Outpatient Prescription Drugs at any time from the RMHP Formulary:*

- *for health and safety concerns,*
- *efficacy, and*
- *other reasons, as We determine in Our discretion.*

⊗ *Outpatient Prescription Drugs that are determined by the Medical Director to be abused or misused. We may impose conditions, limitations and restrictions on dispensation of Outpatient Prescription Drugs in order to prevent misuse or abuse.*

⊗ *Prescription refills for lost or stolen Outpatient Prescription Drugs.*

⊗ *Nonprescription drugs, vitamins, nutrients and food supplements even if recommended or given by a Physician.*

⊗ *Travel immunizations.*

⊗ *Over-the-counter contraceptive drugs or devices which do not require a prescription, except those included in the RMHP Formulary.*

⊗ *Abortifacient drugs.*

(35) **Reconstructive Surgery**

Coverage is provided for reconstructive surgery to correct a functional defect resulting from an Injury, Sickness or surgery. The surgery must reasonably be expected to correct the defect. See also **Mastectomy Services**.

- ⊗ *Cosmetic surgery or treatment for complications caused by non-covered cosmetic surgery.*
- ⊗ *Reversal of cosmetic surgery or non-covered reconstructive surgery.*
- ⊗ *Reconstructive surgery that does not result in functional gain.*
- ⊗ *Reconstructive surgery primarily for cosmetic reasons.*
- ⊗ *Breast reduction, unless Medically Necessary or as part of a mastectomy. Breast reduction is not covered in connection with cosmetic implants or primarily for cosmetic reasons.*
- ⊗ *Surgical treatment for obesity or conditions related to obesity except for covered bariatric services.*
- ⊗ *Reversal of obesity services.*
- ⊗ *Treatment of any complications caused by obesity treatment except for covered bariatric services.*

(36) Skilled Nursing Facility (SNF) Services

Coverage is provided for inpatient care, health care supplies, equipment and prescribed drugs from a SNF.

When discharged from a Hospital, You may get SNF services covered as In-Network Benefits from a Non-Network Provider if all of the following apply:

- before being hospitalized, You lived in the non-Network SNF;
- You had a contractual or other right to return to the non-Network SNF;
- the facility is licensed by the State of Colorado and is Medicare certified,
- the non-Network SNF agrees to follow the same terms and conditions that apply to Network Providers; and
- the services are Prior Authorized by Us.

L *We will not pay a non-Network SNF a higher rate than We pay Network Providers in the same geographic area for the same level and intensity of services.*

M *See Coverage Schedule*

⊗ *Custodial Care.*

⊗ *Nursing home and domiciliary care.*

(37) **Therapy Services**

- **Inpatient and Outpatient therapy**

Coverage is provided for Habilitative and rehabilitative speech, physical and occupational therapy. Also see **Cleft Lip and Palate Services**.

M *See Coverage Schedule*

- **Therapies for Congenital Defects and Birth Abnormalities**

Coverage is provided for physical, occupational and speech therapy for Members under age 6.

M *See Coverage Schedule*

L *Services for Members under age 3 are only covered if:*

- *the Member is not eligible for Early Intervention Services; or*
- *such services are not provided as part of a written individualized family service plan.*

- **Pulmonary Therapy and Cardiac Rehab**

Coverage is provided for pulmonary therapy and cardiac rehab services, phases I and II.

⊗ *Therapies, self-help programs and other services not specifically covered under the Contract. This includes the following types of therapy:*

- *Recreational;*
- *Sex;*
- *Primal scream;*
- *Sleep;*
- *Z therapies;*
- *Self-help programs;*
- *Stress management programs;*
- *Transactional analysis, encounter groups, and transcendental meditation;*

- *Sensitivity or assertiveness training;*
- *Rolfing;*
- *Religious counseling;*
- *Holistic medicine and other wellness programs;*
- *Educational programs such as cardiac class or arthritis class;*
- *Orthomolecular medicine;*
- *Environmental medicine;*
- *Chelation therapy, except for treatment of metal poisoning;*
- *Cytotoxin testing;*
- *Gene manipulation therapy;*
- *Naturopathic medicine;*
- *Megavitamin therapy;*
- *School-based therapy;*
- *Pain clinic services;*
- *Hypnotherapy;*
- *Educotherapy;*
- *Reflexology;*
- *Hair analysis;*
- *Pool therapy and submersion therapy;*
- *Massage therapy;*
- *Physical therapy performed by an individual when the therapy is not within the scope of his or her license or certification under Colorado law;*
- *Group physical therapy;*
- *Exercise programs;*
- *Isometric exercise;*
- *Phase III cardiac rehab;*
- *Health club fees;*
- *High colonics;*
- *Anodyne therapy;*
- *Extracorporeal shock wave treatment, except for removal of kidney stones;*
- *Behavior modification programs, including, weight loss programs and any related health service;*
- *Services of professional trainers;*
- *Special education, counseling, therapy or other services for learning deficiencies or behavioral problems;*
- *Myofunctional Therapy;*
- *Marriage counseling; and*
- *Biofeedback, except to treat urinary stress incontinence.*

(38) Transplants

Coverage is provided for the following:

- Solid organ transplant:

- cornea;
- kidney;
- liver;
- heart;
- lung or lungs;
- intestine;
- pancreas;
- simultaneous pancreas and kidney;
- Autologous or allogenic human bone marrow or peripheral stem cells for the following conditions:
 - leukemia or aplastic anemia;
 - Severe Combined Immunodeficiency Disease (SCID);
 - Wiskott-Aldrich Syndrome;
 - recurrent or refractory neuroblastoma; or
 - testicular, mediastinal, retroperitoneal and ovarian germ cell tumors.

L *Coverage for transplants is subject to the following:*

- (a) *We or providers will not be responsible to:*
- *find a donor; or*
 - *assure the availability or capacity of approved referral facilities;*
- (b) *We will provide coverage for organ donation costs for a Member receiving a covered transplant. Coverage includes:*
- *costs for testing of the donor;*
 - *organ donation procedures;*
 - *facility charges; and*
 - *organ storage costs.*
- (c) *If the donor is covered by a Policy that covers organ donation, We will be the secondary payor; and*
- (d) *The transplant and related procedures must be the preferred method of treatment.*

L *Multiple organ transplants will be covered only if the organs transplanted are the human kidney, liver, heart, lung(s), intestine and pancreas. If a multiple organ transplant includes an organ that is not a human kidney, liver, heart, lung(s), intestine or pancreas, then none of the transplants will be covered.*

L *An organ transplant recipient must be a Member.*

L *Coverage is provided only for human organ transplants. Mechanical organs are not considered human organs for purposes of this Contract.*

⊗ *Transplants not listed as a Benefit in the Covered Benefits section.*

⊗ *Costs of maintaining a cadaver donor for organ retrieval.*

⊗ *Autologous or allogeneic bone marrow harvest and transplant and autologous or allogeneic peripheral stem cell removal and reintroduction, whether alone or with high dose chemotherapy, except to the extent such harvest and transplant or removal and reintroduction are listed as a Benefit in the Covered Benefits section.*

⊗ *Multiple organ transplants except as provided in the Covered Benefits section.*

C. Pilot Programs

At times, We may provide services for a certain Sickness, Injury or program as part of a pilot program or study. These services may be offered in a limited part of the Service Area or to certain Members or Network Providers.

D. Double Coverage and Coordination of Benefits (COB)

(1) Medicare COB

Medicare will be primary except as required by law.

(2) Auto Insurance Benefits COB

(a) Coordination With Auto Coverage: Your Benefits under this Contract will be coordinated with any no fault coverage or other automobile insurance that provides medical payment coverage or medical expense coverage in any form as allowed by law (Auto Coverage).

(b) Payment: If You are eligible for benefits under Auto Coverage, such coverage will be primary and responsible for all benefits payable under the Auto Coverage. If You are eligible for coverage under more than one automobile insurance policy, each policy will pay its maximum Auto Coverage before We will make any payments. We will apply payments made by Auto Coverage to any Cost Sharing payable under this Contract as required by law. We may request proof that Auto Coverage has paid all benefits required. If We

request information, You must give it to Us before We are obligated to make any payments.

- (c) **Settlement of Auto Coverage Claims:** You may not release or settle any Auto Coverage claim without Our written consent if We paid or may have to pay Benefits for services that would be covered by the Auto Coverage. If You release or settle an Auto Coverage claim without Our consent, We may refuse to provide Benefits for services that would be provided to You by the Auto Coverage. We may also recover amounts You got under the Auto Coverage for any Benefits We provided that should have been provided to You by the Auto Coverage. Amounts You get or may get for future health care services that would be provided by the Auto Coverage will be placed in a trust account as directed by Us for payment of those services.
- (d) **Applicability of Other States' Auto Coverage Laws:** The provisions of this subsection will apply to Auto Coverage.

(3) **Prior Coverage**

Unless not allowed by law, Benefits under this Contract shall be secondary for Care provided during the period of extension of benefits or as the result of accrued liabilities of the Subscriber's or Member's prior coverage, if any.

(4) **Pursuit of Coverage**

If We are the Secondary Policy, You must actively pursue coverage from the Primary Policy before receiving any Benefits from Us. You must follow all rules for coverage under the Primary Policy, including filing claims and providing notice and information needed by the Primary Policy. If You do not follow this rule, We will not provide coverage for any services or Benefits which were subject to coverage by the Primary Policy.

Information about health coverage and services is needed to apply Our right of subrogation. Information is also needed to determine the Benefits to be paid under this Contract and other Policies. We may obtain the information We need from or give it to others to determine benefits under this Contract and other Policies. We do not need to tell anyone or get permission from anyone to do this. You must give Us any information We need within 30 days of Our request. This may include:

- copies of Policy contracts, EOCs and other similar documents,
- automobile insurance policies providing coverage to You, and
- any statements You have made, including witness statements and police reports.

You will not be entitled to Benefits for claims for which You do not give Us requested information in a timely manner.

(5) **No Double Recovery**

In no event will You be entitled to obtain double recovery from Policies for health care services provided to You.

(6) **Insurance With Other Insurers**

This applies if You have Double Coverage and no other coordination of benefits provision applies. This generally occurs where one of the Policies that provides Double Coverage is not a group policy.

For this Section, “Other Valid Coverage” means coverage provided by:

- entities subject to the insurance laws or regulations of Colorado or any other state;
- hospital or medical service entities; or
- HMOs.

If You have Other Valid Coverage, not with Us, that provides benefits for the same Benefits as this Contract on a provision of service basis or on an expense incurred basis and You have not given Us written notice of Your Other Valid Coverage prior to the occurrence or start of loss, Our only liability will be for:

- the proportion of the loss as the amount that would otherwise have been payable under this Contract, plus the total of like amounts under all such other valid coverages for the same loss of which We had notice bears to the total like amounts under all valid coverages for such loss, and
- for the return of such portion of the Premiums paid that exceed the pro-rata portion for the amount so determined.

For the purpose of applying this provision when other coverage is on a provision-of-service basis, the “like amount” of such other coverage will be taken as the amount which the services rendered would have cost in the absence of such coverage.

8. LIMITATIONS/EXCLUSIONS (What is Not Covered)

A. Limitations:

L *Failure to Live in the Service Area: If the Subscriber has a Monument Health plan and does not live in Mesa County, the Subscriber and Dependents are not eligible for Benefits under this Contract.*

This includes Benefits for Medical Emergencies and Urgent Care Services. This Limitation does not apply to a Subscriber if allowed by Us in writing under Our rules.

