1. SCHEDULE OF BENEFITS (Who Pays What)

ROCKY MOUNTAIN HEALTH PLANS
GOOD HEALTH PPO HSA 3500B / 100 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. Deductibles and Yearly Out-of-Pocket Maximums are subject to a yearly cost of living adjustment per IRC rules for HDHPs. Please see 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 (for In-Network and Out-of-Network Benefits combined) 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 appropriate In and Out-of-Network Yearly Out-of-Pocket Maximum. Deductible must be satisfied before services will be covered, except as noted. Copays and Coinsurance do not apply to the Deductible.	a) $3,500 per Calendar Year b) $6,500 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 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 unless otherwise noted. If the Yearly Out-of-Pocket Maximum is met before the Deductible, all services will be covered without Copay or Coinsurance.	a) $3,500 per Calendar Year b) $6,500 per Calendar Year	a) $6,750 per Calendar Year b) $13,500 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 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.

Benefits	In-Network Copays and Coinsurance	Out-of-Network Copays and Coinsurance
Care not shown on this Coverage Schedule	After Deductible, No Copay	After Deductible, 50% Coinsurance
Ambulance Services	After Deductible, No Copay The Deductible applies to the In-Network Yearly Out-of-Pocket Maximum for ambulance services	
Asthma Education – outpatient	After Deductible, No Copay	After Deductible, 50% 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) - c) After Deductible, No Copay	a) - c) After Deductible, 50% Coinsurance
Blood Services – outpatient	After Deductible, No Copay	After Deductible, 50% Coinsurance
Chiropractic Care (Chiro Care) **M -** 20 visits per Member per Calendar Year.	After Deductible, No Copay	⊗ 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	After Deductible, No Copay	After Deductible, 50% Coinsurance
Dialysis – outpatient	After Deductible, No Copay	After Deductible, 50% 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 See the RMHP Formulary at www.rmhp.org.	a) See the Prescription Drug Products section on this Coverage Schedule b) After Deductible, No Copay	a) ⊗ Not covered Out-of-Network b) After Deductible, 50% 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 Products section on this Coverage Schedule b) Rental or purchase: No Copay Not subject to Deductible c) After Deductible, No Copay	a) ⊗ Not covered Out-of-Network b) Purchase: No Copay Not subject to Deductible ⊗ Rental**:** Not covered Out-of-Network c) ⊗ Not covered Out-of-Network, except that glucometers not obtained from a pharmacy are covered as follows: After Deductible, 50% 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.	After Deductible, No Copay The Deductible applies to the In-Network Yearly Out-of-Pocket Maximum for EIS services	
Emergency Room Care	After Deductible, No Copay The Deductible applies to the In-Network Yearly Out-of-Pocket Maximum for Emergency Care	
Enteral Nutrition **L** - Covered for Members up to age 3. a) Picked up from a pharmacy b) Not picked up from a pharmacy See the RMHP Formulary at www.rmhp.org.	a) & b) After Deductible, No Copay	a) ⊗ Not covered Out-of-Network b) After Deductible, 50% Coinsurance
Eyeglasses and Contact Lenses **L –** Covered when required as a result of eye surgery or with a diagnosis of keratoconus.	After Deductible, No Copay	After Deductible, 50% 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 Products section of this Coverage Schedule 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, 50% Coinsurance
Hospice Services – inpatient and outpatient **M** - Respite Care is limited to periods of 5 days or less.	After Deductible, No Copay	After Deductible, 50% Coinsurance
Hospital – inpatient and outpatient (Applies to all Hospital Care unless otherwise provided in this Coverage Schedule)	After Deductible, No Copay	After Deductible, 50% Coinsurance
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 Products section of this Coverage Schedule b) ⊗ Not covered In-Network	a & b) ⊗ Not covered Out-of-Network

Benefits	In-Network Copays and Coinsurance	Out-of-Network Copays and Coinsurance
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 See the RMHP Formulary at www.rmhp.org.	a) & b) After Deductible, No Copay	a) ⊗ Not covered Out-of-Network b) After Deductible, 50% Coinsurance
Laboratory Services – outpatient	After Deductible, No Copay	After Deductible, 50% 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, No Copay	a) – c) After Deductible, 50% Coinsurance
Medical Foods and Therapeutic Formulas a) Picked up from a pharmacy b) Not picked up from a pharmacy See the RMHP Formulary at www.rmhp.org.	a) & b) After Deductible, No Copay	a) ⊗ Not covered Out-of-Network b) After Deductible, 50% Coinsurance
Nutritional Counseling - outpatient a) At an office visit or an outpatient facility 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, No Copay b) No Copay Not subject to Deductible	a) After Deductible, 50% Coinsurance b) Subject to the applicable Cost Sharing for type of service provided Not subject to Deductible
Office Visits (Applies to all office visit Care unless otherwise provided in this Coverage Schedule)	After Deductible, No Copay	After Deductible, 50% Coinsurance

