

General Multi-Language Insert



ROCKY MOUNTAIN
HEALTH PLANS®

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-282-1420 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-282-1420 (TTY: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-282-1420 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-282-1420 (TTY: 711)。
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-282-1420 (TTY: 711)번으로 전화해 주십시오.
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Amharic	ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-888-280-1420 (መስማት ለተሳናቸው: 711)።
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية متوفرة لك بالمجان. اتصل برقم 888-282-1420--1 (رقم هاتف الصم والبكم: 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-282-1420 (TTY: 711).
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-282-1420 (ATS : 711).
Nepali	ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-282-1420 (टिटिवाइ: 711) ।
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-282-1420 (TTY: 711).
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Cushite/Oromo	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-282-1420 (TTY: 711).
Persian	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-282-1420 (TTY: 711) تماس بگیرید.
Ibo/Igbo	Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-888-282-1420 (TTY: 711).
Kru-Bassa	Dè dè nià ke dyédé gbo: ɔ jũ ké m̄ [Bàsòò-wùdù-po-nyò] jũ ní, níí, à wuɖu kà kò dò po-poò béin m̄ gbo kpáa. Ǻá 1-888-282-1420 (TTY: 711)
Yoruba	AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-888-282-1420 (TTY: 711).

Notice of Nondiscrimination

Rocky Mountain Health Plans (RMHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. RMHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

RMHP takes reasonable steps to ensure meaningful access and effective communication is provided timely and free of charge:

- Provides free auxiliary aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters (remote interpreting service or on-site appearance)
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, such as:
 - Qualified interpreters (remote or on-site)
 - Information written in other languages

If you need these services, contact the RMHP Member Concerns Coordinator at 800-346-4643, 970-243-7050, or TTY 970-248-5019, 800-704-6370, Relay 711; para asistencia en español llame al 800-346-4643.

If you believe that RMHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: the RMHP EEO Officer at 800-346-4643, 970-244-7760, ext. 7883, or TTY 970-248-5019, 800-704-6370, Relay 711; para asistencia en español llame al 800-346-4643, or eeoofficer@rmhp.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the RMHP EEO Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

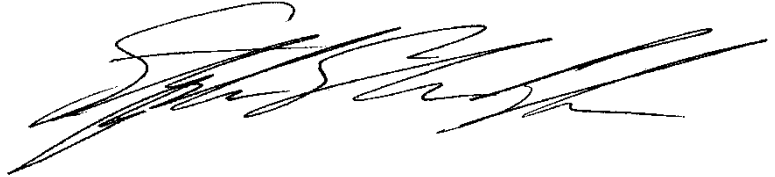
RMHP is a Medicare-approved Cost plan. Enrollment in RMHP depends on contract renewal.

2. TITLE PAGE (Cover Page)

ROCKY MOUNTAIN HEALTH PLANS
ROCKY MOUNTAIN GOOD HEALTH/ROCKY MOUNTAIN VISTA
HEALTH MAINTENANCE ORGANIZATION
EVIDENCE OF COVERAGE
Underwritten by Rocky Mountain Health Maintenance Organization, Inc.

By enrolling with and/or obtaining Benefits from Us, each Contracting Group, Subscriber and Member agrees to all terms of this Contract.

ROCKY MOUNTAIN HEALTH
MAINTENANCE ORGANIZATION, INC.



By _____
Stephen K. ErkenBrack, President and CEO

3. CONTACT US

Customer Service	
Address:	Rocky Mountain Health Plans 2775 Crossroads Blvd. PO Box 10600 Grand Junction, CO 81502-5600
Hours:	8:00 A.M. – 5:00 P.M. Monday – Friday
Phone Number:	970-243-7050 or 800-346-4643 Para asistencia en español llame al 970-243-7050 or 800-346-4643
TTY Number:	If you are hearing impaired and use TTY equipment, call 711.
Fax:	Fax: 970-244-7880
Email Address:	customer_service@rmhp.org
Interpretation Services:	Help is available for callers who speak other languages. Please call Us at the phone numbers above.
Other Important Contacts	
Complaints About the Care You Get	Rocky Mountain Health Plans Attention: Member Appeals 2775 Crossroads Blvd. PO Box 10600 Grand Junction, CO 81502-5600 Fax: 970-244-7828
Privacy Complaints	Rocky Mountain Health Plans Attention: Privacy Complaint 2775 Crossroads Blvd. PO Box 10600 Grand Junction, CO 81502-5600

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5. ELIGIBILITY

A. General Eligibility Rules

You must meet all of the “General Eligibility Rules” below to enroll with Us, unless the rules are not allowed by law:

- The Subscriber must work or live in the Service Area. This rule does not apply to Subscribers:
 - as allowed by Us in writing under Our rules; or
 - who have COBRA coverage;
- You must meet the rules of this Contract;
- We must get Your accurate and complete application and other requested information;
- Dependents must meet the eligibility rules in this Contract;
- You must meet any waiting period, which will not exceed 90 days;
- You must meet any eligibility rules in the GSA;
- A Network Provider, a Non-Network Provider or anyone affiliated with a Network Provider or Non-Network Provider who has provided or intends to provide You Care may not pay Your Premium. This will not apply if We are required by law to accept such payment; and
- Dependents may enroll only if the Eligible Employee has enrolled.

We will not refuse to enroll You solely because You are a medical assistance recipient and coverage is sought per section 25.5-4-210, C.R.S.

B. Eligibility of Subscriber

A Subscriber may enroll if he or she meets all the General Eligibility Rules.

C. Eligibility of Dependent Spouse

A Dependent Spouse may enroll if he or she meets the General Eligibility Rules.

D. Eligibility of a Dependent Child

A Dependent Child must meet the General Eligibility Rules and one of the following rules to be eligible to enroll:

- Be under 26 years old. (Eligibility ends the last day of the month when the child becomes 26 years old.)
- Be medically certified as disabled and dependent on the Subscriber,

Dependent Spouse, Domestic Partner or DB. A disabled Dependent Child can be any age. The Subscriber must give Us proof of the disability and dependency each Calendar Year. This requirement may be waived by Us in writing.

E. Eligibility of Same-Sex Domestic Partner

A Same-Sex Domestic Partner (“Domestic Partner”) may enroll if the Contracting Group elects to cover Domestic Partners. The Domestic Partner must meet the eligibility rules of the GSA and the General Eligibility Rules.

F. Eligibility of a Designated Beneficiary

A Designated Beneficiary (DB) may enroll if:

- the Contracting Group elects to cover DBs;
- the DB meets the eligibility rules of the GSA;
- the DB meets the General Eligibility Rules; and
- the DB has a Designated Beneficiary Agreement (DBA) per Colorado law.