L ***Payment of Premium:** If a Network Provider, a Non-Network Provider or anyone affiliated with a Network Provider or Non-Network Provider who has provided or intends to provide Care to a Member pays Premium amounts due under this Contract, Members are not eligible for Benefits. This will not apply if We are required by law to accept such payment.*

B. General Exclusions. The following are not covered:

- ⊗ *Any services or supplies not listed in the Covered Benefits section even if We arrange the service except if Prior Authorized.*
- ⊗ *Any services or supplies not Medically Necessary.*
- ⊗ *Any services or supplies that do not follow the accepted standards of health care practice in the area where services are provided.*
- ⊗ *Personal comfort or convenience items.*
- ⊗ *Surrounding services and supplies used for any treatment not listed as a Benefit in the Covered Benefits section. The phrase “used for any treatment” includes, but is not limited to, services and supplies that are an integral part of, derived from, or supportive of, a service which is not a Benefit listed in the Covered Benefits section.*
- ⊗ *Confinement, treatment, services or supplies You get outside the U.S. that are not the type and nature available in the U.S.*
- ⊗ *Confinement, treatment, services or supplies if paid or provided by the government. This does not apply if You must pay for the treatment or service in the absence of coverage, or if the law requires You to pay.*
- ⊗ *Confinement, treatment, services or supplies needed for insurance, travel, employment, school, camp, or similar purposes.*
- ⊗ *Confinement, treatment, services or supplies that are not ordered and approved by a provider.*
- ⊗ *Confinement, treatment, services or supplies that are not under the care and treatment of a provider.*

- ⊗ *Treatment, services or supplies provided to the Member by the Subscriber, his or her spouse, a child, sibling or parent of the Subscriber or of the Subscriber's spouse, or any other person who lives in the Member's home for which the Member would ordinarily have no obligation to pay in the absence of health care coverage.*
- ⊗ *Any services or benefits not covered by Your primary Policy because You did not follow its terms, except as required by COB rules of this Contract.*
- ⊗ *Services, drugs, supplies or products that are experimental or investigational, unless provided to You as part of a Clinical Trial. We may determine if a service, drug, supply or product is experimental or investigational before or after You request that We provide or pay for such service. The decision will be based on a review of local standards as well as consideration of national or state standards that We find are applicable to making the decision. We may review information from available resources, including the United States Food and Drug Administration, the National Institutes of Health, the American Medical Association, Hayes Technology Assessment, National Library of Medicine, Medline, the Cochrane Library, and the Centers for Medicare and Medicaid Services.*
- ⊗ *Treatment for work-related illnesses and injuries, unless Your employer does not have to provide workers' compensation insurance. If a workers' compensation policy is in place, that policy is responsible for health benefits for work-related illnesses and injuries. "Work-related illnesses and injuries" include, but are not limited to, work-related aggravations of existing illnesses and injuries.*
- ⊗ *Treatment for Injury or Sickness incurred in connection with a felony You committed.*
- ⊗ *Equipment, supplies and drugs that are not approved by the Food and Drug Administration for health purposes.*
- ⊗ *Fees and costs that are not for treatment, such as copying charges, file set up charges, financing charges and interest and other billing charges imposed by providers. This does not apply to copying charges for records requested by Us, or to interest and late fees that We are required to pay.*
- ⊗ *Treatment and services at a bloodless surgery center or religious science center, holistic medicine or other religion-oriented program.*
- ⊗ *Charges for visits to a health care provider that are not kept.*

- ⊗ *Treatment for services You get while You are incarcerated or confined in any federal, state or local correctional facility or institution.*
- ⊗ *Charges in excess of the Maximum Benefit Allowance.*
- ⊗ *Services provided by a Network Provider, Non-Network Provider, or anyone affiliated with a Network Provider or Non-Network Provider who has paid Your Premium. This will not apply if We are required by law to accept such payment.*

C. **Specific Exclusions.** The following are not covered:

- ⊗ *If not set forth on the RMHP Formulary, injectable drugs, medications and adult immunizations.*
- ⊗ *Transportation that serves only as a convenience for You or Your family.*
- ⊗ *Court ordered treatment that would not otherwise be covered.*
- ⊗ *Blood and blood products that are not provided as part of a service covered under this Contract.*
- ⊗ *Chiro Care for children 3 years of age and younger.*
- ⊗ *Chiro Care provided in excess of what is necessary for maximum improvement. This is the point at which the patient shows little or no improvement with additional therapy.*
- ⊗ *Chiro Care provided on an inpatient basis.*
- ⊗ *Chiro Care which is maintenance care. Maintenance care is defined as a treatment program designed to maintain optimal health in the absence of symptoms.*
- ⊗ *Neuromusculoskeletal manipulation under anesthesia.*
- ⊗ *Clinical laboratory services and any associated procedures related to Chiro Care involved in the collection and/or testing of biological or lab specimens.*

- ⊗ *Preventive care, educational programs, therapies, nonmedical self-care, self-help training and any related diagnostic testing, except that which occurs during the normal course of providing Chiro Care.*
- ⊗ *Vocational or long-term rehab related to Chiro Care.*
- ⊗ *Advanced diagnostic testing and imaging performed as part of Chiro Care, including:*
 - *MRI, CT or bone scans;*
 - *diagnostic ultrasound;*
 - *videoflourosocopy;*
 - *thermography;*
 - *electrodiagnostic testing, such as nerve conduction velocity (NCV); and*
 - *electromyography (EMG) or evoked potentials.*
- ⊗ *Radiological procedures related to NM Service performed on equipment not certified, registered or licensed by the state where the services are performed.*
- ⊗ *Radiological procedures that We determine cannot be safely utilized in diagnosis or treatment.*
- ⊗ *Chiro Care for or related to diagnosis and treatment of jaw joint problems, including TMJ or craniomandibular disorders.*
- ⊗ *Technique-specific radiographs exposed to support such techniques.*
- ⊗ *Transportation costs related to Chiro Care, including ambulance charges.*
- ⊗ *Any part of a Clinical Trial that is paid for by a government or biotechnical, pharmaceutical or medical industry.*
- ⊗ *Any drug or device used in a Clinical Trial that is paid for by the manufacturer, distributor or provider of the drug or device.*
- ⊗ *Extraneous expenses related to taking part in a Clinical Trial, including travel, housing and other expenses that You, or a person traveling with You, may incur.*

- ⊗ *Any items or care provided as part of a Clinical Trial only to satisfy a need for data collection or analysis that are not directly part of Your clinical management.*
- ⊗ *Costs for the management of research relating to a Clinical Trial.*
- ⊗ *Care that, except for the fact that it is being provided in a Clinical Trial, is otherwise specifically excluded from coverage.*
- ⊗ *Dental splints, implants or prostheses.*
- ⊗ *Treatment for periodontal disease.*
- ⊗ *Dental treatment or services on or to the teeth, gums or jaws. This Exclusion does not apply to treatment for Injuries to Sound and Natural Teeth or to Children's Dental Services.*
- ⊗ *Treatment for pain or infection known or thought to be due to a dental cause and near the teeth or jaw, unless not treating such an infection may result in a systemic illness.*
- ⊗ *Surgical correction of malocclusion, services, supplies or appliances provided to alter, correct, fix, improve, remove, replace, reposition, restore or treat the jaw, or any jaw implant. This Exclusion does not apply to services for cleft lip and cleft palate and reconstructive surgery services. (See section 7.B.(9)).*
- ⊗ *Maxillofacial and/or mandibular orthognathic surgery, oral surgery and orthodontia treatment including all outpatient and related costs, if the services are related to a dental condition.*
- ⊗ *Treatment of craniomandibular joint disorders and TMJ by use of orthodontic appliances and treatment, crowns, bridges or dentures.*
- ⊗ *Removal of a tooth, except for treatment for Injuries to Sound and Natural Teeth.*
- ⊗ *Treatment for Injury to Sound and Natural Teeth caused by biting or chewing.*

- ⊗ *Services, including related orthodontic treatment, to repair or replace teeth.*
- ⊗ *Alveoplasty when performed with an excluded service.*
- ⊗ *Care provided with non-covered dental services, except for general anesthesia for dental procedures for Dependent Children.*
- ⊗ *Dental cleaning, in-mouth scaling, planing, or scraping, except for Children's Dental Services.*
- ⊗ *Myofunctional Therapy.*
- ⊗ *Non-emergency transport, Respite Care, service coordination, and assistive technology (unless otherwise covered under the Covered Benefits section).*
- ⊗ *EIS services for children age 3 and older.*
- ⊗ *Follow-up care You get in an emergency room.*
- ⊗ *Coverage for out of Service Area Emergency Care, if You left the Service Area to seek medical treatment.*
- ⊗ *Eyeglasses, contacts and the fitting of contacts, except:*
 - *for children under age 19,*
 - *after covered eye surgery, or*
 - *with a diagnosis of keratoconus.*
- ⊗ *Replacement of lost or broken lenses or frames.*
- ⊗ *Vision therapy, including the use of lenses and/or prisms for the treatment of a traumatic brain Injury, learning disabilities, and dyslexia.*
- ⊗ *Refractive keratoplasty, including radial and laser keratotomy (Lasik surgery), and any procedure to fix a refractive defect.*
- ⊗ *Hearing aids and devices, including bone anchored hearing aids and auditory devices or implants attached to the bone, and fitting for Members age 18 and older.*

- ⊗ *Cochlear implants and equipment and devices related to cochlear implants. This includes:*
 - *internal receivers/stimulators,*
 - *transmitters, and*
 - *speech processors.*

- ⊗ *Private Duty Nursing, unless determined to be Medically Necessary by a Physician.*

- ⊗ *Custodial Care.*

- ⊗ *Housekeeping, homemaker and meal services.*

- ⊗ *Grief support services, except as provided as a part of hospice services.*

- ⊗ *Private room unless it is Medically Necessary.*

- ⊗ *Care for complications that arise after You leave a Hospital against medical advice.*

- ⊗ *Surgical treatment for obesity or conditions related to obesity except for covered bariatric services.*

- ⊗ *Treatment of any complications caused by obesity treatment except for covered bariatric services.*

- ⊗ *Services and supplies related to any care that is not covered. This includes services and supplies that are an integral part of a non- covered benefit.*

- ⊗ *Clinical pathology services unless the services are within the scope of practice of the individual providing the services and are either rendered personally by the pathologist or are performed under the pathologist's direct supervision.*

- ⊗ *Hair transplants or implants.*

- ⊗ *Pain clinic services.*

- ⊗ *Amniocentesis to find out if the baby is a boy or a girl.*

- ⊗ *Services performed by a direct-entry or lay midwife.*
- ⊗ *Over-the-counter contraceptive drugs or devices which do not require a prescription, except those included in the RMHP Formulary.*
- ⊗ *Abortifacient drugs.*
- ⊗ *Reversal of voluntary sterilization.*
- ⊗ *Services and procedures to verify the success of reversal of voluntary sterilization.*
- ⊗ *The following treatments for infertility or to cause pregnancy for both fertile and infertile couples:*
 - *prescription drugs;*
 - *donor eggs and semen;*
 - *procurement and storage of donor eggs and semen;*
 - *artificial insemination;*
 - *in vitro fertilization (IVF);*
 - *gamete intrafallopian transfer (GIFT);*
 - *ovum transplants;*
 - *zygote intrafallopian transfer (ZIFT); and*
 - *embryo transplants.*
- ⊗ *Elective abortions.*
- ⊗ *Costs to operate DME, orthotic devices and prosthetic devices.*
- ⊗ *Air filters, purifiers and/or humidifiers.*
- ⊗ *Changes made to Your home or vehicles to make them handicap accessible.*
- ⊗ *Home modification equipment.*
- ⊗ *Wigs or hairpieces.*
- ⊗ *Home exercise equipment.*

- ⊗ *Bionic prostheses.*
- ⊗ *Power enhancements or controls for prosthetic limbs and terminal devices.*
- ⊗ *Myoelectric prostheses.*
- ⊗ *Peripheral nerve stimulators.*
- ⊗ *Repairs and replacements of DME, orthotic devices and prosthetic devices due to Your misuse or loss.*
- ⊗ *Court ordered treatment that would not otherwise be covered.*
- ⊗ *Behavior modification, such as weight loss programs.*
- ⊗ *Medical foods are not covered for Members with cystic fibrosis or for Members who are lactose- or soy-intolerant.*
- ⊗ *Outpatient nutrition products, including Medical Foods, TPN and therapeutic formulas, except as provided in the "Nutrition" subparagraph.*
- ⊗ *Weight loss programs and services.*
- ⊗ *Third party testing, such as lab and x-rays that are not part of suggested screening or routine physicals.*
- ⊗ *Costs for health reports, including presentations and preparation.*
- ⊗ *Third party physical and/or psychological exams for employment, licensing, insurance, adoption or any other non-health reasons.*
- ⊗ *Screening tests that are done in multiple phases.*
- ⊗ *Checkups not associated with any Injury or Sickness, except as stated in the Covered Benefits section.*
- ⊗ *Clinical ecology services and services for treatment of multiple chemical sensitivity and idiopathic environmental illness.*

- ⊗ *Genetic testing, except for:*
 - *diagnosing You with a condition or illness that will affect Your health;*
 - *treating a condition or illness that will affect Your health; or*
 - *preventive care recommended by the USPSTF or HRSA, including, for example, BRCA testing and counseling.*

- ⊗ *Routine foot care.*

- ⊗ *Trimming of corns and calluses.*

- ⊗ *Treatment of flat feet.*

- ⊗ *Partial dislocations in the feet.*

- ⊗ *Drugs and injectables excluded from, or not included in, the RMHP Formulary. We reserve the right to exclude any Outpatient Prescription Drugs at any time from the RMHP Formulary:*
 - *for health and safety concerns,*
 - *efficacy, and*
 - *other reasons, as We determine in Our discretion.*

