ROCKY MOUNTAIN HEALTH PLANS®
Good health. That's the plan.

# Colorado Health Plan Description Form

## Rocky Mountain HMO

**Rocky Mountain Good Health Savings Plans**
**HMO HDHP $1000 Deductible**
**(HSA ELIGIBLE)**

### PART A: TYPE OF COVERAGE

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| **1. TYPE OF PLAN** | Health Maintenance Organization (HMO) |
| **2. OUT-OF-NETWORK CARE COVERED?[1]** | Only for emergency and urgent care. |
| **3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE** | Plan is available throughout Colorado except in the following areas: Gunnison County, Routt County, Baca County |

### PART B: SUMMARY OF BENEFITS

**Important Note**: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

| | **IN-NETWORK ONLY (out of network care is not covered except as noted)** |
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| **4. ANNUAL DEDUCTIBLE[2]**<br>**a) Individual**<br>**b) Family** | a) $1,000<br>An employee enrolling for single coverage will only be required to satisfy the Individual deductible. If an employee enrolling for single coverage subsequently changes to family coverage, the family deductible will then be required to be satisfied.<br><br>b) $2,000 aggregate<br>Family deductible must be met by one or more family members before copayments apply.<br><br>Deductibles shall be applied to satisfy the out-of-pocket maximum. Deductible must be satisfied before services will be covered, except as noted. |
| **5. OUT-OF-POCKET ANNUAL MAXIMUM[3]**<br>**a) Individual**<br>**b) Family**<br>**c) Is deductible included in the out-of-pocket maximum?** | a) $4,000<br>b) $8,000<br>c) Deductible is included in the out-of-pocket maximum<br>All copayments apply toward the out-of-pocket maximum, except prescription drug copayments. Services for which the copayments do not apply toward the annual out-of-pocket maximum will remain payable after the out-of-pocket maximum has been reached. |
| **6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE** | No lifetime maximum |
| **7A. COVERED PROVIDERS** | Rocky Mountain HMO Network, Horizon Behavioral Health. See participating provider directory for a complete list of current providers. |
| **7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?** | Yes |
| **8. ROUTINE MEDICAL OFFICE VISITS[4]**<br>**a) Primary Care Providers**<br>**b) Specialists** | a) $20 per visit copayment after deductible - for visits to designated PCP<br>b) $40 per visit copayment after deductible - for visits to any other participating provider |

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| **9. PREVENTIVE CARE**<br>**a) Children's services (well-child services as age appropriate)**<br>**b) Adults' services (routine physical and gynecological exam – 1 per member per calendar year)**<br>**c) Routine screening mammograms, pap smears, prostate screenings**<br>**d) Routine child immunizations and travel immunizations** | a) $20 per visit copayment, not subject to deductible<br>b) $20 per visit copayment, not subject to deductible – for exam office visit only. Associated services will have the applicable copayment for the type of service.<br>c) No copayment (100% covered), not subject to deductible – office visit copayment may apply<br>d) No copayment (100% covered), not subject to deductible – office visit copayment may apply |
| **10. MATERNITY**<br>**a) Prenatal care (routine)**<br>**b) Delivery & inpatient well baby care[5]**<br><br>**Non-routine prenatal care will have the applicable copayment for the type of service** | a) 20% copayment, not subject to deductible<br><br>b) 20% copayment after deductible |
| **11. PRESCRIPTION DRUGS[6]**<br>**Level of coverage and restrictions on prescriptions**<br>**a) Inpatient prescription drugs and injectables**<br><br>**b) Outpatient prescription drugs and Insulin (not including injectables)**<br><br>**c) Injectable medication (except Insulin)** | a) Included in inpatient hospital copayment<br><br>b) See benefit schedule attached<br><br>c) 20% copayment after deductible<br><br>For Drugs on our approved list, contact Customer Service at 800-346-4643. |
| **12. INPATIENT HOSPITAL** | 20% copayment after deductible |
| **13. OUTPATIENT/AMBULATORY SURGERY** | 20% copayment after deductible |
| **14. DIAGNOSTICS**<br>**a) Laboratory & x-ray**<br>**b) MRI, nuclear medicine, and other high-tech services** | a) 20% copayment after deductible<br>b) 20% copayment after deductible |
| **15. EMERGENCY CARE[7], [8]**<br>**a) Emergency Room**<br>**b) Follow-up treatment for out of service area medical emergencies** | a) 20% copayment after deductible<br>b) Not covered |
| **16. AMBULANCE** | 20% copayment after deductible |
| **17. URGENT, NON-ROUTINE, AFTER HOURS CARE**<br>**a) Urgent Care Services**<br>**b) Follow-up treatment for out of service area urgent care services** | a) $40 per visit copayment after deductible. Out-of-network urgent care covered only if traveling or temporarily absent from the service area.<br>b) Not covered |
| **18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]** | Coverage is no less extensive than the coverage provided for any other physical illness. |
| **19. OTHER MENTAL HEALTH CARE**<br>**a) Inpatient care**<br>**b) Outpatient care** | a) 20% copayment after deductible. Maximum Benefit Level: 45 days or 90 partial days per member per calendar year<br>b) $20 per visit copayment after deductible. Maximum Benefit Level: 20 visits or $1,000 payable by plan per member per calendar year, whichever is greater, except that for groups over 50 employees are limited to 20 visits and the $1,000 limit does not apply. |