G. Prior Coverage

This section is only for Members who had Prior Coverage, including any Benefit extension, within 31 days before the Effective Date. This section will follow Colorado law and will not impose any more obligations on Us than the law requires. We will provide coverage for You under this Contract on the Effective Date, subject to these terms:

If You meet the General Eligibility Rules, You will be covered according to the terms and at the level of Benefits of this Contract.

If You are not eligible for coverage under this Contract, Your Benefits will be covered at the Prior Coverage level minus any benefits paid under the Prior Coverage until the earliest of these happen:

- (1) the date You become eligible under this Contract; or
- (2) the date Benefits terminate under this Contract (examples: if Your job ends with the Employer Entity, or when You are no longer an eligible Dependent).

H. Deductible Carryover

We will apply amounts incurred in the current Calendar Year that applied to the Prior Coverage’s deductible to the Deductible. The expenses must be Allowed Charges under this Contract.

You must send Us proof of the deductible amount met under the Prior Coverage.

I. **Group Service Agreement (GSA)**

To the extent allowed by law, the eligibility rules for Members in the GSA control over any different eligibility rules in this Contract.

J. **Adding a Dependent**

(1) **New Dependents**

(a) **Newborns:** A newborn Dependent Child is covered under this Contract for 31 days after birth. Coverage will continue after the first 31 days unless the Subscriber asks Us to disenroll the newborn. The request to disenroll must be made within 30 days of the birth. Any Premium changes will start the 32nd day after the birth. All Care is subject to applicable Cost Sharing.

(b) **New Dependents Due to Marriage:** A person who becomes a Dependent by marriage or Civil Union after the Effective Date may enroll if he or she meets the General Eligibility Rules. The request to enroll must be made within 30 days after the marriage or Civil Union. Coverage will begin on the date of the marriage or Civil Union if We get the request to enroll before that date. If not, coverage begins the first day of the month after the date of the marriage or Civil Union. If Premiums change, they will change on:

- the first day of the month the coverage began if the Effective Date is the 1st through the 15th day of the month, or
- the first day of the month after the Effective Date if the coverage began after the 15th day of the month.

(c) **New Dependents Who Are Designated Beneficiaries (DB):** A person who becomes a DB after the Effective Date may enroll if:

- the DB meets the General Eligibility Rules; and
- the Contracting Group elects to cover DBs.

The request to enroll must be made within 30 days after the DBA is recorded. If We get the request to enroll before the DBA is recorded, coverage begins on the date the DBA is recorded. If not, coverage begins the first day of the month after the date the DBA is recorded.

(d) **New Dependents Due to Adoption or Placement for Adoption (Adoption):** A person who becomes a Dependent by Adoption after the Effective Date may enroll if:

- he or she meets the General Eligibility Rules; and
- the request to enroll is made within 30 days of the Adoption.

Coverage begins on the date of the Adoption if the request to enroll is timely. Premiums will change on:

- the first day of the month the coverage began if the Effective Date is the 1st through the 15th day of the month, or
- the first day of the month after the Effective Date if the coverage began after the 15th day of the month.

However, if You did not have to pay more Premium to enroll the person who became a Dependent Child by Adoption, the Dependent Child may be enrolled after the 30 days. Coverage begins on the first day of the month after he or she becomes a Dependent.

(e) **New Dependents Due to Placement in Foster Care:** A person who becomes a Dependent by placement in foster care after the Effective Date may enroll if:

- he or she meets the General Eligibility Rules; and
- the request to enroll is made within 30 days of the placement in foster care.

Coverage begins on the date of the placement in foster care if the request to enroll is timely. Premiums will change on:

- the first day of the month the coverage began if the Effective Date is the 1st through the 15th day of the month; or
- the first day of the month after the Effective Date if the coverage began after the 15th day of the month.

(2) **Eligible Employees and Existing Dependents Who Want to Enroll**

(a) **Eligible Employees and Other Dependents:** Eligible Employees and/or Dependents, as applicable, may enroll after the initial enrollment period if they meet the General Eligibility Rules and:

(i) they told Us they did not enroll under this Contract when they first could have enrolled because they had other Creditable Coverage (CC), which was later lost for one of these reasons:

- legal separation or divorce;
- death;
- termination or reduction in the number of hours of employment (voluntary or involuntary, whether or not COBRA was chosen);
- the dependent status ended or he or she moved out of the other CC's service area;
- the CC ended involuntarily;
- the employer stopped paying part of the premium for CC;

- the Subscriber became eligible for Medicare; or
 - COBRA coverage ended.
- (ii) the request to enroll must be made within 30 days after the CC ended; or
- (iii) a court orders Dependent coverage under this Contract. The request to enroll must be made within 30 days of the court order unless:
- the parent the child lives with less than 50% of the time is eligible to enroll or is a Member and requested enrollment for the Dependent Child and parent (if the parent is not already a Member); or
 - the parent the child lives with less than 50% of the time is a Member and enrollment is requested by the parent the child lives with more than 50% of the time or by an authorized government agency.

or

- (iv) a person becomes a Dependent through marriage, birth, Adoption, placement in foster care, DBA, or Civil Union and enrollment is requested no later than 30 days after the person becomes a Dependent, except as otherwise set forth above for a newborn Dependent Child or for a new Dependent Child who becomes a Dependent Child due to Adoption; or
- (v) the Dependent Child is disenrolled from CHP+ coverage by a parent or legal guardian. We must get the request no later than 60 days after the coverage ends; or
- (vi) the right to Medicaid or CHP+ coverage ends due to a loss of eligibility. We must get the request no later than 60 days after the coverage ends; or
- (vii) the Subscriber or the Dependent becomes eligible for Medicaid or CHP+ premium assistance, including under any waiver or demonstration project. We must get the request within 60 days after the Subscriber or Dependent is found eligible; or
- (viii) the Employer Entity no longer helps pay for the group health plan coverage (not including COBRA) for the Eligible Employee or Dependent. We must get the request to enroll within 30 days after contributions end.
- (b) **Effective Date of Coverage:** The effective date of coverage for an Eligible Employee and new Dependents through birth, Adoption or

placement in foster care will be the date the Dependent becomes a Dependent if the request to enroll is made on time. In all other cases, the effective date of coverage will be no later than the first day of the month after the request for enrollment. If You are notified or become aware of a qualifying event to occur in the future, You may apply for coverage thirty (30) calendar days before the date of the qualifying event. In such event, coverage will begin no earlier than the date of the qualifying event.

K. Member ID Card

We will send You a Member ID Card when You enroll with Us. The Member ID Card does not prove eligibility or that You will get Benefits. You cannot get Benefits under this Contract if:

- You are no longer eligible; or
- the Contract ends.