- ⊗ *Outpatient Prescription Drugs that are determined by the Medical Director to be abused or misused. We may impose conditions, limitations and restrictions on dispensation of Outpatient Prescription Drugs in order to prevent misuse or abuse.*

- ⊗ *Prescription refills for lost or stolen Outpatient Prescription Drugs.*

- ⊗ *Over-the-counter contraceptive drugs or devices which do not require a prescription, except those included in the RMHP Formulary.*

- ⊗ *Abortifacient drugs.*

- ⊗ *Nonprescription drugs, vitamins, nutrients and food supplements even if recommended or given by a Physician.*

- ⊗ *Travel immunizations.*

- ⊗ *Cosmetic surgery or treatment for complications caused by non-covered cosmetic surgery.*
- ⊗ *Reversal of a cosmetic surgery or non-covered reconstructive surgery.*
- ⊗ *Reconstructive surgery that does not result in functional gain.*
- ⊗ *Reconstructive surgery primarily for cosmetic reasons.*
- ⊗ *Breast reduction, unless Medically Necessary or as part of a mastectomy. Breast reduction is not covered in connection with cosmetic implants or primarily for cosmetic reasons.*
- ⊗ *Surgery or treatment related to sexual dysfunction. This Exclusion includes therapy, Physician services, surgical treatment, injectables, prescription drugs and any other treatment for impotency.*
- ⊗ *Nursing home and domiciliary care.*
- ⊗ *Therapies, self-help programs and other services not specifically covered under the Contract. This includes the types of therapies listed as Exclusions under subsection 7.B.(37) – **Therapy Services**.*
- ⊗ *Transplants not listed as a Benefit in the Covered Benefits section.*
- ⊗ *Costs of maintaining a cadaver donor for organ retrieval.*
- ⊗ *Autologous or allogeneic bone marrow harvest and transplant and autologous or allogeneic peripheral stem cell removal and reintroduction, whether alone or with high dose chemotherapy, except to the extent such harvest and transplant or removal and reintroduction are listed as a Benefit in the Covered Benefits section.*
- ⊗ *Multiple organ transplants except as provided in the Covered Benefits section.*
- ⊗ *Educational testing (services and supplies), assessments, counseling, therapy or other services for learning or behavior problems.*

- ⊗ *Third party exams for employment, licensing, insurance, adoption or any non-health related purpose.*
- ⊗ *Qualified medical expenses, as defined by the IRC, which are not Benefits of this Policy.*
- ⊗ *Panniculectomy for cosmetic reasons.*
- ⊗ *Gastric balloon.*
- ⊗ *Intestinal bypass.*
- ⊗ *Reversal of obesity services.*
- ⊗ *Cosmetic surgery related to bariatric services.*
- ⊗ *Vagal stimulation.*

9. MEMBER PAYMENT RESPONSIBILITY

A. Payment

You or the Subscriber must pay all Premiums, Cost Sharing, and all other fees or amounts owed to Us, the provider, or the Exchange, as applicable, under this Contract when due. A Network Provider, a Non-Network Provider, or anyone affiliated with a Network Provider or Non-Network Provider who has provided or intends to provide You Care may not pay Your Premium. This will not apply if We are required by law to accept such payment. Premium is owed up to the date of termination. If Your coverage ends any day other than the last day of a month, this includes a pro-rated amount for the month in which this Contract ends. You must pay Your Cost Sharing directly to the provider at the time You get the Care. You or the Subscriber and Members must pay amounts that are more than the Allowed Charges for services from Non-Network Providers and amounts for services that are not Benefits under this Contract.

You must pay Premium until You give Us notice as required by this Contract that You:

- are not eligible; or
- will not be covered under this Contract.

B. Assessments

Subscriber shall reimburse Us for Exchange fees imposed on Colorado carriers as allowed by law. The Subscriber must pay such assessment by the due date We specify.

C. Yearly Out-of-Pocket Maximum

Your Policy with Us may have both a Member and a Subscriber/Dependent Yearly Out-of-Pocket Maximum. Please refer to Your Coverage Schedule for Cost Sharing and Yearly Out-of-Pocket Maximum amounts.

In-Network Benefits: When the Cost Sharing owed for In-Network Benefits provided in a Calendar Year equals the In-Network Yearly Out-of-Pocket Maximum amount, You will not have to pay additional Cost Sharing for those In-Network Benefits provided during the rest of the Calendar Year. If Your Policy has Preferred Network Providers, Cost Sharing for In-Network Benefits may be less than for the same Benefits received from other Network Providers.

Out-of-Network Benefits: When the Cost Sharing owed for Out-of-Network Benefits provided in a Calendar Year equals the Yearly Out-of-Network Out-of-Pocket Maximum amount, You will not have to pay additional Cost Sharing for those Out-of-Network Benefits provided during the rest of the Calendar Year.

Yearly Out-of-Pocket Maximums are subject to annual adjustments in accordance with federal law.

D. Change of Health Care Plans

If You change between Policies offered by Us, the Cost Sharing amounts You paid on Your prior Policy may count toward the new Policy's Cost Sharing amounts if:

- (1) You change between Policies offered by Us during any special enrollment period described in Section 5.I; or
- (2) You got this Policy on the Exchange and are receiving federal cost-sharing reductions. The Cost Sharing amounts You paid will count toward a different variation of the same QHP. This applies if Your federal cost sharing reduction eligibility changes at any time during the Calendar Year.

Also, Benefits that count toward Your Maximum Benefit Levels will be applied to Your new Policy's Maximum Benefit Levels. This paragraph does not apply to CHP+ or Medicaid Policies.

E. Incentives

We may choose to pay travel costs or reduce Cost Sharing for specific types of Care You get from certain Network Providers. If We decide to offer an incentive to You, We will tell You in writing.

F. **Third Party Liability**

(1) **Applicability**

This section applies when We have paid or incurred costs for which You have a claim against a third party or insurer for any Injury, Sickness or condition (“Conditions”). This includes all current or future costs. “Third party” means any person, entity, Subscriber or Member other than the Member to whom We are subrogated. We are entitled to subrogation and reimbursement as allowed by law and as described below. Any dispute regarding subrogation or reimbursement will be resolved by arbitration. In case of arbitration, You and Rocky Mountain will each pay one half of the cost. Any arbitration related to subrogation or reimbursement will follow the rules for arbitration in section 13, Appeals/Complaints.

(2) **Subrogation**

We will have the benefit of and become the owner of all rights, claims, remedies, and security against a third party for Conditions for which:

- You have a legal claim against a third party for damages; or
- You have a right to get payment from any insurer, with or without regard to fault, to the extent of costs paid or incurred, or that may be paid or incurred, by Us on Your behalf.

We will have the full power and authority to enforce these claims in Our name as allowed by law.

We may seek to recover amounts from a third party or obtain information about Your claims against a third party. You will actively cooperate with Us by:

- securing and giving evidence as needed for recovery efforts. This includes attending, participating in and giving testimony at depositions, hearings and trials;
- giving information, documents, and written information to Us when requested; and
- helping secure other witnesses in the conduct of administrative or legal proceedings.

Our recovery through subrogation will not affect Your obligation to pay Premiums, Cost Sharing or other sums due under this Contract.

(3) **Reimbursement of Proceeds**

This section applies to a payment of a claim or judgment by a third party or other insurer. Any money, proceeds or property paid to You or recovered by You for Conditions will be considered held in trust by You for Us to the extent We pay current or future costs for related Benefits. This includes Auto

Coverage or medical payments coverage. As allowed by law, You agree to promptly pay Us money, proceeds or property received to the extent of Our costs paid or incurred now or in the future. You agree that this payment will be made to Us whether:

- the money, proceeds or property are for a particular type of Conditions or claim;
- Your efforts to recover from a third party were known, approved or shared by Us; and
- the recoveries were the result of a lawsuit, a settlement, or otherwise.

(4) Settlement of Third-Party Liability Claims

You must give Us notice about any settlement with or recovery against:

- any third party or other insurer, including Your insurer;
- any liability insurer; or
- a third party insurer

of any claim or judgment for damages from Conditions that We have paid or may pay or incur in the future for Benefits provided to You. As allowed by law, We may recover from You any amounts paid to You up to the amount incurred or paid by Us or that in the future may be paid or incurred by Us for Benefits.

G. Interest

Cost Sharing owed to Us will be due and payable on the due date shown on the Member billing statement. Past due amounts will accrue interest up to the rate of 24% per year. Interest accrues from the date the amount is due until paid.

10. CLAIMS PROCEDURE (How to File a Claim)

A. Filing Claims

(1) Time Limit

Except for claims for Outpatient Prescription Drugs, when You pay for Care and ask Us to repay You, You will be liable for no more than the applicable In-Network Cost Sharing for the Care if:

- (a) You submit Your request within 12 months of getting the Care;
- (b) the Care did not need Prior Authorization; and
- (c) a contract was in place between the provider and Us when You got the Care.

In other cases, You or Your provider must submit all claims to Us within 180 days after You got the Care. If We do not get the claim timely, We may not pay the claim.

You must send claims for Outpatient Prescription Drugs to Us within 120 days of the date that You receive the Outpatient Prescription Drug.

Clean Claims will be paid, settled or denied by Us within:

- 30 days if sent electronically; or
- 45 days if sent by other means.

All claims except Clean Claims will be paid, settled or denied by Us within 90 days after receipt if there is not Fraud.

(2) **Required Information**

You can download a claim form from our website, www.rmhp.org, or call Us. You or Your provider may submit a claim:

- by U.S. mail, first class or overnight delivery;
- electronically;
- by fax; or
- by hand delivery.

To get Your claim paid, You or Your provider must send Us or Delta Dental (if the claim involves Children's Dental Services) an authorized claim form and original bill.

Send claims for Care other than Children's Dental Services to Us at:

RMHP
Attention: Claims
2775 Crossroads Boulevard
Grand Junction, Colorado 81506
Fax: 970-244-7880

Send claims for Children's Dental Services to Delta Dental at:

Delta Dental of Colorado
Attention: Claims
P.O. Box 173803
Denver, CO 80217-3803
Customer_service@ddpco.com

Claims must include the following:

- The Subscriber's Rocky Mountain identification number;
- The Subscriber's name and address;

- The name of the Member who got the Care;
- The age and relationship to the Subscriber of the Member who got the Care;
- The date(s) of the accident, Care or purchase;
- The diagnosis and type of treatment;
- An original itemized statement of expenses;
- The provider's name, address and federal tax ID number; and
- Expenses for prescription drugs must include:
 - pharmacy name and address;
 - drug name and prescription number; and
 - the original bill or receipt from the pharmacy.

If We do not timely get required information from You, We may not pay Your claim.

(3) **Manner of Payment**

We will decide if We will pay Benefits to You or to Your providers.

(4) **Minor or Incompetency**

We may pay an individual or institution directly if it appears to have assumed the custody or the principal support of a Member if:

- (a) the Member is a minor, or in Our opinion, the Member is not competent to give a valid receipt for payment due the Member under this Contract; and
- (b) We have not received a request from a duly appointed guardian or other legally-appointed representative.

B. Time Lines for Our Decisions

After You file a claim, We will tell you of Our decision within the time frames below. If We verbally tell You within the time frames set forth below, written or electronic notification will be given to You within 3 days.

- (1) **Urgent Care Claims** Upon Our receipt of an Urgent Care Claim, We will tell You of Our decision as soon as possible, but no later than 72 hours after Our receipt of Your Urgent Care Claim. If there is insufficient information to decide whether Benefits are covered or payable by Us, We will notify You as soon as possible, but no later than 24 hours after Our receipt of Your Urgent Care Claim. We will tell You the specific information needed to complete such Urgent Care Claim. You will be given a reasonable time to provide the specified information, depending on the circumstances, but no less than 48

hours after You have been notified. We will tell You of Our decision as soon as possible, but no later than 48 hours after the earlier of:

- Our receipt of the specified information; or
- the end of the period given to You to provide the additional specified information.

(2) **Pre-Service Claims** We will tell you of Our decision regarding a Pre-Service Claim within a reasonable time (appropriate to the medical circumstances), but no later than 15 days after Our receipt of Your Pre-Service Claim. We may extend the initial 15 day period for up to an additional 15 days if there are matters beyond Our control. In this case, We must notify You prior to the end of the initial 15 day period:

- of the circumstances requiring the extension, and
- the date on which We expect to make Our decision.

If the extension is necessary because You failed to submit the information needed to make a decision, the notice must describe the information required. You will have at least 45 days from the date of receipt of such notice to provide the requested information.

