1. SCHEDULE OF BENEFITS (Who Pays What)

ROCKY MOUNTAIN HEALTH PLANS
GOOD HEALTH PPO $350 DEDUCTIBLE / 90 PLAN
COLORADO MESA UNIVERSITY
LARGE GROUP
EVIDENCE OF COVERAGE
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 refer to Your Contract for a description of Your Benefits, Limitations, and Exclusions. Benefits are subject to all terms of the Contract.

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:	**In-Network**	**Out-of-Network**
Deductible a) Member (Individual) b) Subscriber and Dependents (Family) 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. Amounts paid by You to satisfy 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.	a) $350 per Calendar Year b) $600 per Calendar Year	a) $500 per Calendar Year b) $1,000 per Calendar Year
Yearly Out-of-Pocket Maximum a) Member (Individual) b) Subscriber and Dependents (Family) 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. 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.	a) $3,000 per Calendar Year b) $5,000 per Calendar Year	a) $4,000 per Calendar Year b) $6,000 per Calendar Year

You may have to pay in full for services from Non-Network Providers. You can then send claims for those services to Us to be paid. If You choose to receive Care from Non-Network Providers, You may be responsible to pay any billed amounts over the Allowed Charges for Out-of-Network Care.

Benefits
The Benefits listed below are subject to Copays or Coinsurance until the Yearly Out-of-Pocket Maximum is satisfied, unless otherwise noted. 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.

Benefits	In-Network Copays and Coinsurance	Out-of-Network Copays and Coinsurance
Care not shown on this Coverage Schedule	After Deductible, 10% Coinsurance	After Deductible, 30% Coinsurance
Ambulance Services	$150 per trip Not subject to Deductible Copay for In and Out-of-Network ambulance services applies to the In-Network Yearly Out-of-Pocket Maximum	
Asthma Education – outpatient Related services are subject to the Cost Sharing for the type of service.	No Copay Not subject to Deductible	After Deductible, 30% Coinsurance
Autism Spectrum Disorders (ASD)	Benefit level determined by place and type of service	Benefit level determined by place and type of service
Behavioral, Mental Health and Substance Use Disorders a) Inpatient and other facility based Care b) Outpatient Care c) Intensive Outpatient Care (does not include detox) **L** – Detox is limited to removal of toxic substances from the body	a) After Deductible, $500 per admission b) $30 per visit Not subject to Deductible c) No Copay Not subject to Deductible	a) - c) After Deductible, 30% Coinsurance
Blood Services – outpatient Office visit Cost Sharing may apply.	After Deductible, 10% Coinsurance	After Deductible, 30% Coinsurance
Chiropractic Care (Chiro Care) **M** - 20 visits per Member per Calendar Year. Related services are subject to the Cost Sharing for the type of service.	$30 per visit Not subject to Deductible	⊗ Not covered Out-of-Network

Benefits	In-Network Copays and Coinsurance	Out-of-Network Copays and Coinsurance
Colorectal Cancer Screenings – outpatient (Including screening colonoscopies, screening 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
Diabetic Education - outpatient Related services are subject to the Cost Sharing for the type of service.	No Copay Not subject to Deductible	After Deductible, 30% Coinsurance
Dialysis – outpatient Related services are subject to the Cost Sharing for the type of service.	After Deductible, 10% Coinsurance	After Deductible, 30% Coinsurance
Disposable Medical Supplies (including diabetic disposable medical supplies) a) Picked up from a pharmacy and on Tiers 1-4 of the RMHP Formulary **L** - Subject to quantity limits noted in the RMHP Formulary. b) All other Disposable Medical Supplies Office visit Cost Sharing may apply. See the RMHP Formulary at www.rmhp.org.	a) See the Prescription Drug Product Supplement included with this Contract Not subject to Deductible b) After Deductible, 10% Coinsurance	a) ⊗ Not covered Out-of-Network b) After Deductible, 30% Coinsurance
Durable Medical Equipment (DME) and Repairs a) Picked up from a pharmacy and on Tiers 1-4 of the RMHP Formulary **L** - Subject to quantity limits noted in the RMHP Formulary. b) Breast pumps and supplies **L –** Covered with the birth of a child. **L –** Rental or purchase is covered up to the cost of the RMHP Preferred Model. c) All other Durable Medical Equipment (including insulin pumps) Office visit Cost Sharing may apply See the RMHP Formulary at www.rmhp.org.	a) See the Prescription Drug Product Supplement included with this Contract Not subject to Deductible b) Rental or purchase: No Copay Not subject to Deductible c) After Deductible, 10% Coinsurance	a) ⊗ Not covered Out-of-Network b) Purchase: No Copay Not subject to Deductible ⊗ Rental**:** Not covered Out-of-Network d) ⊗ Not covered Out-of-Network, except that glucometers not obtained from a pharmacy are covered as follows: After Deductible, 30% Coinsurance