L. False Statements

Any Fraud by You with regard to a Member's eligibility (included in an application or request to enroll, or in any additional information needed by Us), may cause the Subscriber's and the Member's enrollment to be Rescinded. We will give the Subscriber and each Member notice at least 30 days before enrollment is Rescinded. If the Contract between the Subscriber and Us is Rescinded for Fraud, the Subscriber will pay Us for Benefits paid or costs incurred by Us on behalf of the Subscriber and Dependents.

6. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

The rules described in this paragraph 1 are called the "Primary Care Procedures."

A. Compliance with Primary Care Procedures

To get Benefits, You must get Care from Network Providers. This does not apply to Emergency Care or Urgent Care, or if You get Prior Authorization. You must follow all terms of the Primary Care Procedures when receiving Care.

B. Payment for Non-Covered Services

We will not cover, and You must pay for, all health services or supplies which:

- are not Benefits under this Contract; or
- You get in violation of this Contract.

You agree to pay Us back any amounts paid by Us for non-covered services and supplies.

C. Choosing a PCP

You must choose a PCP who is in Our Network. You may choose a PCP from any county in the Service Area. If You do not make this choice, We will pick a PCP for You. Each Member may pick a different PCP. Before choosing a PCP, You should check with the new PCP to be sure that they are accepting new patients. For help choosing a PCP, and for a list of PCPs, visit www.rmhp.org or call Us.

You may choose a pediatrician as the PCP for Your child.

Women may choose an obstetrician (OB), gynecologist (GYN), or a certified nurse midwife (CNM) provider as their PCP.

In most cases, Your Cost Sharing will be lower when You get Care from a PCP instead of from a Network Specialist or other Network Provider.

D. Changing Your PCP

You may change Your PCP by calling Us or by going to www.rmhp.org. Please call Us before getting Care from Your new PCP. If Your PCP is no longer a PCP in Our Network, You will need to choose a new PCP. If You visit the new PCP before You tell Us, You may have higher Cost Sharing. Before changing Your PCP, You should check with the new PCP to be sure they are accepting new patients. You should have Your health records sent to Your new PCP as soon as possible.

E. Your Member ID Card

When You enroll with Us, You will get a Member ID Card. You must show the Member ID Card to the provider each time You get Care. We will send You a new Member ID Card if information on the card changes.

F. Getting Care

(1) PCP Visits

You should see a PCP for routine Care. In most cases, Your Cost Sharing will be lower when You get Care from Your PCP or another PCP.

(2) Emergency Care

An Emergency occurs when You have a life- or limb-threatening emergency. A “life- or limb-threatening emergency” means any event that a prudent layperson would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health. You do not need to call a PCP before getting Emergency Care.

In an Emergency, You have the option to:

- **call the local pre-hospital emergency medical service system by dialing the emergency telephone access number 9-1-1 or its local equivalent whenever You are confronted with a life- or limb-threatening emergency;**
- **call the local emergency number; or**
- **go to an emergency room.**

If You go to an emergency room and You do not have an Emergency, You will have to pay for Care You get.

(3) Network Specialist and Other Provider Visits

You may see a Network Specialist or a Network Provider for Care. You do not need a referral from Your PCP. In most cases, Your Cost Sharing for Network Specialist visits will be more than for PCP visits.

You do not need approval from Us or Your PCP to get Care from an OB, GYN or CNM in Our network. The provider may need to follow certain procedures. This includes getting Prior Authorization for some services, following a pre-approved treatment plan, and making referrals. For a list of Network Providers who are OBs, GYNs, or CNMs, call Us or review the Provider Directory on our website, www.rmhp.org.

(4) Non-Network Providers

In general, services from Non-Network Providers are not covered, except for:

- Emergency Care; and
- Urgent Care.

Services from Non-Network Providers will be approved only in limited circumstances.

If You need Care that You cannot get from a Network Provider, We will arrange for Care from a Non-Network Provider. The cost of the Care will be no more than if the Care was from a Network Provider. You must get Prior Authorization from Us before going to the Non-Network Provider. We will let You know in writing if the request to see the Non-Network Provider has been approved or denied.

We will not deny or restrict in-network Benefits to You only because You got care from a Non-Network Provider. However, We will not pay for services or supplies from Non-Network Providers except as provided in this Contract.

Care provided at a Network Provider facility, including ancillary Care provided by a Non-Network Provider, will not cost more than if You received the Care from a Network Provider. But if You seek care on purpose from a Non-Network Provider, this care is considered out-of-network Care and will

be a Benefit only under limited circumstances. This rule applies even if You got the care at a Network Provider facility.

(5) On-Going Care from Non-Network Providers

If You got care from a Non-Network Provider before this Contract began, You may be able to keep seeing the Non-Network Provider if changing providers would harm the outcome of Your Care. On-going Care from Non-Network Providers requires Prior Authorization. We may deny the request for Care from the Non-Network Provider and/or may put Limitations on the approval.

(6) Immunizations

You may get covered immunizations from Network Providers or from Non-Network Providers in Colorado. We will not pay a Non-Network Provider more than the usual and customary rates for immunizations. You must pay any additional amount owed for immunizations from Non-Network Providers.

(7) Termination of Network Provider

If We terminate a Network Provider without cause and do not provide notice of the termination to Members as required by Colorado law, We will allow Members to continue to get Care from the provider for at least 60 days from the date of termination. We will allow Members in their second or third trimester of pregnancy to continue to get Care from the provider through the postpartum period.

G. Prior Authorization

We require Prior Authorization for some Care before You get it. All requests for Prior Authorization must be:

- sent to Us in writing; and
- approved by Us before You get the services.

You may go to www.rmhp.org or call Us to find out if a service needs Prior Authorization. Some examples of services which may need Prior Authorization are:

- admission to a Hospital, SNF or inpatient rehab facility;
- DME, prosthetic devices (PD), orthotic devices (OD) and oxygen;
- Care from Non-Network Providers;
- treatment of TMJ;
- diagnostic imaging;
- surgery;
- transplants; and
- high dose chemo.

Your PCP, Network Specialist or other Network Provider is responsible for getting any Prior Authorizations.

If You are in the National Network which allows access to Care outside of Colorado, the National Network providers are responsible for getting the Prior Authorization for services You get from National Network providers.

We will send You or Your Network Provider a written notice when We make a Prior Authorization decision. If We deny Prior Authorization, You or Your provider may ask that We review and reconsider Our decision. If the Prior Authorization request is denied (and not overturned), and You still get the care:

- benefits will be denied; and
- You must pay for the care.

If We Prior Authorized Care in writing, We cannot deny the Benefit after You get the Care. This does not apply in cases of fraud or abuse by the Subscriber or Member. If We give Prior Authorization for Care that is a not a Benefit, We will pay for the Care as Prior Authorized with no penalty to You.

All Benefits, including Care which needs Prior Authorization, are subject to the terms and conditions of this Contract.

H. **Referrals**

You do not need a referral to get specialty services from any Network Provider that is qualified to provide Benefits.