If You fail to follow Our procedures for filing a Pre-Service Claim, You will be notified as soon as possible, but no later than 5 days (24 hours in the case of a Pre-Service Claim that also qualifies as an Urgent Care Claim) after Our receipt of Your claim, that Your claim has been improperly filed. You will be given a description of the proper procedures for filing Your Pre-Service Claim. Such notice may be given verbally, unless You have specifically requested written notification.

(3) **Post-Service Claims** For a Post-Service Claim, We will notify you of Our decision within a reasonable time period, but no later than 30 days after Our receipt of the Post-Service Claim. We may extend the initial 30 day period for up to an additional 30 days if there are matters beyond Our control. In this case, You will be notified, prior to the end of the initial 30 day period:

- of the circumstances requiring the extension, and
- the date on which We expect to make Our decision.

If such extension is necessary because You failed to submit the information required to make a decision, the notice must describe the information required. You will have 45 days from Your receipt of the notice to provide the requested information.

(4) **Concurrent Care Claims** We will notify You of Our decision with respect to a Concurrent Care Claim sufficiently in advance of the termination of the pre-approved course of Care, or reduction in the specific number of treatments, to allow You to appeal and obtain a decision on review prior to such termination or reduction.

Your request to extend a course of Care beyond the prescribed period of time, or the specific number of pre-approved treatments, that also qualifies as an Urgent Care Claim must be decided as soon as possible, taking into account the medical exigencies. We will notify you of Our decision within 24 hours after Our receipt of the claim; if Your claim is made at least 24 hours prior to the end of the prescribed course of Care or specific number of pre-approved treatments.

C. RMHP Formulary Exception Requests

You, Your designee, or Your provider may request clinically appropriate drugs not otherwise covered by Us through a special process. If We grant Your request, We will cover the non-formulary drug for the duration of the prescription. If We deny Your request, You, Your designee, or Your provider may request an external review of the decision by an independent review organization.

For more information about the special process for drugs not on the RMHP Formulary, please contact RMHP Customer Service.

(1) Standard Review

You, Your designee or Your provider may request a standard review of Our decision to not include a drug in the RMHP Formulary.

We will make a decision on Your standard review request and notify You or Your designee and Your provider of Our decision no later than 72 hours after We receive Your request. If We grant Your standard review request, the drug will be covered for the duration of the prescription, including any refills.

(2) Expedited Review

If there are exigent circumstances, You, Your designee or Your provider may request an expedited review of Our decision to not include a drug in the RMHP Formulary. Exigent circumstances exist when:

- You have a health condition that may seriously jeopardize Your life, health or ability to regain maximum function; or
- You are currently undergoing a course of treatment with a drug not in the RMHP Formulary.

We will make a decision on Your expedited review request and notify You or Your designee and Your provider of Our decision no later than 24 hours after We receive Your request. If We grant Your expedited review request, the drug will be covered for the duration of the exigent circumstances.

(3) **External Review**

If We deny a standard or expedited review request, You, Your designee or Your provider may request an external review of the denial by an independent review organization.

You or Your designee and Your provider will be notified of the decision no later than:

- 72 hours after We receive Your request, if it is a review of a standard review request; or
- 24 hours after We receive Your request, if it is a review of an expedited review request.

If Your standard review request is granted, the drug will be covered for the duration of the prescription, including any refills. If Your expedited review request is granted, the drug will be covered for the duration of the exigent circumstances.

11. GENERAL POLICY PROVISIONS

A. Reporting Rules for Subscribers and Members

(1) **Double Coverage**

You must tell Us when You have Double Coverage so We can determine which Policy pays first. (See section 7.)

(2) **Tell Us if You are Admitted to a Non-Network Hospital**

You or Your Physician must tell Us if:

- You deliver a baby in a non-Network Hospital; or
- You are admitted to a non-Network Hospital for Urgent Care or Emergency Care.

This notification must occur within 24 hours or the next business day. We will make an exception to the time limits if Your medical condition prevented timely notice.

(3) **Report Third-Party Claims**

You must promptly tell Us about any claims and potential claims against any third party. (See section 9.)

(4) **If Your Eligibility Changes**

If You did not get this Policy on the Exchange, You must send proof of eligibility to Us. We will decide if the proof meets all eligibility rules. (See

section 5 for eligibility rules.) You must tell Us immediately if You have a change in status that may affect Your eligibility under this Contract. Eligibility status changes start on the first day of the next month after the date of change. If a change in status causes You to be ineligible, Your coverage will end the last day of the month You tell Us of the change.

If You got this Policy on the Exchange, all eligibility will be decided by the Exchange. You must comply with Exchange rules on eligibility.

(5) Tell Us if Your Address Changes

You must tell Us if Your address changes. We will change Your address in Our records if the United States Postal Service notifies Us that Your address changed.

B. Duration

This Contract is between Us and the Subscriber on behalf of each Member. This Contract begins on the Effective Date. The Contract will Renew on the Renewal Date, unless:

- this Contract is terminated; or
- You do not select this Policy for another year on the Exchange. This only applies if You first got this Policy on the Exchange.

If there is no Renewal Date, this Contract will Renew on January 1 of each Calendar Year.

C. Application and Effective Date

If You got this Policy on the Exchange, the Effective Date of this Contract is the date the Exchange specifies after the Premium has been paid. If You did not get this Policy on the Exchange, the Effective Date of this Contract is the date We specify after the Premium has been paid. Benefits begin on the Effective Date.

D. Confidentiality of Records

We will keep Your information confidential. However, You agree to let Us obtain, use, and share health records and information about Care provided to You:

- as allowed or required by law;
- for use in medical research and education (without identifying You); or
- as needed to administer this Contract.

You also agree to promptly give Us, Network Providers and other providers written consent for release of records related to Your Care if requested.

E. Relationship with Providers

It is the intent of You and Rocky Mountain that:

- Network Providers and Non-Network Providers will be independent contractors and are not Our agents or employees; and
- Our employees will not be the employer or agent of any Network Provider.

We do not insure against and are not liable for, the negligence or other wrongful act or omission of any Network Provider or Non-Network Provider, their employees or other persons or agencies, or for any act or omission of any Member. Network Providers, Non-Network Providers, or their employees or agents, are solely responsible for Care provided to You. You agree that We cannot and do not, practice medicine.

F. Controlling Costs

We use cost control tools including the following:

- regular utilization review of Network Providers;
- second opinions (See subsection 7.B.(32));
- Prior Authorization;
- managed care including:
 - education
 - use of a drug formulary;
 - support of community health programs;
 - quality improvement review;
 - the Primary Care Procedures;
- dispute resolution process (See section 13);
- incentives (See subsection 9.D.); and
- pilot programs or studies (See subsection 7.C.)

G. Notice

Except as noted in section 13 and this subsection, any required notice, including change of address, will be in writing. Notices are effective upon mailing, postage prepaid, to Our address in section 3, or to the Subscriber and Members at the address that appears in Our records. (See section 13 for additional notice requirements.)

This Contract may be made available to You electronically. It has very important information about Your Benefits that should be shared with all Dependents covered under this Contract. If You chose an electronic copy, We will email You when an electronic copy of this Contract is ready. You must give Us Your email address and notify Us if it changes. If We cannot send this Contract to the email address You gave Us, We will send You a paper copy. You can ask for a paper copy of this Contract at any time by asking customer service. You can also ask that We only send You paper copies.

H. Assignment

The rights of the Subscriber or Member under this Contract may not be assigned or delegated. However, a Member is allowed to assign payments due for Benefits under this Contract to a licensed Hospital, licensed health care provider, occupational therapist or massage therapist. We have the right to assign this Contract.

I. Enforcement

If We seek to enforce or interpret this Contract, except for matters submitted for review by the internal review committee and arbitration, We will be awarded Our costs, including reasonable attorneys' fees.

J. Offset

We have the right to recover sums owed to Us by a Subscriber or Member by withholding sums We owe to the Subscriber or Member. No terms of this Contract will restrict this right.

K. Binding Effect

Subject to the terms restricting assignment or delegation, the terms of this Contract will be binding upon and confer to the benefit of the Rocky Mountain, the Subscriber and Members, and their successors and assigns.

L. Headings

The headings are for reference only and are not to be used to interpret this Contract. The headings do not in any way qualify, modify or explain any terms or their effect.

M. Unexpected or Uncontrollable Events

Rocky Mountain and Network Providers will not have any liability or obligation, beyond a good faith effort, for delay or failure to provide any services if the delay or failure is caused by conditions beyond their control. This may include lack of available facilities, personnel or financial resources because of:

- disaster;
- epidemic;
- riot;
- civil insurrection;
- labor disputes;
- complete or partial destruction of facilities;
- disability of a significant number of Network Providers; or
- any other emergency or similar situation.

N. Entire Agreement

This Contract constitutes the entire agreement between the parties. This Contract will not be changed except as provided in this Contract.

O. Interpretation

The interpretation of this Contract will be guided by:

- the IRC; and
- the Affordable Care Act; and
- the Colorado Health Care Coverage Act; and
- the federal Health Maintenance Organization Act of 1973, as applicable; and
- other applicable Colorado and federal law.

Any provision of this Contract that does not conform with the IRC, the Affordable Care Act, the Colorado Health Care Coverage Act and other applicable law will not be invalid, but will be construed and applied as if it was in full compliance with the laws and regulations.

12. TERMINATION/NON-RENEWAL/CONTINUATION

A. Termination for Cause

As allowed by law, We may end or not Renew coverage under this Contract for these reasons:

- (1) Premiums due to Us or the Exchange, as applicable, have not been timely paid.
 - Nonpayment of Premiums by a Subscriber after the Grace Period has ended.
 - Payment of Premiums after the Grace Period has ended will not entitle a Member to coverage if the Member is no longer eligible.

The Grace Period does not apply to the first Premium owed under this Policy. The Subscriber may terminate coverage under this Policy during the Grace Period by giving Us written notice. The Subscriber will owe Us a pro-rata amount of Premium for the time during the Grace Period that this Policy was in force. We will pay claims during a 31 day Grace Period or the first month of a three month Grace Period. We will not pay claims for the second and third months of a three month Grace Period if we do not receive Premium owed for such months during the Grace Period.

- (2) Fraud by You about Your eligibility, enrollment or in any other matter.
- (3) Allowing someone else to fraudulently use Your Member ID Card to get Benefits.

(4) Any other reason allowed by law.

B. Procedure to Terminate for Cause

If We end this Contract for cause, We will notify the Subscriber on behalf of the Member. The notice will explain why the Contract is ending. The Subscriber will have 30 days from the date of the notice to resolve the cause of termination. This chance to resolve the issue does not apply if the Contract ended due to Fraud. If the cause for ending the Contract is not resolved, the Contract will end 30 days from the date of notice. You will not be entitled to Benefits as of the date the Contract ends. You must pay for any health care services You get after that date. We may end this Contract immediately for Fraud.

C. Other Terminations

As allowed by law, coverage under this Contract may end or not be Renewed for these reasons. If You did not get this Policy on the Exchange and if You are the Subscriber, You must notify Us to end coverage. If You got this Policy on the Exchange and if You are the Subscriber, You must notify the Exchange to end coverage. Ending the Subscriber's coverage ends coverage for all the Subscriber's Dependents under this Contract.

(1) If We are notified You are no longer eligible.

The termination will be 30 days after We give notice to You.

If the Subscriber no longer lives in the Service Area, this will not cause a Member to lose eligibility. However, a Member will not be entitled to Benefits except as provided in this Contract.

(2) The Subscriber decides to end the Subscriber's coverage or the coverage for any Dependent.

The termination date will be:

- the date specified by You, if You provide at least 14 days' notice to Us;
- 14 days after the termination is requested by You, if You do not provide at least 14 days' notice to Us;
- the date determined by Us, if We are able to terminate this Contract in less than 14 days and You request an earlier termination effective date;
- if the Subscriber is newly eligible for Medicaid, CHP+, or a basic health plan, if a basic health plan is operating in the service area of the Exchange, the last day of coverage is the day before such new coverage begins; or

- the date of death of the Subscriber or any Member.

- (3) If You can show the Exchange You tried to terminate Your coverage or enrollment in a QHP and had a technical error that did not let You terminate Your coverage or enrollment through the Exchange. You must have asked for retroactive termination within 60 days after You found the technical error.

Termination will be no sooner than 14 days after the date that You can show You asked the Exchange to terminate Your coverage or enrollment. This does not apply if We agree to an earlier date.

- (4) If You show the Exchange Your enrollment in a QHP through the Exchange was unintentional, inadvertent, or a mistake. It must have been due to the mistake or misconduct of an officer, employee, or agent of the Exchange or HHS, or a non-Exchange entity which gave enrollment help or conducted enrollment activities. You must ask for cancellation within 60 days of finding out You were enrolled.

