

## Colorado Health Plan Description Form

### Rocky Mountain Health Care Options

#### Rocky Mountain Direct PPO Plan C600

**PART A: TYPE OF COVERAGE**

<b>1. TYPE OF PLAN</b>	Preferred Provider Plan
<b>2. OUT-OF-NETWORK CARE COVERED?<sup>1</sup></b>	Yes, but patient pays more for out-of-network care.
<b>3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE</b>	Plan is available throughout Colorado except in the following areas: Routt County and Baca County

**PART B: SUMMARY OF BENEFITS**

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

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>4. ANNUAL DEDUCTIBLE<sup>2</sup></b> a) Individual b) Family	No deductibles	a) \$600 b) \$1,800 aggregate Deductibles shall not be applied to satisfy the out-of-pocket maximum. Deductible must be satisfied before services will be covered, except as noted.
<b>5. OUT-OF-POCKET ANNUAL MAXIMUM<sup>3</sup></b> a) Individual b) Family c) Is deductible included in the out-of-pocket maximum?	a) \$3,000 b) \$6,000 c) No deductibles  All copayments apply toward the out-of-pocket maximum, unless otherwise noted. Out-of-pocket maximum is calculated separately for in-network and out-of-network benefits. 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.	a) \$5,000 b) \$10,000 c) Deductible is excluded from the out-of-pocket maximum. All copayments apply toward the out-of-pocket maximum, unless otherwise noted. Out-of-pocket maximum is calculated separately for in-network and out-of-network benefits. 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.
<b>6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE</b>	\$2 million per member per lifetime (in-network and out-of-network benefits combined)	\$2 million per member per lifetime (in-network and out-of-network benefits combined)
<b>7A. COVERED PROVIDERS</b>	Rocky Mountain HCO Network, Private Healthcare Systems (national network), Horizon Behavioral Health. See participating provider directory for a complete list of current providers.	All providers licensed or certified to provide covered benefits
<b>7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?</b>	Yes – some network providers are available outside of Colorado.	Not applicable

<p><b>8. ROUTINE MEDICAL OFFICE VISITS<sup>4</sup></b>  a) <b>Primary Care Providers</b>  b) <b>Specialists</b></p>	<p>a) \$25 per visit copayment for visits to designated PCP  b) \$50 per visit copayment for visits to any other participating provider  Copayments do not apply toward annual out-of-pocket maximum.</p>	<p>a) 40% coinsurance after deductible  b) 40% coinsurance after deductible</p>
<p><b>9. PREVENTIVE CARE</b>  a) <b>Children's services (well-child services as age appropriate)</b>  b) <b>Adults' services (routine physical and gynecological exam – 1 per member per calendar year)</b>  c) <b>Routine screening mammograms, pap smears, prostate screenings</b>  d) <b>Colorectal cancer screenings (preventive and diagnostic)</b>  e) <b>Routine child immunizations and travel immunizations</b></p>	<p>a) No copayment (100% covered)  b) \$25 per visit copayment – for exam office visit only. Copayment does not apply toward annual out-of-pocket maximum. Associated services will have the applicable copayment for the type of service.  c) No copayment (100% covered) – office visit copayment may apply  d) 20% coinsurance  e) No copayment (100% covered) – office visit copayment may apply</p>	<p>a) 40% coinsurance, not subject to deductible  b) 40% coinsurance, not subject to deductible  c) No copayment (100% covered), not subject to deductible. Maximum Benefit Level: \$80 payable by plan per service for mammograms, pap smears, and prostate screenings. Office visit coinsurance may apply.  d) 40% coinsurance after deductible  e) No copayment (100% covered), not subject to deductible. Office visit coinsurance may apply.</p>
<p><b>10. MATERNITY</b>  a) <b>Prenatal care (routine)</b>  b) <b>Delivery &amp; inpatient well baby care<sup>5</sup></b>  Non-routine prenatal care will have the applicable copayment/coinsurance for the type of service.</p>	<p>a) No copayment (100% covered)  b) \$750 per day copayment up to 4 days, no copayment thereafter</p>	<p>a) 40% coinsurance after deductible  b) 40% coinsurance after deductible</p>
<p><b>11. PRESCRIPTION DRUGS<sup>6</sup></b>  Level of coverage and restrictions on prescriptions  a) <b>Inpatient prescription drugs and injectables</b>  b) <b>Outpatient prescription drugs and Insulin (not including injectables)</b>  <u><b>Injectable medication and infusion drugs:</b></u>  c) <b>Select Injectable List and injectables obtained at a pharmacy (except Insulin).</b>  - Maximum copayment: \$500 per fill  - Maximum benefit level: 31-day supply per fill  d) <b>All other injectable medication and infusion drugs (except Insulin).</b></p>	<p>a) Included in inpatient hospital copayment  b) See benefit schedule attached  c) 20% coinsurance - Coinsurance does not apply toward annual out-of-pocket maximum.  d) 20% coinsurance  For Drugs on our approved list, contact Customer Service at 800-346-4643.</p>	<p>a) 40% coinsurance after deductible  b) Not covered  c) Not covered  d) 40% coinsurance after deductible  For Drugs on our approved list, contact Customer Service at 800-346-4643.</p>
<p><b>12. INPATIENT HOSPITAL</b></p>	<p>\$750 per day copayment up to 4 days, no copayment thereafter</p>	<p>40% coinsurance after deductible</p>
<p><b>13. OUTPATIENT/AMBULATORY SURGERY</b></p>	<p>\$350 per visit copayment for outpatient surgery and invasive diagnostic tests</p>	<p>40% coinsurance after deductible for outpatient surgery and invasive diagnostic tests</p>