I. **Access Plan**

You have the right to request a copy of Our access plan(s). You can also review a copy at any of Our offices.

J. **Non-Discrimination**

We will not discriminate:

- with respect to participation under this Contract; or
- coverage

against any provider who is acting within the scope of his or her license or certification.

7. **BENEFITS/COVERAGE (What is Covered)**

A. **Benefits**

Benefits are the services and supplies described in the Covered Benefits section. Benefits are subject to:

- the Limitations and Exclusions in this section; and
- the Limitations and Exclusions in any Supplements included with this Contract; and
- any Cost Sharing and Maximum Benefit Levels listed on the Coverage Schedule.

This section uses the following symbols to identify Maximum Benefit Levels, Limitations and Exclusions:

M	Maximum Benefit Level may apply - see Coverage Schedule
L	Limitation may apply
⊗	Exclusion – Not a Benefit of the Contract

Benefits are covered only when these conditions are met:

- the services are Medically Necessary;
- You comply with the Primary Care Procedures to get the services;
- the Premium is paid, except for:
 - automatic coverage of Dependent newborns for 31 days (see subsection 5.K); and
 - continued coverage for inpatients (see subsection 12.I);
- the services are provided within the Service Area, except for:
 - Emergency Care;
 - Urgent Care;
 - Benefits for a Dependent Child who lives outside the Service Area are limited to services for:
 - Emergency Care;
 - Urgent Care; and
 - follow-up treatment.

This limitation does not apply to Members who are Temporarily Absent from Colorado and are in Our National Network. Call Us if You will be Temporarily Absent from Colorado and want to be in the National Network.

Deductibles, if applicable, are shown in the Coverage Schedule. Required Deductibles must be satisfied before You can get Benefits. Some services are not subject to a Deductible. All or any part of a Deductible paid during the last 3 consecutive months of a Calendar Year will be applied to Your Deductible for the next Calendar Year. Deductibles are applied to the Yearly Out-of-Pocket Maximums. Deductibles are subject to annual adjustments in accordance with federal law.

B. Covered Benefits

(1) Alcohol and Substance Abuse Treatment

- **Detoxification (detox).** Coverage is provided for inpatient (at a Residential Treatment Facility or a Hospital) and outpatient detox services.

⊗ *Limited to removal of toxic substances from the system.*

- **Rehabilitation (rehab).** Coverage is provided for inpatient (at a Residential Treatment Facility or a Hospital) and outpatient rehab services for the treatment of alcohol and substance abuse.

⊗ *Court ordered treatment that would not otherwise be covered.*

(2) Allergy Testing

Allergy injections and diagnostic testing performed with an allergy work-up are covered.

⊗ *If not set forth on the RMHP Formulary, allergy injections, injectable drugs, medications and adult immunizations.*

(3) Ambulance Services

Coverage is provided for transportation by licensed or certified ground or air ambulance when needed to bring You to the Hospital or other facility for:

- an Emergency; or
- Non-emergency transport.

L *Non-emergency transport is provided only when transport by other means would put Your life or health in danger.*

L *Air ambulance service is provided only when:*

- *Ordered by an emergency responder because of an Emergency;*
- *Ground ambulance transport would put Your life or health in danger; or*
- *The cost of air ambulance transport would be less than the cost of ground ambulance transport.*

⊗ *Transportation that serves only as a convenience for You or Your family.*

(4) **Autism Spectrum Disorders (ASD)**

Coverage is provided for treatment for ASD when ordered by a Physician or licensed psychologist and includes the following:

- evaluation and assessment;
- behavior training, behavior management and ABA, including consultations, direct care, supervision, treatment, or any combination, for ASD provided by Autism Services Providers;
- habilitative or rehabilitative care, including occupational therapy, physical therapy, speech therapy, or any combination;
- supplies and medicine from a pharmacy;
- psychiatric care;
- psychological care, including family counseling; and
- therapeutic care.

(5) **Blood Services**

Coverage is provided for the following services related to blood:

- processing;
- handling;
- transportation; and
- administration

⊗ *Blood and blood products that are not provided as part of a service covered under this Contract.*

(6) **Chemotherapy (chemo) and Radiation**

Coverage is provided for chemo, oral anti-cancer drugs and radiation, subject to Our policies.

L *High dose chemo along with bone marrow transplant, including peripheral stem cell removal and reintroduction, is provided only for the diagnoses in this Covered Benefits section entitled “Transplants” for autologous or allogeneic human bone marrow or peripheral stem cells.*

(7) **Chiropractic Services (Chiro Care)**

The following services are covered for diagnosis and treatment of Neuromusculoskeletal Disorders related to Injury or Sickness. These services are referred to herein as “Chiro Care”:

- evaluations, manipulations and adjustments; and
- lab and x-ray services.

M *See Coverage Schedule*

- ⊗ *Chiro Care for children 3 years of age and younger.*
- ⊗ *Chiro Care provided in excess of what is necessary for maximum improvement. This is the point at which the patient shows little or no improvement with additional therapy.*
- ⊗ *Chiro Care provided on an inpatient basis.*
- ⊗ *Chiro Care which is maintenance care. Maintenance care is defined as a treatment program designed to maintain optimal health in the absence of symptoms.*
- ⊗ *Neuromusculoskeletal manipulation under anesthesia.*
- ⊗ *Clinical laboratory services and any associated procedures related to Chiro Care involved in the collection and/or testing of biological or lab specimens.*
- ⊗ *Preventive care, educational programs, therapies, nonmedical self-care, self-help training and any related diagnostic testing. This does not apply if such services occur during the normal course of providing Chiro Care.*
- ⊗ *Vocational or long-term rehab related to Chiro Care.*
- ⊗ *Advanced diagnostic testing and imaging performed as part of Chiro Care, including:*
 - *MRI, CT or bone scans;*
 - *diagnostic ultrasound;*
 - *videoflourosopy;*
 - *thermography;*
 - *electrodiagnostic testing, such as nerve conduction velocity (NCV); and*
 - *electromyography (EMG) or evoked potentials.*
- ⊗ *Radiological procedures related to Chiro Care performed on equipment not certified, registered or licensed by the state where the services are performed.*

- ⊗ *Radiological procedures that We determine cannot be safely utilized in diagnosis or treatment.*
- ⊗ *Chiro Care for or related to diagnosis and treatment of jaw joint problems. This includes TMJ or craniomandibular disorders.*
- ⊗ *Technique-specific radiographs exposed to support such techniques.*
- ⊗ *Transportation costs related to Chiro Care. This includes ambulance charges.*

(8) Cleft Lip and Palate Services

Coverage is provided if You were born with a cleft lip and/or cleft palate. Benefits are provided regardless of age. Services include:

- oral and facial surgery, surgical management and follow-up care;
- prosthetic devices , such as speech and feeding appliances;
- orthodontic treatment;
- prosthodontic treatment;
- speech therapy;
- otolaryngology treatment; and
- hearing assessments and treatment.