Termination will be the effective date of this Contract, or a later date if the Exchange decides Your Contract should have a different end date.

- (5) If You show the Exchange that You were enrolled in a QHP without Your knowledge or consent by any third party, including third parties who have no connection with the Exchange. You must have asked for cancellation within 60 days of finding out You were enrolled.

Termination will be the effective date of this Contract, or a later date if the Exchange decides Your Contract should have a different end date.

- (6) We stop offering or do not Renew all of Our individual Policies delivered or issued for delivery in Colorado. If this happens, We will send notice to all Members and to the insurance commissioner in each state in which an affected Member is known to live. This notice will be sent at least 180 days before the non-Renewal. Notice to the insurance commissioner will be sent at least 3 working days before the notice to the affected Members. If We stop offering Policies of one market type but still offer Policies of other market types, We will still provide Benefits up to the date this Contract would Renew, but not more than 12 months after We send notice.

- (7) We stop offering the Policy under which You are enrolled. If this happens, We will act uniformly without regard to the claims experience of the policyholders or any health-status-related factor of any individual, participant, or beneficiary covered by the Policy or new individuals, participants, or beneficiaries who may become eligible for coverage. We will notify the insurance commissioner and certify:

- (a) the premiums for other Policies We offer are not excessive, inadequate, or unfairly discriminatory relative to the plan that We are discontinuing; and

- (b) the benefit levels We offer in the other Policies comply with the requirements of law applicable to individual and small employer Policies.

We will send notice to the Subscriber and each Member. Such notice will be sent at least 90 days before the date We stop offering the Policy. We will offer You the choice to buy any other Policy currently being offered by Us in the same individual market, and specify the applicable special enrollment periods.

- (8) If You got this Policy on the Exchange, and We:

- are decertified as a QHP, or
- chose to non-renew as a QHP,

this Contract will end. We will send notice to each Member. Such notice will be sent within:

- 3 business days after We determine coverage will end if sent electronically, and
- 5 business days if sent using paper.

- (9) Any other reason allowed by law.

D. Reinstatement of Contract

We will reinstate a Subscriber or Member whose enrollment was ended in error.

E. Requests for Retroactive Termination

We may approve retroactive requests to end this Contract at Our discretion.

F. Effect of Ending Subscriber's Coverage

If a Subscriber's coverage ends, coverage for all the Subscriber's Dependents ends without further action by Us. No additional notice will be given.

G. Termination for Any Reason

You will not have coverage for Benefits after the date the Contract ends. There is an exception for continued inpatient Care. (See subsection I below.)

H. Renewability of this Contract

Unless this Contract has ended, We will not discontinue coverage or refuse to Renew this Contract, except for one of these reasons:

- (1) Nonpayment of, or failure to timely pay, Premiums owed to Us.

- (2) Fraud on the part of the Subscriber or Member with respect to individual coverage.
- (3) We stop offering or do not Renew all of Our individual Policies delivered or issued for delivery in Colorado. We will send notice to all Members and to the insurance commissioner in each state in which an affected Member is known to live. This notice will be sent at least 180 days before the non-Renewal. Notice to the insurance commissioner will be sent at least 3 working days before the notice to the affected Members.

If We stop offering Policies of one market type but still offer Policies of other market types, We will still provide Benefits up to the date this Contract would Renew, but not more than 12 months after We send notice.
- (4) If coverage is made available only through one or more bona fide associations, Your membership in such an association ends.
- (5) Any other reason allowed by law.

I. Continued Inpatient Care

If You are in an inpatient facility on the date this Contract ends, Your coverage will continue until You are discharged. “Discharge” includes a discharge or transfer to a lower level of Care or Your home. This continued coverage does not apply if this Contract ends due to:

- nonpayment of Premium due under this Contract; or
- fraud or abuse.

J. Continuation of Coverage

Members shall have no continuation of coverage or conversion rights except as provided in this Contract or required by law.

13. APPEALS AND COMPLAINTS

We want You to be satisfied with the Care You get and the services We provide. We give You many ways to tell Us about any questions, concerns or complaints (“Complaint Process”). We list each of these options below.

If You need help with the Complaint Process, You may choose a Designated Representative to help You. You must notify Us if You choose a Designated Representative. If a health care provider who knows about Your health condition asks for a Fast Review, We will assume this person is Your Designated Representative.

In this section only, the terms “You,” “Your” and “Member” include a Designated Representative.

A. Informal Procedure

If You have questions or concerns, You may call or write Us. You may hand deliver, mail, or fax Your written questions or concerns to Us. If We cannot resolve Your questions or concerns at that time, You must follow the Complaint Process steps below.

B. Review Time Lines

There are two time lines for review – Standard Review and Fast Review. Standard Review is the review procedures and time lines that We follow if a Fast Review or a Fast External Review do not apply.

(1) Fast Review

You can ask for a Fast Review if the time lines for Standard Review would:

- (a) seriously risk Your life or health;
- (b) seriously risk Your ability to recover maximum function;
- (c) if You have a disability, create an imminent and substantial limit on Your existing ability to live on Your own; or
- (d) if a Physician who knows about Your condition believes that lack of treatment will subject You to severe pain that You cannot adequately control.

You can also ask for a Fast Review if You got Emergency services and have not been released from the facility. A Fast Review is not available for Our denial of a waiver or an alternate standard for a wellness program.

Our Medical Director will review Your request for a Fast Review. If We decide to use the Standard Review time line, We will notify You within 72 hours after We get Your request. If Your Physician determines You need a Fast Review, We will do a Fast Review.

We will decide a Fast Review within 72 hours after We get the request. If We tell You Our decision by phone, We will also send it to You in writing within 3 calendar days.

(2) Fast External Review

You can ask for a Fast External Review if the standard time line for External Review would:

- (a) seriously risk Your life or health;
- (b) seriously risk Your ability to recover maximum function; or

- (c) if You have a disability, create an imminent and substantial limit on Your existing ability to live on Your own.

You can ask for a Fast External Review at the same time that You request a Fast Review.

A Fast Review is not available for Our denial of a waiver or an alternate standard for a wellness program.

C. **Review Procedure**

The Complaint Process includes:

- an Internal Review; and
- in some cases, an optional External Review.

You may request an External Review without completing Our internal review process if We do not follow law regarding internal or external review. In such case, You may also seek judicial relief under state or federal law. (See subsection 13.E.)

(1) **Filing a Complaint**

You must follow the Complaint Process below if You:

- do not agree with and want to appeal Our decision to deny all or part of a claim, reduce or terminate services, or to not provide or pay for services, including a denial of a Prior Authorization;
- do not agree with Our decision to deny, reduce, terminate, or fail to provide or make payment, in whole or in part, for Care resulting from any utilization review We apply;
- do not agree with Our decision to not cover an item or service because We decided the item or service was experimental, investigational or not Medically Necessary or appropriate;
- if We do not cover an item or service because we decided the item or service was not provided in the right setting or at the right level of care;
- were harmed when Care was provided and You think We are responsible for the adequacy or competency of the Care You got;
- claim We did not provide services or did not perform duties owed to You;
- do not agree with Our decision to Rescind a Member's enrollment under this Contract; or
- do not agree with Our denial of Your request for a waiver or alternate standard for a wellness program that offers a reward for meeting a health related standard.

Complaints about the privacy of Your information under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") follow different

steps described later in this section. Concerns about the quality of care You get from providers also follow different steps described later in this section.

For complaints about all Care except Children’s Dental Services, You must submit Your complaint to Us in *writing* by mail, hand delivery, e-mail or fax to:

Address: RMHP
Attention: Member Appeals
2775 Crossroads Boulevard
Grand Junction, Colorado 81506
Fax: 970-244-7828
Email: customer_service@rmhp.org

For complaints about adverse determinations regarding Children’s Dental Services, You must submit Your complaint to Delta Dental in *writing* by mail to:

Address: Delta Dental of Colorado
Attention: Appeals Analyst
P. O. Box 172528
Denver, CO 80217-2528

“Adverse determinations” means a decision that a requested service is:

- not Medically Necessary, or
- not appropriate, effective, efficient, is not provided in or at the appropriate health care setting or level or care, or
- determined to be experimental or investigational

and is therefore denied, reduced or terminated. An adverse determination also means a denial for a service excluded by this Contract when You are able to present evidence from a medical professional that there is a reasonable medical basis that the Exclusion does not apply.

We must get Your complaint within 180 days of the earliest of:

- the date We notify You of Our decision; or
- the denial of Benefits, or failure to provide services or perform duties owed to You; or
- the date on which You knew, or should have known, of the event giving rise to Your claim about the adequacy or competency of Care.

We will not review Your complaint if We do not get it by the deadline above.

- (2) **Internal Review:** Your complaint will be reviewed and the decision made by someone who was not involved in the initial decision. This may include an internal review committee. You may review Your appeal file as part of the Internal Review appeal.

If Your complaint is about one of the items listed below, a medical professional or professionals will decide the outcome:

- Medical Necessity of a treatment or service; or
- If a treatment or service is experimental or investigational; or
- There is a reasonable medical basis that an Exclusion does not apply to the treatment or service You requested. If You claim that an Exclusion does not apply, You must give Us evidence from a medical professional to support a reasonable medical basis for Your claim.

The decision will be made only after the medical professional consults with someone in the same or similar specialty typically needed to manage Your case.

An Internal Review hearing will be held. We will notify You of the date of the hearing at least 20 days before it is scheduled. If You ask that We delay the Internal Review hearing, We will not unreasonably deny Your request.

No reviewer will have a direct financial interest in the appeal or its outcome. A medical professional who was involved in the initial decision shall not evaluate or be consulted regarding the Internal Review. A person who was previously involved with the initial decision may answer questions.

You and Your attorney, advocates, health care professionals and other witnesses may be at the Internal Review hearing in person or by phone or by using other technology, if it is available and not unduly costly for Us to use.

At the Internal Review hearing, You and Rocky Mountain will have the chance to:

- bring counsel, advocates and health care professionals;
- give testimony and materials to the review committee. (A copy of the materials must be given to each party at least 5 days in advance. If new information arises after the deadline, this material may be presented at the hearing, if feasible); and
- have an audio or visual recording made by Rocky Mountain. (If a recording is made, You may have a copy. If You appeal this decision, a copy will be sent to the External Review group if You or We request it.)

The reviewer will issue a written decision to You within 30 days after receiving your request for an Internal hearing. The reviewer will give notice of the decision to any providers You designated.

The Internal Review decision will be final and binding unless We get a timely request for an External Review (if available to You) or arbitration, or unless you seek de novo review by a court of a claim for benefits that We denied in whole or in part.

(3) **External Review:**

You may ask Us in writing to submit the Internal Review decision to an External Review group if Your complaint is about:

- the Medical Necessity of a treatment or service;
- if a treatment or service is experimental or investigational;
- if a treatment or service is not provided in the right setting or at the right level of care; or
- if there is a reasonable medical basis that an Exclusion does not apply to a treatment or service.

You may also request an External Review or a Fast External Review of Our initial decision denying coverage of a recommended or requested service that is experimental or investigational. In such case, your treating Physician must tell Us in writing that the requested service would be less effective if not begun immediately and at least one of the following applies:

- standard health care services or treatments have not improved Your condition or are not medically appropriate for You; or
- there is no available standard health care service or treatment covered by Us that is more beneficial to You than the recommended or requested service, and the Physician is a board-certified or board-eligible Physician qualified to practice in the area of medicine appropriate to treat Your condition.

The Physician must also tell Us that scientifically valid studies support the requested service that is the subject of the denial is likely to be more beneficial to You than any available standard health care services or treatments.

There is no minimum dollar amount for a claim to be eligible for External Review or Fast External Review.

You can also ask Us for External Review if We deny Your request for a waiver or an alternate standard for a wellness plan. This External Review cannot be a Fast External Review.

You can also ask Us for External Review if We fail to follow the review process required by law.

Complaints or appeals that do not involve these types of decisions may not be submitted to External Review.

You must ask in writing that the External Review be either a Standard Review or a Fast External Review, by mail, hand delivery, e-mail or fax to one of the addresses above within four months from the date You get the Internal Review decision or notice of exhaustion of Internal Review.

If the deadline falls on a weekend or holiday, You will have until the next business day to request an External Review. We will consider Your receipt to be not less than 3 business days after We postmark the notice. Requests for a Fast External Review must include a certification from a Physician that Your condition meets the criteria for a Fast External Review, as explained above. You can ask for a Fast External Review at the same time You request a Fast Review.