Benefits	In-Network Copays and Coinsurance	Out-of-Network Copays and Coinsurance
Prescription Drug Products **L** - Retail Pharmacy and Mail Order Pharmacy – up to a 90-day supply. Specialty Prescription Drug Products on any tier and Prescription Drug Products on Tier 4 are limited to a 31-day supply. This Limitation doesn't apply to oral contraceptive drugs, patches and rings. You can get up to a 1 year supply after an initial 3 month supply for oral contraceptive drugs and patches. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Cost Sharing that applies will reflect the number of days dispensed or days the drug will be delivered. Benefits are subject to the Limitations and Exclusions specified in the RMHP Formulary and Your Contract. **There is no Cost Sharing for contraceptive drugs and devices noted as "H" or "H-PA" on any tier of the RMHP Formulary. "H" means Health Care Reform Preventive. "PA" means requires Prior Authorization. There is also no Cost Sharing after Deductible for oral anti-cancer drugs on any tier of the RMHP Formulary.** **Your Cost Sharing will not exceed $100 per 30 day supply of insulin, regardless of the amount or type of insulin needed to fill Your Prescription Order(s).** You will be charged an Ancillary Charge when a Prescription Drug Product is dispensed at Your or Your provider's request and a Chemically Equivalent Prescription Drug Product is available. For example, if You choose to fill a Prescription Order for a Brand-name Prescription Drug Product when a Generic is available, Your Ancillary Charge will be the difference in cost between the Brand-name and the Generic Prescription Drug Product. The Ancillary Charge does not apply to Your Yearly Out-of-Pocket Maximum. You will continue to pay the Ancillary Charge once Your Yearly Out-of-Pocket Maximum is met. See the RMHP Formulary at www.rmhp.org.	See chart below	⊗ Not covered Out-of-Network

Benefits	In-Network Copays and Coinsurance	Out-of-Network Copays and Coinsurance
In Network Prescription Drug Product Benefits	**Preventive Generic Prescription Drug Products on the RMHP Formulary and listed on the HSA Preventive Drug List**	**All other Prescription Drug Products**
Up to 31 day supply* at all Network Pharmacies	$10.00 Copay Not subject to Deductible	After Deductible, No Copay
32 to 60 day supply* at a Retail Pharmacy & Mail Order Pharmacy Specialty Prescription Drug Products on all tiers are limited to a 31-day supply*.	$20.00 Copay Not subject to Deductible	After Deductible, No Copay
61 to 90 day supply* at a Retail Pharmacy & Mail Order Pharmacy Specialty Prescription Drug Products on all tiers are limited to a 31-day supply*.	$20.00 Copay Not subject to Deductible	After Deductible, No Copay
***When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Cost Sharing that applies will reflect the number of days dispensed or days the drug will be delivered.**		
Oxygen Service – outpatient	After Deductible, No Copay	⊗ Not covered Out-of-Network
Physician Services Physician's office and outpatient facility Care.	After Deductible, No Copay	After Deductible, 50% Coinsurance
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 - c) 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) Additional exams - Type 2 diabetes screenings and eye exams for children under age 5 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 immunizations, 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 Copay and Coinsurance for type of service provided Not subject to Deductible

Benefits	In-Network Copays and Coinsurance	Out-of-Network Copays and Coinsurance
Prosthetic Devices (PD) and Orthotic Devices (OD) (Including repairs)	After Deductible, No Copay	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, 50% 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, No Copay	After Deductible, 50% Coinsurance
Skilled Nursing Facility Services **M** - In and Out-of-Network combined: 60 days per Member per Calendar Year.	After Deductible, No Copay	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, No Copay	a) & b) After Deductible, 50% Coinsurance
Therapy Services – inpatient physical, speech, occupational therapy, 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, No Copay	After Deductible, 50% Coinsurance
Therapy Services – outpatient physical, speech and occupational therapy, 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.	After Deductible, No Copay	After Deductible, 50% Coinsurance
Total Parenteral Nutrition (TPN) – outpatient	After Deductible, No Copay	After Deductible, 50% Coinsurance

Benefits	In-Network Copays and Coinsurance	Out-of-Network Copays and Coinsurance
Transplants – inpatient and outpatient	After Deductible, No Copay	⊗ Not covered Out-of-Network
Urgent Care Services – outpatient	After Deductible, No Copay	After Deductible, 50% Coinsurance
Vision Screening - outpatient **M** - One per Member per Calendar Year.	After Deductible, No Copay	⊗ Not covered Out-of-Network
X-ray and Other Imaging Services – outpatient	After Deductible, No Copay	After Deductible, 50% Coinsurance