<b>14. DIAGNOSTICS</b> a) <b>Laboratory &amp; x-ray</b> b) <b>MRI, nuclear medicine, and other high-tech services</b>	a) Lab: \$25 per visit copayment X-ray: \$50 per visit copayment Copayments for lab and x-ray services do not apply toward annual out-of-pocket maximum. b) \$150 per visit copayment	a) 40% coinsurance after deductible b) 40% coinsurance after deductible
<b>15. EMERGENCY CARE<sup>7, 8</sup></b>	\$100 per visit copayment for emergency room (waived if admitted)	40% coinsurance, not subject to deductible, for emergency room
<b>16. AMBULANCE</b>	\$50 per trip copayment	\$50 per trip copayment after deductible
<b>17. URGENT, NON-ROUTINE, AFTER HOURS CARE</b>	\$50 per visit copayment Copayments do not apply toward annual out-of-pocket maximum.	40% coinsurance, not subject to deductible
<b>18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE<sup>9</sup></b>	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.
<b>19. OTHER MENTAL HEALTH CARE</b> a) <b>Inpatient care</b> b) <b>Outpatient care</b>	a) \$750 per day copayment up to 8 days, no copayment thereafter. Copayment does not apply toward annual out-of-pocket maximum. Maximum Benefit Level: 45 days or 90 partial days per member per calendar year b) 50% coinsurance - Coinsurance does not apply toward annual out-of-pocket maximum. 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.	a) Not covered b) Not covered
<b>20. ALCOHOL &amp; SUBSTANCE ABUSE</b> <u>Rehabilitation:</u> a) <b>Inpatient care</b> b) <b>Outpatient care</b>  <u>Detoxification:</u> c) <b>Inpatient care</b> d) <b>Outpatient care</b>	a) 50% coinsurance - Coinsurance does not apply toward annual out-of-pocket maximum. Maximum Benefit Level: 45 days or 90 partial days per member per calendar year. b) 50% coinsurance - Coinsurance does not apply toward annual out-of-pocket maximum. Maximum Benefit Level: \$500 payable by plan per member per calendar year for alcohol and \$500 paid by plan per member per calendar year for substance abuse. c) \$750 per day copayment up to 4 days, no copayment thereafter – limited to removal of toxic substances from the body. d) \$50 per visit copayment – limited to removal of the toxic substances from the body. Copayments do not apply toward the annual out-of-pocket maximum.  No coverage unless entire treatment program is completed as prescribed.	a) Not covered b) Not covered c) 40% coinsurance after deductible – limited to removal of the toxic substances from the body d) 40% coinsurance after deductible – limited to removal of the toxic substances from the body

