1. SCHEDULE OF BENEFITS (Who Pays What)

ROCKY MOUNTAIN HEALTH PLANS

GOOD HEALTH HMO $1250 DEDUCTIBLE / 75 PLAN

EVIDENCE OF COVERAGE

LARGE GROUP

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:	
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 do not apply to the Deductible.	a) $1,250 per Calendar Year b) $2,500 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 apply to the Yearly Out-of-Pocket Maximum.	a) $4,500 per Calendar Year b) $9,000 per Calendar Year

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

Benefit	Copay
Care not shown on this Coverage Schedule	After Deductible, 25% Copay
Ambulance Services	After Deductible, 25% Copay
Asthma Education – outpatient Related services are subject to the Cost Sharing for the type of service.	No Copay Not subject to Deductible
Autism Spectrum Disorders (ASD)	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, 25% Copay b) $45 per visit Not subject to Deductible c) After Deductible, 25% Copay
Blood Services – outpatient Office visit Copay may apply.	After Deductible, 25% Copay
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.	$45 per visit Not subject to Deductible
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
Diabetic Education – outpatient Related services are subject to the Cost Sharing for the type of service.	No Copay Not subject to Deductible
Dialysis – outpatient Related services are subject to the Cost Sharing for the type of service.	After Deductible, 25% Copay

Benefit	Copay
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 Copay 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, 25% Copay
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 Copay 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, 25% Copay
Early Intervention Services (EIS) **M** - 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	After Deductible, 25% Copay
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 Copay may apply. See the RMHP Formulary at www.rmhp.org.	a) 20% Copay, not to exceed $150 per claim Not subject to Deductible b) After Deductible, 25% Copay
Eyeglasses and Contact Lenses **L** – Covered when required as a result of eye surgery or with a diagnosis of keratoconus.	After Deductible, 25% Copay

Benefit	Copay
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 Copay 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 Copay for type of service provided
Home Health Services **M** - 60 visits per Member per Calendar Year.	After Deductible, 25% Copay
Hospice Services – inpatient and outpatient **M** - Respite Care is limited to periods of 5 days or less.	25% Copay Not subject to Deductible
Hospital – inpatient and outpatient (Applies to all Hospital Care unless otherwise provided in this Coverage Schedule)	After Deductible, 25% Copay
Injectable and Infusion Drugs – Self-Administerable 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
Injectable Drugs, including allergy injections and Infusion Drugs – Non Self-Administerable 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 Copay may apply. See the RMHP Formulary at www.rmhp.org.	a) & b) After Deductible, 25% Copay

Benefit	Copay
Laboratory Services – outpatient Office visit Copay may apply. Related services are subject to the Cost Sharing for the type of service.	$25 per visit Not subject to Deductible
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, 25% Copay
Medical Foods and Therapeutic Formulas a) Picked up from a pharmacy b) Not picked up from a pharmacy Office visit Copay may apply. See the RMHP Formulary at www.rmhp.org.	a) 20% Copay, not to exceed $150 per claim Not subject to Deductible b) After Deductible, 25% Copay
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) After Deductible, 25% Copay b) No Copay Not subject to Deductible
Office Visits (Applies to all office visit Care unless otherwise provided in this Coverage Schedule) a) PCP b) Any other Network Provider 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.	a) $45 per visit Not subject to Deductible b) $60 per visit Not subject to Deductible
Orthotic Devices (OD) (Including repairs) Office visit Copay may apply.	After Deductible, 25% Copay

Benefit	Copay
Oxygen Service – outpatient	After Deductible, 25% Copay
Physician Services Physician's office and outpatient facility Care. Office visit Copay may apply.	After Deductible, 25% Copay
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
Preventive Cancer Screenings – outpatient **M** - 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

Benefit	Copay
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, 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 recommendations; • 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

Benefit	Copay
Prosthetic Devices (PD) a) Arm and leg prosthetic devices b) All other prosthetic devices c) Repairs Office visit Copay may apply.	a) 20% Copay Not subject to Deductible b) & c) After Deductible, 25% Copay
Psychological Testing – outpatient	Covered as a Behavioral, Mental Health and Substance Use Disorder service
Radiation Therapy	After Deductible, 25% Copay
Skilled Nursing Facility Services **M** - 60 days per Member per Calendar Year.	After Deductible, 25% Copay
Surgery – inpatient, outpatient surgery and invasive diagnostic testing	After Deductible, 25% Copay
Therapy Services – inpatient physical, speech, occupational therapy, cardiac and pulmonary rehabilitation **M -** Physical, occupational and speech therapies (combined) are limited to 2 months per Episode per medical condition.	After Deductible, 25% Copay
Therapy Services – outpatient a) Physical, occupational and speech therapy **M** - Physical, occupational and speech therapies are limited to 20 visits per Member per therapy per Calendar Year. **M** - 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 Benefits received by the Member in a Calendar Year for the same condition. b) Cardiac and pulmonary rehabilitation	a) $60 per visit Not subject to Deductible b) After Deductible, 25% Copay
Total Parenteral Nutrition (TPN) – outpatient Office visit Copay may apply.	After Deductible, 25% Copay
Transplants – inpatient and outpatient	After Deductible, 25% Copay
Urgent Care Services – outpatient (In and out of Service Area) Related services are subject to the Cost Sharing for the type of service.	$60 per visit Not subject to Deductible
Vision Screening – outpatient **M** - One per Member per Calendar Year. Related services are subject to the Cost Sharing for the type of service.	$45 per visit Not subject to Deductible

Benefit	Copay
X-ray and Other Imaging Services – outpatient a) X-rays and other imaging b) MRI, PET and CT scans Office visit Copay may apply. Related services are subject to the Cost Sharing for the type of service.	a) $50 per visit Not subject to Deductible b) After Deductible, 25% Copay