L *If a Dependent Child was covered under any other Policy for dental care at the time of birth or after birth, the benefits for dental and orthodontic treatment will be paid under the dental Policy, not this Contract. If a Dependent Child is not covered under any other Policy for dental care benefits, then the Benefits for dental treatment and orthodontic treatment will be covered under this Contract.*

(9) Clinical Trials

Coverage is provided for services included in this Covered Benefits section when You are part of a Clinical Trial if:

- You have a disabling, progressive or life-threatening condition that will be treated in the Clinical Trial;
- Your Physician recommends taking part in the Clinical Trial for therapeutic health benefits;
- the Clinical Trial is: approved under the Medicare National Coverage Decision regarding Clinical Trials; federally-funded; or a study or investigation conducted under an investigational new drug application reviewed by the FDA or a drug trial that is exempt from this type of application;

- Your care is provided by a certified, registered or licensed health care provider practicing within the scope of his/her practice with the experience and training to provide the treatment in a competent way; and
 - You have signed a statement of consent.
- ⊗ *Any part of a Clinical Trial that is paid for by a government or biotechnical, pharmaceutical or medical industry.*
 - ⊗ *Any drug or device used in a Clinical Trial that is paid for by the manufacturer, distributor or provider of the drug or device.*
 - ⊗ *Extraneous expenses related to taking part in a Clinical Trial. This includes travel, housing and other expenses that You, or a person traveling with You, may incur.*
 - ⊗ *Any items or care provided as part of a Clinical Trial only to satisfy a need for data collection or analysis that are not directly part of Your clinical management.*
 - ⊗ *Costs for the management of research relating to a Clinical Trial.*
 - ⊗ *Care that, except for the fact that it is being provided in a Clinical Trial, is otherwise specifically excluded from coverage.*

(10) **Dental Services and Oral Surgery**

General Anesthesia for Dental Procedures for Dependent Children:
Coverage is provided for general anesthesia provided in a Network Hospital, a Network Provider outpatient surgical facility or other Network Provider facility for dental care provided to a Dependent Child if:

- the child has a physical, mental or medically compromising condition; or
- local anesthesia is not working due to acute infection, anatomic variations or allergy; or
- the child is extremely uncooperative, anxious, or uncommunicative and the dental care cannot be delayed; or
- the child has sustained extensive orofacial and dental Injury.

Coverage includes associated Hospital or facility charges for dental care provided to a Dependent Child.

L *Anesthesia services do not include treatment provided for TMJ.*

Injuries to Sound and Natural Teeth: Coverage is provided for basic restorative services and supplies (fillings and root canals), and orthodontic care needed to quickly repair Sound and Natural Teeth damaged or removed as a result of an accidental Injury.

L *Treatment must begin within 60 days of the accident. Services must be completed within 24 months of the accident.*

L *Services must be provided while You are entitled to Benefits under this Contract.*

Oral Surgery: Coverage is provided for oral and maxillofacial surgery for treatment of the temporomandibular joint due to congenital defect or Injury of such joint by an illness, for removal of tumors and cysts, and for treatment of fractures.

⊗ *Dental splints, implants or prostheses.*

⊗ *Treatment for periodontal disease.*

⊗ *Dental treatment or services on or to the teeth, gums or jaws. This Exclusion does not apply to treatment for Injuries to Sound and Natural Teeth.*

⊗ *Treatment for pain or infection known or thought to be due to a dental cause and near the teeth or jaw, unless not treating such an infection may result in a systemic illness.*

⊗ *Surgical correction of malocclusion, services, supplies or appliances provided to alter, correct, fix, improve, remove, replace, reposition, restore or treat the jaw, or any jaw implant. This Exclusion does not apply to services for cleft lip and cleft palate and reconstructive surgery services. (See section 7.B.(8))*

⊗ *Maxillofacial and/or mandibular orthognathic surgery, oral surgery and orthodontia treatment including all outpatient and related costs, if the services are related to a dental condition.*

⊗ *Treatment of craniomandibular joint disorders and TMJ by use of orthodontic appliances and treatment, crowns, bridges or dentures, if the disorder is not caused by an Injury for which coverage is provided.*

- ⊗ *Removal of a tooth. This does not apply to treatment for Injuries to Sound and Natural Teeth.*
- ⊗ *Treatment for Injury to Sound and Natural Teeth caused by biting or chewing.*
- ⊗ *Alveoplasty when performed with an excluded service.*
- ⊗ *Care provided with non-covered dental services, except for general anesthesia for dental procedures for Dependent Children.*
- ⊗ *Dental cleaning, in-mouth scaling, planing, or scraping.*
- ⊗ *Myofunctional Therapy.*

(11) **Diabetic Services**

Coverage is provided for treatment of diabetes, including:

- disposable medical equipment;
- Disposable Medical Supplies;
- DME;
- eye care;
- podiatry services;
- outpatient training and education on managing Your diabetes; and
- health nutrition therapy when prescribed by a Physician or other provider.

(12) **Dialysis**

Coverage is provided for dialysis services for chronic renal disease.

(13) **Early Intervention Services (EIS)**

Coverage is provided for EIS for a qualified Dependent Child under age 3 with a written individualized family service plan who:

- (a) has major delays in development;
- (b) has been diagnosed with a physical or mental condition that has a high probability of resulting in a major delay in development, or
- (c) is a child with a developmental delay as defined by the Colorado Department of Human Services.

Examples of EIS include:

- audiology;
- developmental intervention;
- nutrition;
- occupational therapy;
- speech therapy; and
- vision.

M *See Coverage Schedule*

⊗ *Non-emergency transport, Respite Care, service coordination, and assistive technology (unless otherwise covered under the Covered Benefits section).*

⊗ *EIS services for children age 3 and older.*

(14) **Education Services**

Coverage is provided for the following education services:

- asthma education for Members with asthma;
- basic health education through newsletters from Us and services from Network Providers;
- specialized health education such as health risk profiles, workshops, physical fitness programs, and CPR classes which may be offered to You. These services are arranged by Us and provided by Our staff or providers.

(15) **Emergency Care and Urgent Care**

Within the Service Area

- (a) Coverage is provided for Emergency Care 24 hours a day, 7 days a week.
- (b) Coverage is provided for Urgent Care when needed to avoid a serious decline of Your health before You are able to get Care during a routine office visit. Extra services, including labs, x-rays and diagnostic testing, are covered and may be subject to additional Cost Sharing.

Out of Service Area

- (a) Coverage is provided for Emergency Care when You are traveling or Temporarily Absent from the Service Area, until Your Physician decides You can safely travel back to the Service Area to get Care.