Benefits	In-Network Copays and Coinsurance	Out-of-Network Copays and Coinsurance
Early Intervention Services (EIS) **M** - In and Out-of-Network combined - 45 therapeutic visits per Member per Calendar Year. 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 **L** - EIS are only a Benefit for Members who are under age 3.	No Copay Not subject to Deductible	
Emergency Room Care	$150 per visit Not subject to Deductible Copay for In and Out-of-Network Emergency Care apply to the In-Network Yearly Out-of-Pocket Maximum. If the Member is admitted as an inpatient directly from the emergency room, the $150 Copay will be waived.	
Enteral Nutrition **L** - Covered for Members up to age 3. a) Picked up from a pharmacy b) Not picked up from a pharmacy Office visit Cost Sharing may apply. See the RMHP Formulary at www.rmhp.org.	a) 10% Coinsurance, not to exceed $150 per claim Not subject to Deductible b) After Deductible, 10% Coinsurance	a & b) ⊗ Not covered Out-of-Network
Eyeglasses and Contact Lenses **L –** Covered when required as a result of eye surgery or with a diagnosis of keratoconus.	After Deductible, 10% Coinsurance	After Deductible, 30% Coinsurance

Benefits	In-Network Copays and Coinsurance	Out-of-Network Copays and Coinsurance
Family Planning and Sterilization a) Any medically acceptable device or procedure used to prevent pregnancy not listed below b) Counseling and information on birth control **Birth control for women** 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. c) Diaphragms d) IUDs and subdermal implants e) Hormone injections f) Surgical sterilization for women g) Prescription Drug Products picked up from a pharmacy **Birth control for men** h) Surgical sterilization for men ⊗ Over-the-counter contraceptive drugs or devices which do not require a Prescription Order or Refill. This does not include those on the RMHP Formulary. See the RMHP Formulary at www.rmhp.org.	a) Subject to the Cost Sharing for type of service provided b) – f) No Copay Not subject to Deductible g) See the Prescription Drug Product Supplement included with this Contract Not subject to Deductible h) Subject to the Cost Sharing for type of service provided	a) Subject to the Cost Sharing for type of service provided b) – f) Subject to the Cost Sharing for type of service provided g) ⊗ Not covered Out-of Network h) Subject to the Cost Sharing for type of service provided
Home Health Services **M** - In- and Out-of-Network combined: 60 visits per Member per Calendar Year.	After Deductible, No Copay	After Deductible, 30% Coinsurance
Hospice Services – inpatient and outpatient **M** - Respite Care is limited to periods of 5 days or less.	10% Coinsurance Not subject to Deductible	After Deductible, 30% Coinsurance
Hospital (Applies to all Hospital Care unless otherwise provided in this Coverage Schedule) a) Inpatient Care b) Outpatient Care	a) After Deductible, $500 per admission b) After Deductible, $250 per admission	a) & b) After Deductible, 30% Coinsurance
Infertility Care – outpatient a) Office Visits b) Testing Related services are subject to the Cost Sharing for the type of service.	a) $30 per visit Not subject to Deductible b) Subject to Deductible and Copay or Coinsurance for the type of service	a) After Deductible, 30% Coinsurance b) Subject to Deductible and Copay or Coinsurance for the type of service