You can include new information with Your request if that information is significantly different from the information in Your appeal file. We will tell You if We change Our decision based on the new information within 1 business day of Our decision by email, phone, or fax. We will also tell You by mail.

If We deny Your request for External Review or Fast External Review, We tell You why and how You can appeal to the Colorado Division of Insurance (DOI). We will also send a copy of the denial to the DOI.

If We do not deny Your request for External Review, We will send it to the DOI within 2 business days after We get it. If We change Our decision before then, We will tell You within 1 business day by email, phone, or fax. We will also tell You by mail. If We change Our decision after We send Your request to the DOI, We will tell You, the DOI and the External Review group within 1 business day of the changed decision by email, phone, or fax. We will also tell You by mail.

If We do not deny Your request for Fast External Review, We will send it to the DOI within 1 business day after We get it.

The External Review or the Fast External Review will be done by a group selected by the DOI and will follow the law. We will tell You the External Review group selected by the DOI within 1 business day after the DOI tells Us. Within 2 business days, You must tell the DOI of any possible conflict of interest with the External Review group. We will give the External Review group Your appeal file within 5 business days after We are told of the External Review group (immediately if it is a Fast External Review). If You ask Us, We will give You all relevant information supplied to the External Review group that is not confidential or privileged.

If it is not a Fast External Review, You may submit additional information up to 5 business days after You receive notice of the External Review group. The External Review group may, but is not required to, consider additional information that You provide after the 5 day period. If We change Our decision based on the new information, We will tell You, the External Review group and the DOI within 1 business day of Our decision by email, phone, or fax. We will also tell You by mail.

We will pay the cost of the External Review or the Fast External Review.

The External Review group shall give its decision in writing within 45 calendar days after it received the request for External Review. In the case of a Fast External Review, the External Review group shall give its decision as soon as possible, but no later than 72 hours after it received the request for Fast External Review. If notice of the Fast External Review decision is not written, the External Review group shall provide a written confirmation within 48 hours after notice is given to You, the Physician or other health care professional.

If the External Review group decides a retrospective request for Benefits in Your favor, We will approve Your request for Benefits or for a waiver or alternate standard within 5 business days. For a concurrent or prospective request for Benefits, We will approve Your request for Benefits or for a waiver or alternate standard within 1 business day after the External Review group decides in Your favor. We will notify You within 1 business day of Our approval. The decision of the External Review group will be final and binding unless either You or Rocky Mountain appeal the decision by timely submitting the decision to arbitration.

D. Arbitration

- (1) You may submit any review decision to arbitration. We may submit an External Review decision to arbitration.

Any request for arbitration must be made within 30 days of the decision. Requests must be made by personal service of a demand for arbitration on the other party, or by giving notice of the demand for arbitration to the other party using certified mail, return receipt requested addressed as required by subsection 11.G.

Any claims that You may assert against Us are subject to arbitration. Arbitration will be governed by the Colorado Uniform Arbitration Act (Act), except as stated in this Contract. Consolidation of arbitration proceedings and/or class action arbitrations are not allowed under this Contract.

- (2) The arbitration will be decided by one or more arbitrators.
 - (a) If We decide that the amount at issue is less than \$100,000.00, the arbitration will be held before a neutral person selected by You and Rocky Mountain. If You and Rocky Mountain are unable to agree to a neutral person, the arbitrator will be selected using the rules in the Act.
 - (b) If We decide that the amount at issue is \$100,000.00 or more, the arbitration will be held before 3 arbitrators. One will be selected by Us, one will be selected by You, and the third will be a neutral person selected by the first two arbitrators. If the two arbitrators are unable to agree on a third neutral person, the third person will be selected using the rules in the Act.

- (c) The arbitrator or arbitrators will be called the “Panel”.
- (3) If We decide that the amount at issue is more than \$200,000.00, the parties may take pre-hearing depositions. Such depositions are limited to a maximum of 3 per party, of no more than 6 hours’ time each. If we decide that the amount at issue is less than \$200,000.00, no depositions are allowed.
 - (4) The Panel will hold a scheduling conference which will be attended by the parties.
 - (5) The Panel will issue an “arbitration case management order: which will be consistent with Colorado Rule of Civil Procedure (CRCP) 26, or as otherwise agreed on by the Panel and the parties. Unless otherwise agreed upon, each party must:
 - make the disclosures required by CRCP 26(a)(1) within 10 days after a date is selected for the arbitration hearing; and
 - disclose expert testimony as required by CRCP 26(a)(2)(A) and 26(a)(2)(B) at least 10 days before the date of the hearing.
 - (6) The arbitration will be held in Mesa County, Colorado, or in the county where You reside, if in Colorado. If the parties are unable to agree on the venue, the Panel will decide if the arbitration will be held in Mesa County or in the Colorado county where You reside. If You reside outside of Colorado, the venue for the arbitration will be only in Mesa County, Colorado.
 - (7) The Panel will follow Colorado law in making an award. The Panel will issue written findings of fact and conclusions of law.
 - (8) We will pay the Panel’s fees and costs. You must pay for Your costs, including travel, food, lodging and other costs for You. You must also pay for the fees and costs for Your attorney and witnesses, if any, unless Colorado law allows for, and the Panel awards You, attorneys’ fees and costs.

The decision or award of the Panel will be final and binding upon the parties to the same extent as if the matter had been decided by a court, except as provided in subsection 13.E. 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 payment of money, the clerk may issue execution on the judgment.

E. De Novo Review

After You have exhausted Your remedies under this Contract, not including arbitration, You have the right to have a de novo review by any court with jurisdiction of a claim for Benefits that We denied in whole or in part. You also have the right to a trial by a jury for that review. All other kinds of complaints subject to section 13 are not subject to de novo review or trial by jury.

You can file a claim for Benefits in court if We fail to follow the review process required by law unless Our failure:

- is a minimal error;
- does not, and is not likely to, harm or prejudice You;
- was for good cause or was beyond Our control;
- happened while We were exchanging information with You in good faith; and
- is not part of a pattern or practice of violations by Us.

F. Jurisdiction and Venue

No court shall have subject matter jurisdiction of any disagreement or complaint referred to in this section 13. This includes any disagreements, disputes or claims that are or may be the subject of a class action, other than as expressly stated in this section 13. The Complaint Process is the exclusive and mandatory dispute resolution procedure under this Contract. In the event any disagreement or dispute, other than de novo review, is attempted to be resolved in any court, the venue of the matter shall only be in Mesa County, Colorado. This section 13 shall not apply to claims by Us for amounts You may owe to Us.

G. Time is of the Essence

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

H. Contact the Insurance Commissioner

You have the right to call or write the DOI about any complaint, dispute or disagreement at any time at:

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

I. HIPAA Privacy Complaints

If You have a complaint controlled by Our HIPAA Notice of Privacy Practices, or about Our or any of the Network Provider's privacy practices under HIPAA, You must send the HIPAA complaint in writing by mail, hand delivery or fax to:

RMHP
Attention: Privacy Complaint
2775 Crossroads Boulevard
Grand Junction, Colorado 81506
Fax: 970-244-7880

We will investigate the complaint. We will respond in writing within 30 calendar days after We get Your complaint. You will not be entitled to any further review of this complaint after We respond to You. You may make a 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 tell Us of a concern about the quality of Care You got from a provider, Our Quality Improvement Department may investigate Your concern. The matter may be referred to a medical practice review committee. The records of such committees are confidential under Colorado law.

K. Release of Records

By submitting a complaint, You authorize Us to obtain and review all necessary medical records, similar documents and information related to the complaint. You also authorize Us to release the necessary medical records, similar documents and information to the internal review committee and to the External Review group.

L. Changes to the Complaint Process

We reserve the right to change the Complaint Process at any time by amending this Contract, according to the terms of this Contract.

14. INFORMATION ON POLICY AND RATE CHANGES

A. Amendment

We may change this Contract as allowed by law:

- (1) At any time to comply with state or federal law, statutes or regulations;
- (2) On the Renewal Date, to change any terms of the Contract, which may include increasing, reducing or eliminating Benefits; or
- (3) With 30 days' notice to change any terms of the Contract which do not increase, reduce or eliminate Benefits, except that a material change will require 60 days' notice.

Notice of changes will be given to the Subscriber in writing. Any change to this Contract which changes the terms of coverage or Benefits will apply to all Members. This includes Members who got Benefits that are no longer provided.

B. Premium Changes

Premiums are set based on:

- the age and tobacco use of the Subscriber and the Subscriber's Dependent Spouse;

- the number of Dependents covered; and
- the county in which the Subscriber lives.

We set Premiums once per Calendar Year. We will give You notice at least 60 days prior to the effective date of the change. Other Premium rating factors may be imposed by state or federal law without notice. Premiums are subject to change at times other than once per Calendar Year if You make changes as described below:

- a Subscriber moves to another county with a different Premium rating; or
- a Dependent is added.

15. DEFINITIONS

A. Definitions

The words used in this Contract will have their usual meanings, except for the words defined below that are capitalized in this Contract.

- (1) “Adoption” means the earlier of a placement for adoption or the adoption itself.
- (2) “Affordable Care Act” or “ACA” means the final, amended version of the comprehensive health care reform law enacted in March 2010, commonly known as the Patient Protection and Affordable Care Act.
- (3) “Allowed Charges” means charges for services allowed by Our agreements with Network Providers or an amount determined under a fee schedule used by Us within the State of Colorado. For Non-Network Providers, Allowed Charges means expenses incurred at the time the Covered Benefit is provided, not to exceed the Maximum Benefit Allowance.

Allowed Charges are not reduced by:

- amounts withheld by Us from payments for Care provided by Network Providers;
- any incentive plan, or
- by any rebates We may get.

Allowed Charges do not include:

- amounts billed by Non-Network Providers which exceed the Maximum Benefit Allowance; or
- amounts billed by Non-Network Providers which exceed the Maximum Benefit Level.

For Outpatient Prescription Drugs only, “Allowed Charges” means charges by Network Pharmacies for Benefits allowed by Our agreements with Network Pharmacies. For non-Network Pharmacies, Allowed Charges means

the amount We would pay for the same or like prescription from a Network Pharmacy in the part of the Service Area where You live.

- (4) “Applied Behavior Analysis” or “ABA” means the use of behavior analytic methods and research findings to change socially important behaviors.
- (5) “Autism Services Provider” means any person who provides direct services to a person with Autism Spectrum Disorder. The person giving services must be licensed, certified, or registered by the state licensing board or by a nationally recognized group, and meet one of the following:
 - (a) has a doctoral degree with a specialty in psychiatry, medicine, or clinical psychology, is actively licensed by the state board of medical examiners, and has one year of direct experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with ASD;
 - (b) has a doctoral degree in one of the behavioral or health sciences and has completed one year of experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with ASD;
 - (c) has a master’s degree or higher in behavioral sciences and is nationally certified as a “Board Certified Behavior Analyst” or certified by a similar nationally recognized group;
 - (d) has a master’s degree or higher in one of the behavioral or health sciences, is credentialed as a Related Services Provider and has completed one year of direct supervised experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with ASD. For the purpose of this subparagraph (d), “Related Services Provider” means a physical therapist, occupational therapist, or speech therapist;
 - (e) has a baccalaureate degree or higher in behavioral sciences and is nationally certified as a “Board Certified Associate Behavior Analyst” by the behavior analyst certification board or certified by a similar nationally recognized group; or
 - (f) is nationally registered as a “Registered Behavior Technician” by the behavior analyst certification board or by a similar nationally recognized organization and provides direct services to a person with ASD under the supervision of an autism services provider described in (a), (b), (c), (d), or (e).
- (6) “Autism Spectrum Disorders” or “ASD” has the same meaning as in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time of the diagnosis, and includes the following:

- autistic disorder;
 - Asperger’s disorder; and
 - atypical autism as a diagnosis within pervasive developmental disorder not otherwise specified.
- (7) “Benefits” means Hospital, medical and other services or supplies Members are entitled to, or that We will pay Allowed Charges for, under this Contract.
- (8) “Biologically-Based Mental Illness” means:
- Schizophrenia;
 - schizoaffective disorder;
 - bipolar affective disorder;
 - major depressive disorder;
 - specific obsessive compulsive disorder; and
 - panic disorder.
- (9) “Calendar Year” means the dates from January 1 to December 31 of any year.
- (10) “Care” means the same as the term “Benefits.”
- (11) “Children’s Basic Health Plan” or “CHP+” means the health insurance plan designed by the Colorado Department of Health Care Policy and Financing.
- (12) “Children’s Dental Services” means the following, each of which is covered per Calendar Year, unless otherwise noted below:
- 2 oral exams and evaluations;
 - 2 fluoride applications;
 - 1 set of x-rays (intra-oral or bitewing);
 - 1 set of x-rays (panoramic or full mouth) – once every 5 years;
 - 2 routine cleanings;
 - 1 space maintainer;
 - sealants; and
 - palliative care.