(b) Coverage is provided for Urgent Care when You are traveling or Temporarily Absent from the Service Area, subject to the terms below:

- *the Urgent Care You need was reasonably unexpected;*
- *You could not arrange to return to the Service Area to get Care from a Network Provider; and*
- *You did not leave the Service Area to seek medical treatment.*

Extra services including labs, x-rays and diagnostic testing may be subject to additional Cost Sharing.

(c) Follow-up Care is provided following Emergency or Urgent Care treatment only if You cannot return to the Service Area. For additional services to be covered, they must be provided within the Service Area.

⊗ *Follow-up Care You get in an emergency room.*

⊗ *Coverage for Emergency Care out of the Service Area if You left the Service Area to seek medical treatment.*

(d) See section 11.A for reporting requirements for out of Service Area Care.

(16) **Eye Care**

Coverage is provided for:

- routine vision screening exams;
- treatment needed for an eye Injury or Sickness;
- eye surgery due to Injury or Sickness (for example, cornea transplants and cataract extractions).
- eyeglasses, contacts and the fitting of contacts after covered eye surgery or if You have keratoconus.

M *See Coverage Schedule*

L *We will not pay more than the Allowed Charges for lenses and basic frames.*

⊗ *Vision therapy, including the use of lenses and/or prisms for the treatment of a traumatic brain Injury, learning disabilities, and dyslexia.*

- ⊗ *Refractive keratoplasty, including radial and laser keratotomy (Lasik surgery), and any procedure to fix a refractive defect.*

(17) **Hearing Care**

Coverage is provided for:

- audio testing and treatment due to Injury or Sickness;
- Hearing aid services and supplies for Members under age 18, including:
 - i. the initial assessment, fitting and adjustments;
 - ii. auditory training;
 - iii. initial hearing aids
 - iv. replacement hearing aids; and
 - v. new hearing aids when changes to the current hearing aid cannot meet the needs of the Member;
- cochlear implants for children up to age 12.

L *Replacement hearing aids are limited to 1 pair every 5 years. This does not apply if changes to the current hearing aid cannot meet the needs of the Member.*

- ⊗ *Routine hearing exams. This does not apply to exams covered as preventive Care for newborns.*

- ⊗ *Hearing aids and devices, including bone anchored hearing aids and auditory devices or implants attached to the bone, and fitting for Members age 18 and older.*

- ⊗ *Cochlear implants for Members age 12 and older.*

(18) **Home Health Services**

Home Health Services must be provided by a Network Home Health Agency and ordered by a Physician. Care must be provided under a Home Health Care Plan established by the Physician and the Network Home Health Agency. Coverage is provided for:

- part-time or intermittent home nursing care for:
 - skilled nursing care under the supervision of a Registered Nurse (RN),
 - home health aide services under the supervision of an RN or therapist,
 - certified nurse aide services,
 - medical social services under the supervision of an RN;

- infusion services;
- physical, occupational, pulmonary, and speech therapies;
- nutritional counseling by a nutritionist or dietitian;
- audiology services; and
- medical supplies and lab services that would be covered if You were an inpatient at a Hospital.

M *See Coverage Schedule*

⊗ *Private Duty Nursing.*

⊗ *Custodial Care.*

⊗ *Housekeeping, homemaker and meal services.*

⊗ *Therapy services provided:*

- *only to retain functioning at the level to which You have been restored; or*
- *when Your condition is not expected to improve (i.e., maintenance care).*

(19) **Hospice Services**

Coverage is provided:

- if You are terminally ill with a life expectancy of 6 months or less as certified by a Physician; and
- for Your Immediate Family, primary caregiver and people close to You.

If You live beyond the 6 month period, Benefits will continue for an extra 3 months. After 9 months, Rocky Mountain, Your attending Physician and the Network Hospice will decide if You need to continue hospice services.

Benefits are actively managed and coordinated by a Network Hospice and must be provided by a Hospice Care Team under the terms of a Hospice Care Program regardless of location. You may get hospice services at home or at a facility. Benefits will be provided for:

- intermittent and 24-hour on-call professional nursing services by or under the supervision of an RN;
- intermittent and 24-hour on-call counseling, and social services;
- certified nurse aid services; or nursing services delegated as allowed by law;

- part-time or intermittent home health aide services under the supervision of an RN or therapist;
- physical, occupational, pulmonary (respiratory or breathing), and speech therapies;
- hearing services;
- nutritional counseling;
- Respite Care;
- medical supplies;
- prostheses and orthopedic appliances;
- drugs and biologicals;
- oxygen and respiratory supplies;
- DME;
- transportation;
- Physician services;
- diagnostic testing;
- short-term inpatient hospice care or continuous home care for a period of crisis; and
- grief support services for Your Immediate Family, primary caregiver and people close to You during the twelve-month period after death.

Care that is not related to the reason You are getting hospice care is subject to the coverage provisions of this Contract.

M *See Coverage Schedule*

⊗ *Private Duty Nursing.*

⊗ *Grief support services, except as provided above.*

(20) **Hospital Services**

Coverage is provided for:

Inpatient Hospital services:

- semi-private room and board;
- nursing care;
- services and supplies;
- use of operating room, recovery room, private room when Medically Necessary, intensive care;
- special diet, including enteral and parenteral nutrition;
- prescribed drugs;
- x-rays; and
- labs.

- ⊗ *Personal comfort or convenience items.*
- ⊗ *Private room unless it is Medically Necessary.*
- ⊗ *Care for complications that arise after You leave a Hospital against medical advice.*

Outpatient Hospital services:

- outpatient surgery facilities;
- x-rays and other imaging services;
- diagnostic tests;
- radiation therapy;
- labs; and
- services You get in an emergency room – see **Emergency Care**.

- ⊗ *Surgical treatment for obesity or conditions related to obesity.*
- ⊗ *The reversal of any obesity treatment.*
- ⊗ *Treatment of any complications caused by obesity treatment.*
- ⊗ *Services and supplies related to any care that is not covered. This includes services and supplies that are an integral part of a non-covered benefit.*
- ⊗ *Clinical pathology services unless the services are within the scope of practice of the individual providing the services and are either rendered personally by the pathologist or are performed under the pathologist's direct supervision.*

(21) **Implanted Devices**

Coverage is provided for cardiac pacemakers and internally implanted prosthetic devices.

- ⊗ *Cochlear implants for Members over age 12.*
- ⊗ *Equipment, supplies and drugs not approved by the Food and Drug Administration for medical use.*
- ⊗ *Hair transplants or implants.*

⊗ *Dental splints, implants or prostheses.*

(22) **Intractable Pain**

Coverage is provided for Benefits listed in this Contract for treatment for Intractable Pain.