Benefits	In-Network Copays and Coinsurance	Out-of-Network Copays and Coinsurance
Injectable Drugs (Self-Administered) a) Picked up from a pharmacy and on Tiers 1-4 of the RMHP Formulary b) Received in a Physician's office or outpatient facility See the RMHP Formulary at www.rmhp.org.	a) See the Prescription Drug Product Supplement included with this Contract Not subject to Deductible b) Not covered	a & b) ⊗ Not covered Out-of-Network
Injectable Drugs, including allergy injections and (Non Self-Administered), and Infusion Drugs a) Picked up from a pharmacy and on Tier 6 or higher of the RMHP Formulary b) Not picked up from a pharmacy Office visit Cost Sharing may apply. See the RMHP Formulary at www.rmhp.org.	a) & b) 10% Coinsurance Not subject to Deductible	a) ⊗ Not covered Out-of-Network b) After Deductible, 30% Coinsurance
Laboratory Services – outpatient Office visits and related services are subject to the Cost Sharing for the type of service.	$15 per visit Not subject to Deductible	After Deductible, 30% Coinsurance
Maternity Care a) Routine prenatal office visits b) Other routine prenatal Care c) Delivery and inpatient well-baby Care Non-routine maternity services are subject to the applicable Cost Sharing for the type of service.	a) & b) No Copay Not subject to Deductible c) After Deductible, $500 per admission	a) – c) After Deductible, 30% Coinsurance
Medical Foods and Therapeutic Formulas a) Picked up from a pharmacy b) Not picked up from a pharmacy Office visit Cost Sharing may apply. See the RMHP Formulary at www.rmhp.org.	a) 10% Coinsurance, not to exceed $150 per claim Not subject to Deductible b) After Deductible, 10% Coinsurance	a & b) ⊗ Not covered Out-of-Network
Nutritional Counseling - outpatient a) At an office visit or an outpatient facility Office visit Cost Sharing may apply. b) For Members per the "A" or "B" recommendations of the USPSTF Cost Sharing may apply for non-preventive Care provided at the same visit.	a) $30 Copay per visit Not subject to Deductible b) No Copay Not subject to Deductible	a) After Deductible, 30% Coinsurance b) Subject to the applicable Cost Sharing for type of service provided Not subject to Deductible

Benefits	In-Network Copays and Coinsurance	Out-of-Network Copays and Coinsurance
Office Visits (Applies to all office visit Care unless otherwise provided in this Coverage Schedule) Related services are subject to the Cost Sharing for the type of service. Visits at an outpatient facility will be subject to the Cost Sharing in addition to any office visit Copay.	$30 per visit Not subject to Deductible	After Deductible, 30% Coinsurance
Orthotic Devices (OD) (Including repairs) Office visit Cost Sharing may apply.	After Deductible, 10% Coinsurance	⊗ Not covered Out-of-Network
Oxygen Service – outpatient	After Deductible, 10% Coinsurance	⊗ Not covered Out-of-Network
Physician Services Physician's office and outpatient facility Care. Office visit Cost Sharing may apply.	Benefit level determined by place and type of service	Benefit level determined by place and type of service
Prescription Drug Products – outpatient **L** -Subject to Limitations and Exclusions noted in the RMHP Formulary and Prescription Drug Product Supplement. See the RMHP Formulary at www.rmhp.org.	See the Prescription Drug Product Supplement Not subject to Deductible	⊗ Not covered Out-of-Network
Preventive Cancer Screenings – outpatient **M** - In- and Out-of-Network combined: One per type of service per Member per Calendar Year. Cost Sharing may apply for non-preventive Care provided at the same visit. a) Mammograms (preventive or diagnostic) b) Prostate screenings c) Routine pap smears (cervical cancer screenings)	a - c) No Copay Not subject to Deductible	a -b) No Copay Not subject to Deductible