Any two of the services from the following list are also covered per Calendar Year as part of Children’s Dental Services:

- amalgam, resin, composite or sedative fillings;
- extractions;
- root canal therapy; and
- surgical periodontal services.

Any one of the services from the following list are also covered per Calendar Year as part of Children’s Dental Services:

- crowns; and

- pin retention.
- (13) “Civil Union” means a relationship between two eligible persons pursuant to the laws of the State of Colorado that entitles them to receive the benefits and protections and be subject to the responsibilities of spouses.
- (14) “Clean Claim” means a claim for payment for Benefits that is submitted to Us on the uniform claim form with all required fields completed with correct and complete information, including required documents. Clean Claim does not include a claim for payment of expenses incurred when Premiums are delinquent, except as required by law.
- (15) “Clinical Trial” means an experiment in which a drug or device is administered to, given to or used by one or more people. An experiment may include the use of a combination of drugs as well as the use of a drug with an alternative therapy or dietary supplement.
- (16) “Coinsurance” means the percentage of Allowed Charges a Member must pay for Care as shown on the Coverage Schedule.
- (17) “Complaint Process” means the process to resolve Your questions, concerns or complaints under this Contract.
- (18) “Complications of Pregnancy” means:
- Conditions (when the pregnancy is not terminated) whose diagnoses are separate from pregnancy but are negatively affected or caused by pregnancy, including:
 - acute nephritis;
 - nephrosis;
 - cardiac decompensation;
 - missed abortion; and
 - similar medical and surgical conditions of comparable severity.

Conditions not within the definition of Complications of Pregnancy include:

- false labor;
- occasional spotting;
- Physician-prescribed rest during the period of pregnancy;
- morning sickness;
- hyperemesis gravidarum;
- preeclampsia; and
- similar conditions associated with the management of a difficult pregnancy not rising to the level of a classifiable, distinct complication of pregnancy.

- Non-elective c-section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs at a point during the pregnancy in which a viable birth is not possible.
- (19) “Concurrent Care Claim” means any decision in which We, after having previously approved an ongoing course of Care provided over a period of time or a specific number of treatments, either:
- now seek to reduce or terminate the course of treatment (other than by plan amendment or termination) or to reduce the specific number of treatments, or
 - You request an extension of such course of Care, or to increase the specific number of treatments, subsequent to the initial approval of the original course of Care, or specific number of treatments.
- (20) “Contract” means this document and the following, if included with this Contract:
- amendments;
 - Coverage Schedule;
 - the enrollment application form;
 - the Member ID Card; and
 - attachments, if any.
- (21) “Copay” means the amount or percentage of Allowed Charges to be paid by the Subscriber for Members for a Benefit, as described in the Coverage Schedule.
- (22) “Cost Sharing” means Copays, Coinsurance and Deductibles.
- (23) “Coverage Schedule” means the document that lists the Cost Sharing, Limitations, Maximum Benefit Levels and Yearly Out-of-Pocket Maximums for a Policy offered by Us.
- (24) “Covered Benefits” means the list of Benefits in subsection 7.B of this Contract.
- (25) “Creditable Coverage” or “CC” means benefits or coverage provided under:
- Medicare, Medicaid or CHP+;
 - an employee welfare benefit plan or group health insurance or health benefit plan;
 - an individual health benefit plan;
 - a state health benefits risk pool (including CoverColorado); or
 - Chapter 55 of Title 10, United States Code,
 - a medical care program of the federal Indian Health Service or of a tribal group,
 - a health plan offered under Chapter 89 of Title 5, United States Code,

- a public health plan, or
- a health benefit plan under section 5(e) of the federal “Peace Corps Act” (22 U.S.C. § 2504(e)).

(26) “Custodial Care” means services to help a person with daily living activities. This includes help with:

- walking;
- getting in and out of bed;
- bathing;
- dressing;
- feeding;
- using the toilet;
- preparing special diets; and
- taking medicine.

Custodial Care is personal care that does not require trained health care personnel. We will look at the level of services and help needed and provided to decide if it is Custodial Care. We do not consider the diagnosis, medical condition, a person’s physical limits or whether a person may overcome physical limits with therapy when making the decision. Custodial Care services may be provided in a facility or at home.

(27) “Deductible” means the amount paid by a Member for most Allowed Charges before the Member is entitled to Benefits, as described in the Coverage Schedule.

(28) “Dependent” means a Dependent Spouse or Dependent Child. A DB or a Domestic Partner may also be a Dependent if he or she meets the General Eligibility Rules.

(29) “Dependent Child” means anyone who is:

- (a) a natural born or adopted child of the Subscriber, Dependent Spouse, Domestic Partner or DB. The child is deemed “adopted” when the state or an adoption agency places the child for adoption with Subscriber, Dependent Spouse, Domestic Partner or DB. The Subscriber, Dependent Spouse, Domestic Partner or DB assumes a legal duty to support the child in hope of the child’s adoption. A placement ends at the time the legal duty ends;
- (b) under the legal guardianship of the Subscriber and in a parent-child relationship with the Subscriber; or
- (c) placed in foster care with the Subscriber, Dependent Spouse, Domestic Partner or DB. “Placed in foster care” means placement in foster care by an authorized agency or court with jurisdiction.

For purposes of this definition, the child of a Domestic Partner or DB will only be included if the Domestic Partner or DB is a Dependent.

- (30) “Dependent Spouse” means a person who is the:
- (a) spouse of the Subscriber in a marriage recognized by the State of Colorado; or
 - (b) Partner in a Civil Union with the Subscriber.

The person cannot be legally separated or divorced from the Subscriber. A Dependent Spouse must meet all of the General Eligibility Rules.

- (31) “Designated Beneficiary” or “DB” means a person who has entered into a DBA. A DB is not a Domestic Partner or a Partner in a Civil Union.

- (32) “Designated Beneficiary Agreement” or “DBA” means an agreement that is entered into pursuant to Colorado law by the Subscriber and another person for the purpose of:

- (a) designating each person as the beneficiary of the other person; and
- (b) ensuring that each person has certain rights and financial protections based upon the designation.

- (33) “Designated Representative” means a person, including a health care professional who is treating You and is chosen by You in writing to represent You in a dispute under this Contract. It also includes other persons who can act for You or give consent on Your behalf under the law. If a dispute is under a Fast Review time line, a health care professional who knows about Your health condition will be assumed to act as Your Designated Representative.

- (34) “Disposable Medical Supplies” means medical supplies (such as syringes, wound Care supplies, and catheters) needed to treat an Injury or Sickness.

- (35) “Double Coverage” means You can get Benefits under this Contract and also have coverage under another Policy for the same services.

- (36) “Durable Medical Equipment” or “DME” means equipment that can withstand repeated use and is needed for medical reasons because of Injury or Sickness, or because You are disabled. DME includes wheelchairs, Hospital beds and traction equipment.

- (37) “Early Intervention Services” means those services available under Part C of the federal “Individuals with Disabilities Education Act” (20 U.S.C. § 1400, et seq.)

- (38) “Effective Date” means the date the Benefits begin under this Contract.

- (39) “Emergency” means an event that a prudent layperson would believe threatens his or her life or limb in a way that immediate health care services are needed to prevent death or serious impairment of health.
- (40) “Emergency Care” is Care due to an Emergency.
- (41) “Emergency Contraception” means an FDA-approved drug that prevents pregnancy after sexual intercourse. Emergency Contraception does not include abortifacient drugs.
- (42) “Episode” means a specific event that caused the need for speech, physical or occupational therapy. You may have and be covered for more than one Episode for the same health condition when a new event or accident causes a change in therapy or a new course of treatment.
- (43) “Essential Health Benefits” means the services required to be Benefits per the ACA.
- (44) “Evidence of Coverage” or “EOC” means the same as “Contract.”
- (45) “Exchange” means the Colorado Health Benefit Exchange, also known as Connect for Health Colorado.
- (46) “Exclusion” means care that is not covered under this Contract.
- (47) “External Review” means review of an Internal Review decision by an independent group. (See section 13.)
- (48) “Fast External Review” means an External Review which is done within 72 hours of Our receiving Your completed request. (See section 13.)
- (49) “Fast Review” means an Internal Review which is done within 72 hours of Our receiving Your completed request. (See section 13.)
- (50) “Fraud” means a statement, act or omission that amounts to fraud or intentional misrepresentation of material fact.
- (51) “Grace Period” means:
- if the Subscriber is accepting a federal Advance Premium Tax Credit subsidy, a 3 month period of time during which Premiums are owed and this Policy remains in force; or
 - if the Subscriber is not eligible for or accepting a federal Advance Premium Tax Credit subsidy, a 31 day period of time during which Premiums are owed and this Policy remains in force.
- (52) “Habilitation Care” means Care that helps You retain, learn or improve skills and functioning for daily living. It is offered in parity with, and in addition to, any rehabilitative Care under this Contract.

- (53) “Health Plan Guide” means a document We provide that assists You in the use of this Contract.
- (54) “High Deductible Health Plan” or “HDHP” means the same as the term high deductible health plan as defined by the IRC, section 223.
- (55) “Home Health Agency” means an agency which:
- has been certified by the Colorado Department of Public Health and Environment as meeting the provisions of Title XVIII of the Federal “Social Security Act,” as amended, for home health agencies; and
 - arranges and provides nursing services, home health aide services and other therapeutic and related services.
- (56) “Home Health Care Plan” means a program of home care that:
- (a) is needed as the result of a Sickness or Injury; and
 - (b) is certified by the Your Physician as a replacement for Hospital confinement that would otherwise be needed.
- (57) “Home Health Services” means skilled nursing services and related Care provided in Your home under Your Physician’s order.
- (58) “Hospice” means a provider that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people.
- (59) “Hospice Care Program” means a program that:
- is managed by a Hospice; and
 - set up by a Hospice, Hospice Care Team, and a Physician to meet the special physical, psychological, and spiritual needs of dying Members and their Immediate Family.
- (60) “Hospice Care Team” means:
- a Physician;
 - a patient Care coordinator (Physician or nurse who serves as go between for the Hospice Care Program and the Physician);
 - a nurse;
 - a mental health specialist;
 - a social worker;
 - a chaplain; and
 - lay volunteers.
- (61) “Hospital” means an inpatient acute care facility (not including any nursing or rest home, intermediate care facility, rehab facility or Skilled Nursing Facility) licensed or certified as a hospital which:

- (a) is primarily engaged in providing facilities for surgery and medical diagnosis and treatment of injured or ill persons under the supervision of Physicians;
- (b) is accredited by the Joint Commission on Accreditation of Healthcare Organizations or certified by Medicare; and
- (c) is recognized as a hospital by the American Hospital Association or the American Osteopathic Association.

A facility providing residential treatment services, whether as a stand-alone facility or as a part of a larger facility, shall not be considered a Hospital.

- (62) “HRSA” means the Health Resources and Services Administration.
- (63) “Immediate Family” means Your mother, father, sister, brother, spouse, Partner in a Civil Union, Domestic Partner, DB and child.
- (64) “Indian” means any person who is a member of an Indian Tribe (includes Alaskan Natives).
- (65) “Indian Health Program” means:
 - any health program administered directly by the Indian Health Service, including referrals for the contract health services program;
 - any tribal health program; and;
 - any Indian Tribe or tribal organization to which the Secretary of Health and Human Services provides funding pursuant to 25 USC 47 (commonly known as the ‘Buy Indian Act’).
- (66) “Indian Tribe” means any Indian tribe, band, nation, pueblo or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.
- (67) “Inherited Enzymatic Disorder” means a disorder caused by single gene defects involved in the metabolism of amino, organic and fatty acids, including treatment for the following diagnosed conditions:
 - phenylketonuria (PKU);
 - maternal PKU;
 - maple syrup urine disease;
 - tyrosinemia;
 - homocystinuria;
 - histidinemia;
 - urea cycle disorders;
 - hyperlysinemia;

- glutaric acidemias;
 - methylmalonic acidemia; and
 - propionic acidemia.
- (68) “Injury” means accidental bodily harm.
- (69) “In-Network Benefits” means Benefits for Care received from Network Providers or otherwise described in writing by Us.
- (70) “Internal Review” means either a Standard Review or a Fast Review of Our initial decision. (See section 13.)
- (71) “Intractable Pain” means pain for which the cause of pain cannot be removed, and:
- which in the generally accepted course of medical practice no relief or cure for the cause of the pain is possible; or
 - no relief or cure of the cause of the pain has been found after reasonable efforts, including evaluation by the attending Physician and one or more Physicians specializing in the treatment of the area, system or organ of the body thought to be the source of the pain.
- (72) “Limitation” means a restriction on a Benefit.
- (73) “Mail Order Pharmacy” means a pharmacy We designate to provide up to a 90-day supply of Outpatient Prescription Drugs to You through mail order service.
- (74) “Maximum Benefit Allowance” means the maximum amount We will approve as a charge for particular Care. We will base this decision on:
- (a) the range of charges generally billed for similar or identical Care; and
 - (b) what a reasonable charge is for such Care.
- (75) “Maximum Benefit Level” means limits on the amount of coverage We will provide for a Benefit.
- (76) “Medicaid” means the state-administered health insurance program for people with limited income.
- (77) “Medical Director” means the person employed or contracted by Us as a Medical Director or persons designated to act for him or her.
- (78) “Medical Foods” means prescription metabolic formulas and their modular counterparts, which:
- You get through a pharmacy;
 - are specifically designated and manufactured for the treatment of Inherited Enzymatic Disorders; and

- have medically standard methods of diagnosis, treatment and monitoring.