⊗ *Pain clinic services.*

(23) **Mastectomy Services**

Coverage is provided for:

- mastectomy services;
- treatment for physical complications in all stages of mastectomy, including lymphedemas;
- reconstructive surgery following a mastectomy, including:
 - reconstruction of the breast that was removed;
 - surgery or reduction on the other breast to produce a symmetrical appearance; and
- prostheses and mastectomy bras.

(24) **Maternity Care and Family Planning**

Maternity Care

Coverage is provided for:

- pre-natal care;
- delivery, including special procedures such as cesarean section (C-section);
- post-natal care;
- imaging;
- labs;
- Physician services; and
- Hospital care for a newborn and mother.

The minimum length of stay for a newborn and mother are:

- not less than 48 hours after a normal vaginal delivery. If 48 hours after delivery falls after 8:00 P.M., coverage will continue until 8:00 A.M. the next morning.
- not less than 96 hours after a C-section. If 96 hours after the C-section falls after 8:00 p.m., coverage will continue until 8:00 A.M. the next morning.

A mother and newborn may be discharged before the minimum lengths of stay described above if the decision is made by an attending Physician and the mother agrees.

Complications of Pregnancy are covered the same way as any other Sickness or Injury.

A newborn Dependent Child is covered under this Contract for 31 days after birth. Medically Necessary Care and treatment of medically diagnosed congenital defects and birth abnormalities are included in this coverage, regardless of any Limitations and Exclusions with respect to other Care under this Contract.

⊗ *Amniocentesis to find out if the baby is a boy or a girl.*

⊗ *Services performed by a direct-entry or lay midwife.*

Family Planning and Sterilization Procedures

Coverage is provided for:

- counseling;
- information on birth control;
- intrauterine contraceptive devices (IUD) and subdermal implants;
- insertion, management and removal of IUDs and subdermal implants;
- diaphragms;
- fitting of diaphragms;
- birth control pills;
- Emergency Contraception prescribed by a health care provider;
- hormone injections, vaginal rings, and patches for contraception;
- surgical sterilization;
- any other medically acceptable drug, device or procedure used to prevent pregnancy; and
- screening and treatment for sexually transmitted diseases.

⊗ *Over-the-counter contraceptive drugs or devices which do not require a prescription, except those listed as included in the RMHP Formulary.*

⊗ *Abortifacient drugs.*

⊗ *Reversal of voluntary sterilization.*

⊗ *Services and procedures to verify the success of reversal of voluntary sterilization.*

⊗ *Treatment for infertility or to cause pregnancy, including;*

- *testing;*
- *prescription drugs;*
- *artificial insemination;*
- *in vitro fertilization (IVF);*
- *gamete intrafallopian transfer (GIFT);*
- *zygote intrafallopian transfer (ZIFT); and*
- *embryo transplants.*

Abortion Services

Coverage is provided for:

- pre- and post-abortion counseling;
- therapeutic and elective abortions, unless prohibited by law.

(25) **Medical Equipment, Supplies, Orthotic Devices (OD), Prosthetic Devices (PD) and Repairs and Oxygen**

Coverage is provided for the following equipment and supplies, subject to Medicare local coverage guidelines:

- Disposable Medical Supplies;
- Durable Medical Equipment (DME); and
- Breast pumps and breast pump supplies.

⊗ *Coverage is limited to the most cost effective medically acceptable choices. We will compare the expected medical benefits to the cost of such choices.*

⊗ *We determine if the equipment will be rented or purchased based on how long You will need it and the cost of the equipment. If the equipment is purchased, You will own the equipment after paying any Cost Sharing.*

⊗ *If You choose more costly DME than We have approved, You must pay any extra charges.*

⊗ *Costs to operate DME, OD and PD.*

⊗ *Air filters, purifiers and/or humidifiers.*

⊗ *Changes made to Your home or vehicles to make them handicap accessible.*

⊗ *Home modification equipment.*

⊗ *Wigs or hairpieces.*

⊗ *Home exercise equipment.*

⊗ *Convenience items per Medicare local coverage guidelines. Examples include, cold therapy units, over the bed tables, chair and patient lifts.*

- The following OD:
 - braces;
 - splints;
 - collars;
 - custom orthopedic shoes;
 - custom foot orthoses; and
 - dental OD.

L *Dental OD are only covered if You have symptomatic sleep apnea.*

- Home oxygen service and equipment.

- The following PD:
 - artificial eyes;
 - breast prosthetics and mastectomy bras - see **Mastectomy Services**; and
 - arm and leg PD.

L *Arm and leg PD are limited to the most appropriate model that adequately meets Your medical needs, as determined by a Physician.*

⊗ *Bionic prostheses.*

⊗ *Power enhancements or controls for prosthetic limbs and terminal devices.*

⊗ *Myoelectric prostheses.*

⊗ *Peripheral nerve stimulators.*

- Repairs to DME, OD and PD due to normal wear and tear. You can get replacement equipment for up to 1 month while the repairs are being made.

⊗ *Repairs and replacements of DME, OD and PD due to Your misuse or loss.*

(26) **Mental Health Services**

- **Inpatient Mental Health Services**

Coverage is provided for inpatient treatment at a Residential Treatment Facility or a Hospital if You have a mental or behavioral disorder or require crisis intervention.

- **Outpatient Mental Health Services**

Coverage is provided for:

- evaluation;
- crisis intervention and treatment;
- treatment for Mental Disorders;
- individual and group psychotherapy sessions; and
- family counseling.

Biologically-Based Mental Illness and Mental Disorders are covered the same as any physical illness.

L *Coverage for mental health services will apply only if You have a mental or behavioral disorder or require crisis intervention.*

⊗ *Behavior modification, such as weight loss programs.*

⊗ *Court ordered treatment that would not otherwise be covered.*

(27) **Nutrition**

Enteral Nutrition

Coverage is provided for outpatient specialized formulas for enteral nutrition under certain conditions.

⊗ *Limited to children up to age 3 for treatment of a severe gastrointestinal disorder, malabsorption syndrome or other physical condition when:*

- *normal absorption of nutrition is not possible;*
- *an abnormal growth pattern is diagnosed; and*
- *the child does not respond to other dietary formulas.*

Medical Foods and Treatment for Inherited Enzymatic Disorders

Coverage is provided for Medical Foods for treatment of Inherited Enzymatic Disorders.

⊗ *For treatment of PKU the maximum age is 21 years for males and 35 years for females.*

⊗ *Medical Foods are not covered for Members with cystic fibrosis or for Members who are lactose- or soy- intolerant.*

Nutritional Counseling

Coverage is provided for nutritional counseling services provided by a Physician, a dietitian or a nutritionist.

⊗ *Provided only for members who have a medical diagnosis of, or risk factors for, cardiovascular or diet related chronic disease.*

Total Parenteral Nutrition – Outpatient (TPN)

Coverage is provided for TPN when provided in a Member's home if the Member cannot maintain weight and strength because of a condition of the digestive tract that does not allow absorption of nutrients or if the Member cannot swallow food.