<p><b>21. PHYSICAL, OCCUPATIONAL, &amp; SPEECH THERAPY</b>  a) Inpatient care  b) Outpatient care</p>	<p>a) Included in inpatient hospital copayment. Maximum Benefit Level: 60 days per episode per medical condition  b) \$50 per visit copayment  Copayments do not apply toward annual out-of-pocket maximum. Maximum Benefit Level: 20 visits per episode per medical condition per calendar year.  Maximum Benefit Level for in-network and out-of-network combined.</p>	<p>a) 40% coinsurance after deductible – Maximum Benefit Level: 60 days per episode per medical condition  b) 40% coinsurance after deductible – Maximum Benefit Level: 20 visits per episode per medical condition per calendar year.  Maximum Benefit Level for in-network and out-of-network combined.</p>
<p><b>22. DURABLE MEDICAL EQUIPMENT</b>  - Durable Medical Equipment (DME) and repairs  - Disposable Medical Supplies (DMS)  - Orthotics and Prosthetics</p>	<p>20% coinsurance - Maximum Benefit Level: \$1,500 per member per calendar year paid by plan for DME, Repairs, DMS, Oxygen, and Orthotics/Prosthetics combined.  - Coinsurance does not apply toward annual out-of-pocket maximum  - Disposable Medical Supplies obtained from a pharmacy are limited to a 90-day supply  - Diabetic and injectable supplies are not subject to the annual limit  - Arm, leg, and breast prosthetics and mastectomy bras are not subject to the annual limit  Maximum Benefit Level for in-network and out-of-network combined.</p>	<p>40% coinsurance after deductible - Maximum Benefit Level: \$1,500 per member per calendar year paid by plan for DME, Repairs, DMS, Oxygen, and Orthotics/ Prosthetics combined.  - Coinsurance does not apply toward annual out-of-pocket maximum  - Disposable Medical Supplies obtained from a pharmacy are not subject to deductible and are limited to a 90-day supply  - Diabetic and injectable supplies are not subject to deductible or the annual limit  - Arm, leg, and breast prosthetics and mastectomy bras are not subject to the annual limit  Maximum Benefit Level for in-network and out-of-network combined.</p>
<p><b>23. OXYGEN</b></p>	<p>20% coinsurance - Maximum Benefit Level: \$1,500 per member per calendar year paid by plan for DME, Repairs, DMS, Oxygen, and Orthotics/Prosthetics combined.  - Coinsurance does not apply toward annual out-of-pocket maximum.  Maximum Benefit Level for in-network and out-of-network combined.</p>	<p>40% coinsurance after deductible - Maximum Benefit Level: \$1,500 per member per calendar year paid by plan for DME, Repairs, DMS, Oxygen, and Orthotics/Prosthetics combined.  - Coinsurance does not apply toward annual out-of-pocket maximum.  Maximum Benefit Level for in-network and out-of-network combined.</p>
<p><b>24. ORGAN TRANSPLANTS</b>  a) Inpatient care  b) Outpatient care</p>	<p>a) \$750 per day copayment up to 4 days, no copayment thereafter  b) \$350 per visit copayment</p>	<p>a) Not covered  b) Not covered</p>
<p><b>25. HOME HEALTH CARE</b></p>	<p>20% coinsurance</p>	<p>40% coinsurance after deductible</p>
<p><b>26. HOSPICE CARE</b></p>	<p>No copayment (100% covered)  Maximum Benefit Level: Respite care is limited to periods of 5 days or less.</p>	<p>40% coinsurance after deductible  Maximum Benefit Level: Respite care is limited to periods of 5 days or less.</p>
<p><b>27. SKILLED NURSING FACILITY CARE</b></p>	<p>\$50 per day copayment.  Maximum Benefit Level: 100 days per member per calendar year. Maximum Benefit Level for in-network and out-of-network combined.</p>	<p>40% coinsurance after deductible  Maximum Benefit Level: 100 days per member per calendar year. Maximum Benefit Level for in-network and out-of-network combined.</p>