| | IN-NETWORK ONLY<br>(out of network care is not covered except as noted) |
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| **20. ALCOHOL & SUBSTANCE ABUSE**<br>**Rehabilitation:**<br>**a) Inpatient care**<br>**b) Outpatient care**<br><br>**Detoxification:**<br>**c) Inpatient care**<br>**d) Outpatient care** | a) 50% copayment after deductible. Maximum Benefit Level: 45 days or 90 partial days per member per calendar year.<br>b) 50% copayment after deductible. Maximum Benefit Level: $500 payable by plan per member per calendar year.<br>c) 20% copayment after deductible – limited to removal of toxic substances from the body.<br>d) $20 per visit copayment after deductible – limited to the removal of the toxic substances from the body.<br><br>No coverage unless entire treatment program is completed as prescribed. |
| **21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY**<br>**a) Inpatient care**<br>**b) Outpatient care** | a) Included in inpatient hospital copayment. Maximum Benefit Level: 60 days per episode per medical condition<br>b) $40 per visit copayment after deductible. Maximum Benefit Level: 20 visits per episode per medical condition per calendar year. |
| **22. DURABLE MEDICAL EQUIPMENT**<br>**- Durable Medical Equipment (DME) and repairs**<br>**- Disposable Medical Supplies (DMS)**<br>**- Orthotics and Prosthetics** | 20% copayment after deductible. Maximum Benefit Level: $1,200 per member per calendar year paid by plan for DME, Repairs, DMS, Oxygen, and Orthotics/Prosthetics combined.<br><br>- Diabetic and injectable supplies are not subject to the annual limit and are limited to a 90-day supply when obtained from a pharmacy.<br>- Arm, leg, and breast prosthetics and mastectomy bras are not subject to the annual limit |
| **23. OXYGEN** | 20% copayment after deductible. Maximum Benefit Level: $1,200 per member per calendar year paid by plan for DME, Repairs, DMS, Oxygen, and Orthotics/Prosthetics combined. |
| **24. ORGAN TRANSPLANTS**<br>**a) Inpatient care**<br>**b) Outpatient care** | a) 20% copayment after deductible<br>b) 20% copayment after deductible |
| **25. HOME HEALTH CARE** | 20% copayment after deductible |
| **26. HOSPICE CARE** | 20% copayment after deductible. Maximum Benefit Level: Respite care is limited to periods of 5 days or less. |
| **27. SKILLED NURSING FACILITY CARE** | 20% copayment after deductible. Maximum Benefit Level: 100 days per member per calendar year. |
| **28. DENTAL CARE** | **Routine:** Not covered.<br>**Non-Routine:** $20 per visit copayment after deductible/PCP<br>$40 per visit copayment – after deductible /Any other participating provider<br>- For repair to sound and natural teeth due to accidental injury.<br>- Additional coverage may be obtained as an optional benefit. |
| **29. VISION CARE** | **Annual Routine Vision Screening:** $20 copayment after deductible<br>**Non Routine:** $20 per visit copayment after deductible/PCP<br>$40 per visit copayment after deductible/Any other participating provider<br>- For treatment due to injury or disease of the eye.<br>- Additional coverage may be obtained as an optional benefit. |
| **30. CHIROPRACTIC CARE** | Not covered |