Benefits	In-Network Copays and Coinsurance	Out-of-Network Copays and Coinsurance
Preventive Services – outpatient Cost Sharing may apply for non-preventive Care provided at the same visit. a) Adult physical exams and routine gynecological exams b) Behavioral health screening **M** - For a) and b) above, In-Network: One per type of service per Member per Calendar Year, except for additional preventive services recommended by a Physician. c) Well baby Care, well child Care and child health supervision services, not including immunizations **L** - Well child services as age appropriate. d) Immunizations - Adult and child immunizations, vaccination for cervical cancer, and influenza and pneumococcal immunizations as recommended by ACIP ⊗ - Travel immunizations e) Alcohol misuse screening and behavioral counseling interventions for adults, depression screening for adolescents and adults, and perinatal depression counseling, per the "A" or "B" recommendations of the USPSTF f) Tobacco use screening for adults by any primary care provider, unlimited tobacco cessation interventions for adults per the "A" or "B" recommendations of the USPSTF, access to the Colorado Quitline, and all FDA approved tobacco cessation medications (both prescription and over-the-counter) g) Cholesterol screening for lipid disorders h) Chlamydia screening, for female Members within the ages of the USPSTF recommendation i) Any preventive service or Prescription Drug Product not listed above included: • as an "A" or "B" USPSTF recommendation; • 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.	a - i) No Copay Not subject to Deductible	a) & b) ⊗ Not covered Out-of-Network c) No Copay Not subject to Deductible d) $30 per visit for adult immunization, except influenza and pneumococcal will be covered with no Copay; Child immunizations, vaccination for cervical cancer, influenza and pneumococcal immunizations: No Copay Not subject to Deductible e & g) No Copay Not subject to Deductible h) ⊗ Not covered Out-of-Network i) Subject to the Cost Sharing for type of service provided Not subject to Deductible

Benefits	In-Network Copays and Coinsurance	Out-of-Network Copays and Coinsurance
Prosthetic Devices (PD) a) Arm and leg prosthetic devices b) All other prosthetic devices c) Repairs Office visit Cost Sharing may apply.	a) 10% Coinsurance Not subject to Deductible b) & c) After Deductible, 10% Coinsurance	a) – c) Not Covered Out-of-Network, except for arm, leg and external breast prosthetic devices and mastectomy bras, which will be covered as follows: After Deductible, 30% Coinsurance
Psychological Testing - outpatient	Covered as a Behavioral, Mental Health and Substance Use Disorder service	Covered as a Behavioral, Mental Health and Substance Use Disorder service
Radiation Therapy	After Deductible, 10% Coinsurance	After Deductible, 30% Coinsurance
Skilled Nursing Facility Services **M** - In and Out-of-Network combined: 60 days per Member per Calendar Year.	After Deductible, $250 per visit	After Deductible, 30% 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) After Deductible, $500 per admission b) After Deductible, $250 per admission	a) & b) After Deductible, 30% Coinsurance
Therapy Services – inpatient physical, speech, occupational therapy, and cardiac and pulmonary rehabilitation **M** - In and Out-of-Network combined: Physical, occupational and speech therapies (combined) are limited to 2 months per Episode per medical condition.	After Deductible, $500 per admission	After Deductible, 30% Coinsurance
Therapy Services – physical, speech, occupational therapy, and cardiac and pulmonary rehabilitation **M** - In and Out-of-Network combined: Physical, occupational and speech therapies are limited to 20 visits per Member per therapy per Calendar Year. **M** - In and Out-of-Network combined: Therapies (physical, occupational and speech) for congenital defects and birth abnormalities (for Members up to 6 years of age) - 20 visits for each type of therapy per Member per Calendar Year, reduced by the number of other physical, occupational and speech therapy visits received by the Member in a Calendar Year for the same condition.	$30 per visit Not subject to Deductible	After Deductible, 30% Coinsurance

Benefits	In-Network Copays and Coinsurance	Out-of-Network Copays and Coinsurance
Total Parenteral Nutrition (TPN) – outpatient Office visit Cost Sharing may apply.	After Deductible, 10% Coinsurance	⊗ Not covered Out-of-Network
Transplants a) Inpatient Care b) Outpatient Care	a) After Deductible, $500 per admission b) After Deductible, $250 per admission	a) & b) ⊗ Not covered Out-of-Network
Urgent Care Services – outpatient Related services are subject to the Cost Sharing for the type of service.	$50 per visit Not subject to Deductible	After Deductible, 30% Coinsurance
Vision Screening - outpatient M - One per Member per Calendar Year. Related services are subject to the Cost Sharing for the type of service.	$30 per visit Not subject to Deductible	⊗ Not covered Out-of-Network
X-ray and Other Imaging Services – outpatient a) X-rays and other imaging b) MRI, PET and CT scans Office visits and related services are subject to the Cost Sharing for the type of service.	a) $15 per visit Not subject to Deductible b) After Deductible, $100 per visit	a & b) After Deductible, 30% Coinsurance