These formulas are specifically processed or formulated to be deficient in one or more nutrients and are to be taken or administered enterally either via tube or oral route under the direction of a Physician.

- (79) “Medically Necessary” means services or supplies required to preserve Your health according to the standards of medical practice in the State of Colorado, and are not given only as a convenience. A service or supply recommended, ordered or approved by a Network Provider or any other provider may not be Medically Necessary. If there is not agreement on the standards of medical practice used to decide if particular services or supplies are Medically Necessary, the Medical Director will decide which standards apply.
- (80) “Medicare” means the federal health insurance program for people age 65 or older, certain disabled people, and people with end stage renal disease.
- (81) “Member” means a person whose request to enroll has been accepted, and who is entitled to Benefits under this Contract.
- (82) “Member ID Card” means the card issued by Us which gives basic information about eligibility and Benefits and identifies You as a Member.
- (83) “Mental Disorders” means:
- post-traumatic stress disorder;
 - drug and alcohol disorders;
 - dysthymia;
 - cyclothymia;
 - social phobia;
 - agoraphobia with panic disorder;
 - general anxiety disorder;
 - anorexia nervosa and bulimia nervosa; and
 - Autism Spectrum Disorders.
- (84) “Myofunctional Therapy” means muscle or other training to correct or control bad or harmful habits.
- (85) “National Network” means the program available under some of Our Policies which provides access to a network of providers outside the State of Colorado.
- (86) “Network Hospital” means a Hospital that is a Network Provider.
- (87) “Network Pharmacy” means:
- a Retail Pharmacy,
 - a Specialty Pharmacy, or

- a Mail Order Pharmacy

which is contracted to provide Outpatient Prescription Drugs to You.

- (88) “Network Provider” means any physician, dentist, optometrist, anesthesiologist, hospital, x-ray, laboratory and ambulance service, or other person who:
- is licensed or authorized in Colorado to provide health care services;
 - has a written agreement with Us or a contractor or subcontractor;
 - agrees to provide Care to Members as described in the written agreement; and
 - has been approved by Us to provide Care under this Contract.
- (89) “Network SNF” means a SNF that is a Network Provider.
- (90) “Network Specialist” means any Network Physician who is selected by Us to provide specialty Care for Members according to the Primary Care Procedures.
- (91) “Neuromusculoskeletal Disorders” means misalignments of the skeletal structure and muscular weakness, osteopathic imbalances and disorders related to the spinal cord, neck and joints.
- (92) “Non-Network Provider” means any physician, dentist, optometrist, anesthesiologist, hospital, x-ray, laboratory and ambulance service, or other person who:
- is licensed or authorized in Colorado to provide health care services; and
 - does not have a written agreement with Us or a contractor or subcontractor to provide Care under this Contract.
- (93) “Our” means Rocky Mountain Health Maintenance Organization, Inc.
- (94) “Out-of-Network Benefits” means Benefits for Care received from Non-Network Providers, except as provided in this Contract.
- (95) “Outpatient Prescription Drugs” means the drugs listed as covered on the RMHP Formulary.
- (96) “Partner in a Civil Union” means a person who has established a Civil Union under laws of the State of Colorado. A Partner in a Civil Union is not a Domestic Partner or a Designated Beneficiary.
- (97) “Physician” means a person who:
- holds a degree of Doctor of Medicine or Doctor of Osteopathy;
 - is licensed to practice medicine; and
 - provides services as a PCP or specialist.

- (98) “Policy” means any arrangement, including health care insurance, for the payment or reimbursement of health care services to You, whether offered by an employer, group or organization, or arranged directly by You. A Policy may include coverage arranged, required or provided under state or federal law.
- (99) “Post-Service Claim” means any claim other than a Concurrent Claim or Pre-Service Claim, including a claim for reimbursement for unreimbursed health care expenses and that involves payment or reimbursement for a benefit that has already been provided.
- (100) “Preferred Network Provider” means a Participating Provider We designate as preferred in the Provider Directory for Your Plan.
- (101) “Premium” means all monies paid, including any fees or other contributions, by a Subscriber as a condition of Our agreement to provide Benefits during the calendar month or such other timeframe designated by Us for which the Premium has been paid under this Contract.
- (102) “Pre-Service Claim” means any claim for a benefit that must be approved in advance of receiving Care (for example, requests to pre-certify a hospital stay or for pre-approval under a utilization review program).
- (103) “Primary Care Physician” or “PCP” means any Physician who is designated by Us or by the Member, subject to Our policies and procedures.
- (104) “Primary Care Procedures” means the rules a Member must follow when obtaining Care under this Contract.
- (105) “Primary Policy/Secondary Policy”, for purposes of section 7 only, refers to the order of benefit determination rules which determine whether this Contract is a “Primary Plan” or “Secondary Plan” when compared to another Plan covering the person.

When this Contract is the Primary Plan, its benefits are determined before those of any other Plan and without considering any other Plan’s benefits. When this Contract is the Secondary Plan, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan’s benefits.

- (106) “Prior Authorization” or “Prior Authorized” means written approval for Your Care issued by Us or Our designee before You get the Care.
- (107) “Private Duty Nursing” means individual and continuous full shift nursing services, including those given to people who:
- are dependent at least part of each day on a mechanical ventilator;
 - require prolonged intravenous nutritional substances or drugs; or

- depend daily on other respiratory or nutritional support, including tracheostomy tube Care, suctioning, oxygen support or tube feeding.
- (108) “Provider Directory” means a list of Network Providers We contract with to provide Care to You under Your Contract.
- (109) “Qualified Health Plan” or “QHP” means a health plan that is certified by and offered through the Exchange.
- (110) “Renew” means:
- if You got this Policy on the Exchange: the current Contract will end and a new Contract with the same terms You have now as amended by Us under subsection 14.A begins, if You select this Policy for another year on the Exchange; or
 - if You did not get this Policy on the Exchange: the current Contract will end and a new Contract with the same terms You have now as amended by Us under subsection 14.A, begins without the parties needing to sign or re-issue Contract documents.
- (111) “Renewal Date” means January 1 of each Calendar Year.
- (112) “Rescind” or “Rescission” means a cancellation or discontinuance of coverage that has retroactive effect.
- (113) “Residential Treatment Facility” means a facility that provides 24 hour, 7 day a week facility-based programs. Such programs must provide individualized treatment with a high degree of supervision and structure to persons who have severe and persistent mental disorders. Other services that a Residential Treatment Facility may provide, such as education and recreation, are not Benefits. Residential Treatment Facility services are not a substitute for long term or custodial care and are not appropriate for persons who can be effectively treated as an outpatient. The services must be designed to treat the patient with an appropriate level of care. Residential Treatment Facilities serve persons who have the potential to respond to active treatment, and need a protected and structured environment. Realistic discharge goals must be set at admission. A Residential Treatment Facility must be licensed by all applicable federal, state and local agencies, and have a certificate to participate in Medicare.
- (114) “Respite Care” means services provided in Your home or in a licensed health care facility to give temporary relief to Your family or other providers.
- (115) “Retail Pharmacy” means a pharmacy We designate to provide up to a 90-day supply of Outpatient Prescription Drugs to You.
- (116) “RMHCO” means Rocky Mountain HealthCare Options, Inc.

- (117) “RMHP Formulary” means the RMHP Outpatient Formulary Guidelines which includes the list of prescribed drugs and medicines approved by Us. The RMHP Formulary can be found at www.rmhp.org.
- (118) “RMHP Preferred Model” means the specific breast pump designated by RMHP as Our preferred model.
- (119) “Rocky Mountain” means Rocky Mountain Health Maintenance Organization, Inc.
- (120) “Same-Sex Domestic Partner” or “Domestic Partner” means a same-sex partner who resides with the Subscriber and who is eligible to be covered as a Dependent under the GSA. A Domestic Partner is not a Partner in a Civil Union or a Designated Beneficiary.
- (121) “Service Area” means the area designated by Us and approved by the Colorado Division of Insurance, where We do business and conduct operations.
- (122) “Sickness” means illness, disease, congenital defects or birth abnormalities of a Member.
- (123) “Skilled Nursing Facility” or “SNF” means a facility or a part of a facility that provides skilled nursing services needed after or instead of a Hospital stay and which:
- is certified or licensed as a skilled nursing facility by the appropriate governmental authority; and
 - meets all requirements of the Medicare Program for skilled nursing facilities.
- A Skilled Nursing Facility only includes those beds in a facility that are certified by Medicare as skilled nursing facility beds.
- (124) “Sound and Natural Teeth” means Your own healthy teeth (not artificial or imitation), free from defect or damage. A tooth is considered sound and natural if:
- the tooth does not have more than one surface restoration, does not have a crown or a root canal, and does not have decay on one more than one surface;
 - the tooth is not a denture, an implant or part of a partial plate;
 - the tooth does not have periodontal disease or other conditions; and
 - the tooth does not need treatment for any reason other than the accidental Injury.
- (125) “Specialty Pharmacy” means a pharmacy We designate as a specialty pharmacy to provide up to a 31-day supply of Outpatient Prescription Drugs to You.

- (126) “Standard Review” means a review by Us of Your complaint of Our initial decision. (See section 13.)
- (127) “Subscriber” means:
- the person who signs and submits the accepted enrollment application and other requested information ; or
 - such other person who may be designated as the Subscriber by Us; or
 - the parent or guardian who signed the enrollment application on behalf of a Member if the person or persons enrolled under this Contract is less than 18 years of age. In this circumstance, the parent or guardian shall have all the duties and obligations of a Subscriber under this Contract. The parent or guardian will not be a Member and is not entitled to Benefits under this Contract.
- (128) “Temporarily Absent” means the Member has left the Service Area but intends to return within a reasonable period of time.
- (129) “Tier 1,” “Tier 2,” “Tier 3,” “Tier 4” or “Tier 5” means an Outpatient Prescription Drug which is designated as a particular tier by Us.
- (130) “TMJ” means temporomandibular joint disorder.
- (131) “Tribal Health Program” means an Indian Tribe that operates any health program, service, function, activity, or facility funded, in whole or part, by the Indian Health Service through, or provided for in, a contract or compact with the Indian Health Service under the Indian Self-Determination and Education Assistance Act.
- (132) “Urgent Care” means Care needed in order to avoid a serious deterioration of health.
- (133) “Urgent Care Claim” means any claim for medical care or treatment that has to be decided more quickly:
- because the normal timeframes for decision-making could seriously jeopardize Your life or health, or Your ability to regain maximum function, or
 - in the opinion of a physician with knowledge of Your condition, subject you to severe pain that cannot be adequately managed without the care or treatment addressed in the claim.
- An Urgent Care Claim also includes any claim that a physician with knowledge of Your medical condition determines is a claim involving urgent care.
- (134) “Us” means Rocky Mountain Health Maintenance Organization, Inc.
- (135) “We” means Rocky Mountain Health Maintenance Organization, Inc.

- (136) “Well Child Visit” means an age appropriate visit that includes any examination or preventive service called for in guidelines supported by the HRSA or recommended by the American Academy of Pediatrics.
- (137) “Yearly Open Enrollment Period” means November 1 through January 31.
- (138) “Yearly Out-of-Pocket Maximum” means the total amount paid, including amounts paid by Cost Sharing, by the Member for Benefits provided during a Calendar Year for a Member or for a Subscriber and Dependent(s), as provided in the Coverage Schedule.
- (139) “You” or “Your” means “Member”.