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| **31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)** | 1) Cancer Screening Coverages and Parameters:<br>Subject to the parameters set forth below, cancer screening tests for the following items are covered subject to any applicable copayments/coinsurance, and maximum benefit levels:<br>• Breast – Mammogram<br>• Cervical – PAP test<br>• Colorectal – Colonoscopy, Sigmoidoscopy, Fecal Occult Blood<br>• Ovarian – CA125<br>• Prostate – PSA<br>Coverage for these cancer screening tests are subject to the following parameters:<br>a) the test must be ordered by your physician, and<br>b) you must comply with plan procedures<br><br>2) Medically Necessary Eyeglasses and Contacts:<br>20% copayment after deductible (when required as a result of eye surgery or with a diagnosis of keratoconus). |

**PART C: LIMITATIONS AND EXCLUSIONS**

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| **32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.[10]** | **For Business Groups of One:** Twelve months for all pre-existing conditions (18 months for late enrollees) unless the covered person is a HIPAA-eligible individual as defined under federal and state law, in which case there are no pre-existing condition exclusions.<br><br>**For small groups** (with less than 51 employees): Six months for all pre-existing conditions (18 months for late enrollees) unless the covered person is a HIPAA-eligible individual as defined under federal and state law, in which case there are no pre-existing condition exclusions.<br><br>**For large groups** (with 51 or more employees): Not applicable; plan does not impose limitation periods for pre-existing conditions. |
| **33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?** | No. |
| **34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?** | **For Business Groups of One:** A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last twelve months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.<br><br>**For small groups:** A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last six months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.<br><br>**For large groups:** Not applicable. Plan does not exclude coverage for pre-existing conditions. |
| **35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?** | Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review the list to see if a service or treatment you may need is excluded from the policy. |

**PART D: USING THE PLAN**

| | IN-NETWORK |
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| **36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?** | No |
| **37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?** | Yes |
| **38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?** | No |
| **39. What is the main customer service number?** | **800-346-4643** |
| **40. Who do I write/call if I have a complaint or want to file a grievance?[11]** | **Rocky Mountain Health Plans<br>Member Concerns Coordinator<br>P.O. Box 10600<br>Grand Junction, CO 81502** |
| **41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?** | **Write to:<br>Colorado Division of Insurance, ICARE Section<br>1560 Broadway, Suite 850<br>Denver, CO 80202** |
| **42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.** | Policy Form HMO HDHP 1000 Group Plan - Group - all sizes |
| **43. Does the plan have a binding arbitration clause?** | Yes, to the extent permitted by law. |

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[1] "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

[2] "Deductible" means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible may be noted in boxes 8 through 31.

[3] "Out-of-pocket maximum" means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductibles or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy. Expenses that are applied toward the out-of-pocket maximum may be noted in boxes 8 through 31.

[4] Routine medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically-based mental illness.

[5] Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together; there are not separate copayments.

[6] Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

[7] "Emergency care" means services delivered by an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.

[8] Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours care, then urgent care copayments apply.

[9] "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

[10] Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

[11] Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.