<p><b>28. DENTAL CARE</b></p>	<p><b>Routine:</b> Not covered.  <b>Non-Routine:</b>  \$25 per visit copayment/PCP  \$50 per visit copayment/Any other participating provider</p> <ul style="list-style-type: none"> <li>- For repair to sound and natural teeth due to accidental injury.</li> <li>- Copayments do not apply toward annual out-of-pocket maximum.</li> </ul> <p>Additional coverage may be obtained as an optional benefit.</p>	<p><b>Routine:</b> Not covered  <b>Non-Routine:</b> 40% coinsurance after deductible for treatment due to injury to sound and natural teeth.</p>
<p><b>29. VISION CARE</b></p>	<p><b>Annual Routine Vision Screening:</b>  \$25 copayment  <b>Non Routine:</b>  \$25 per visit copayment/PCP  \$50 per visit copayment/Any other participating provider</p> <ul style="list-style-type: none"> <li>- For treatment due to injury or disease of the eye.</li> <li>- Copayments do not apply toward annual out-of-pocket maximum.</li> </ul> <p>Additional coverage may be obtained as an optional benefit.</p>	<p><b>Annual Routine Vision Screening:</b>  Not covered  <b>Non-Routine:</b>  40% coinsurance after deductible for treatment due to injury or disease of the eye</p>
<p><b>30. CHIROPRACTIC CARE</b></p>	<p>Coverage may be obtained as an optional benefit.</p>	<p>Not covered</p>
<p><b>31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)</b></p>	<p>1) <u>Cancer Screening Coverages and Parameters:</u>  Subject to the parameters set forth below, cancer screening tests for the following items are covered subject to any applicable plan deductibles, copayments/ coinsurance, and maximum benefit levels:</p> <ul style="list-style-type: none"> <li>• Breast – Mammogram</li> <li>• Cervical – PAP test</li> <li>• Colorectal – Colonoscopy, Sigmoidoscopy, Fecal Occult Blood</li> <li>• Ovarian – CA125</li> <li>• Prostate – PSA</li> </ul> <p>Coverage for these cancer screening tests are subject to the following parameters:</p> <ul style="list-style-type: none"> <li>a) the test must be ordered by your physician, and</li> <li>b) you must comply with plan procedures</li> </ul> <p>2) <u>Medically Necessary Eyeglasses and Contacts:</u>  20% coinsurance (when required as a result of eye surgery or with a diagnosis of keratoconus).</p>	<p>1) <u>Cancer Screening Coverages and Parameters:</u>  Subject to the parameters set forth below, cancer screening tests for the following items are covered subject to any applicable plan deductibles, copayments/ coinsurance, and maximum benefit levels:</p> <ul style="list-style-type: none"> <li>• Breast – Mammogram</li> <li>• Cervical – PAP test</li> <li>• Colorectal – Colonoscopy, Sigmoidoscopy, Fecal Occult Blood</li> <li>• Ovarian – CA125</li> <li>• Prostate – PSA</li> </ul> <p>Coverage for these cancer screening tests are subject to the following parameters:</p> <ul style="list-style-type: none"> <li>a) the test must be ordered by your physician, and</li> <li>b) you must comply with plan procedures</li> </ul> <p>2) <u>Medically Necessary Eyeglasses and Contacts:</u>  40% coinsurance after deductible (when required as a result of eye surgery or with a diagnosis of keratoconus).</p>

**PART C: LIMITATIONS AND EXCLUSIONS**

<p><b>32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.<sup>10</sup></b></p>	<p><b>For Business Groups of One:</b> 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.</p> <p><b>For small groups</b> (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.</p> <p><b>For large groups</b> (with 51 or more employees): Not applicable; plan does not impose limitation periods for pre-existing conditions.</p>
<p><b>33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?</b></p>	<p>No.</p>
<p><b>34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?</b></p>	<p><b>For Business Groups of One:</b> 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.</p> <p><b>For small groups:</b> 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.</p> <p><b>For large groups:</b> Not applicable. Plan does not exclude coverage for pre-existing conditions.</p>
<p><b>35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?</b></p>	<p>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.</p>

**PART D: USING THE PLAN**

	IN-NETWORK	OUT-OF-NETWORK
<p><b>36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?</b></p>	No	No
<p><b>37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?</b></p>	Yes	Yes
<p><b>38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?</b></p>	No	Yes
<p><b>39. What is the main customer service number?</b></p>	800-346-4643	
<p><b>40. Who do I write/call if I have a complaint or want to file a grievance?<sup>11</sup></b></p>	<p><b>Rocky Mountain Health Plans Member Concerns Coordinator P.O. Box 10600 Grand Junction, CO 81502</b></p>	

	IN-NETWORK	OUT-OF-NETWORK
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance, ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202	
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy Form <u>PPO C600 Group Plan</u> - Group - all sizes	
43. Does the plan have a binding arbitration clause?	Yes, to the extent permitted by law.	

<sup>1</sup> “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).

<sup>2</sup> “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.

<sup>3</sup> “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.

<sup>4</sup> Routine medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically-based mental illness.

<sup>5</sup> 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.

<sup>6</sup> Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

<sup>7</sup> “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.

<sup>8</sup> 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.

<sup>9</sup> “Biologically based mental illnesses” means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

<sup>10</sup> 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.

<sup>11</sup> Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.