⊗ *Outpatient nutrition products, including Medical Foods, TPN and therapeutic formulas, except as provided in the "Nutrition" subparagraph.*

⊗ *Weight loss programs and services.*

(28) Outpatient Injectable and Infusion Drugs

Injectables on the RMHP Formulary are covered, including IV infusion, self administerable drugs, and drugs given by a health care provider.

M *See Coverage Schedule*

(29) **Physician Services and Preventive Services**

Coverage is provided for:

- Office visits for treatment of Injury or Sickness including:
 - exams;
 - consultations; and
 - surgical procedures.

Other services, including diagnostic testing, x-rays, labs and electrocardiograms, are covered subject to any Cost Sharing.

- Physician services are covered at an inpatient or outpatient facility.
- Second opinions can be requested by You, Your Physician or Us. (If We request a second opinion there will be no cost to You.)

L *Second opinions requested by You or Your Physician are limited to one second opinion per medical condition.*

Preventive Services

Coverage is provided for the following:

- (a) All preventive services with an “A” or “B” rating by the U.S. Preventive Services Task Force (USPSTF), and as recommended by the Health Resources and Services Administration (HRSA) and the Advisory Committee on Immunization Practices to the Centers for Disease Control and Prevention (ACIP). Services may be limited to people of a certain age or sex or who meet other conditions.

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.

The recommendations are updated regularly. Visit Our website or call customer service for the most up to date recommendations.

Examples of covered preventive services include:

- *Adult routine physical exams;*
- *Alcohol misuse screening and behavioral counseling interventions for adults;*
- *Breast cancer screening (mammograms), minimum of one per calendar year;*
- *Cervical cancer screening (pap smears);*

- *Colorectal cancer screenings;*
- *Immunizations and vaccinations;*
- *Cervical cancer vaccinations;*
- *Outpatient well-child care;*
- *Screening for lipid disorders; and*
- *Tobacco use counseling and cessation interventions for adults.*

Mammography screenings will include, at a minimum, the following:

- either a preventive or a diagnostic mammogram per calendar year which is covered in full; and
- further mammograms during a calendar year which are covered the same as any other x-ray.

Prostate screenings are covered and will include, at a minimum, the following:

- A prostate-specific antigen (PSA) blood test and a digital rectal examination.
- One prostate screening per Calendar Year for:
 - men 50 years of age or older; or
 - men between 40 and 50 years of age who are at increased risk of developing prostate cancer as determined by a Physician.

- (b) Other tests or exams provided during a preventive service visit (Cost Sharing may apply).

M *See Coverage Schedule*

⊗ *Charges for visits to a health care provider that are not kept.*

⊗ *Third party testing, such as lab and x-rays that are not part of suggested screening or routine physicals.*

⊗ *Costs for health reports, including presentations and preparation.*

⊗ *Third party physical and/or psychological exams for employment, licensing, insurance, adoption or any other non-health reasons.*

⊗ *Screening tests that are done in multiple phases.*

⊗ *Checkups not associated with any Injury or Sickness, except as stated in the Covered Benefits section.*

- ⊗ *Clinical ecology services and services for treatment of multiple chemical sensitivity and idiopathic environmental illness.*
- ⊗ *Services and supplies related to any care that is not covered. This includes services and supplies that are an integral part of a non-covered service.*
- ⊗ *Genetic testing, except for:*
 - *diagnosing You with a condition or illness that will affect Your health;*
 - *treating a condition or illness that will affect Your health; or*
 - *preventive care recommended by the USPSTF or HRSA, including, for example, BRCA testing and counseling.*

(30) Podiatry Services

Coverage is provided for non-routine foot care provided by a podiatrist.

- ⊗ *Routine foot care.*
- ⊗ *Trimming of corns and calluses.*
- ⊗ *Treatment of flat feet.*
- ⊗ *Partial dislocations in the feet.*

(31) Prescribed Drugs and Immunizations

- Inpatient prescription drugs approved by the United States Food & Drug Administration are covered when You are in a Hospital or SNF.
- Outpatient prescription drugs as described in the Prescription Drug Supplement.
- Immunizations are covered, except for travel immunizations.
- Drugs approved by the FDA for use in treatment of cancer will not be excluded or restricted if the drug:
 - is prescribed for treatment of cancer that is not an FDA approved use; and
 - is recognized for treatment of that cancer by an authoritative listing of drugs as identified by the U.S. Department of Health and Human Services; and
 - will be used to treat a covered condition.

⊗ *Over the counter, nonprescription drugs or medicines, vitamins, nutrients and food supplements even if prescribed or given by a Physician. This does not apply to items that are listed as included in the RMHP Formulary.*

⊗ *Travel immunizations.*

(32) **Psychological Testing**

Coverage is provided for testing to evaluate Your mental condition and establish a treatment plan.

⊗ *Educational testing (services and supplies), assessments, counseling, therapy or other services for learning or behavior problems.*

⊗ *Third party exams for employment, licensing, insurance, adoption or any non-health related purpose.*

(33) **Reconstructive Surgery**

Coverage is provided for reconstructive surgery to correct a functional defect resulting from an Injury, Sickness or surgery. The surgery must reasonably be expected to correct the defect. See also **Mastectomy Services**.

⊗ *Cosmetic surgery or treatment for complications caused by non-covered cosmetic surgery.*

⊗ *Reversal of cosmetic surgery or non-covered reconstructive surgery.*

⊗ *Reconstructive surgery that does not result in functional gain.*

⊗ *Reconstructive surgery primarily for cosmetic reasons.*

⊗ *Breast reduction, unless Medically Necessary or as part of a mastectomy. Breast reduction is not covered in connection with cosmetic implants or primarily for cosmetic reasons.*

⊗ *Surgical treatment for obesity or conditions related to obesity.*

⊗ *The reversal of any obesity treatment.*

⊗ *Treatment of any complications caused by obesity treatment.*

(34) **Sexual Dysfunction Services**

Coverage is provided for Benefits listed in this Contract for treatment of sexual dysfunction due to surgical or radiation treatment of prostate cancer.

⊗ *Sexual dysfunction services for any reason other than surgical or radiation treatment of prostate cancer. This Exclusion includes therapy, Physician services, surgical treatment, injectables, prescription drugs and any other treatment for impotency.*

(35) **Skilled Nursing Facility (SNF) Services**

Coverage is provided for inpatient care, health care supplies, equipment and prescribed drugs from a Network SNF.

When discharged from a Network Hospital, You may get covered SNF services from a Non-Network Provider if all of the following apply:

- before being hospitalized, You lived in the non-Network SNF;
- You had a contractual or other right to return to the non-Network SNF;
- the facility is licensed by the State of Colorado and is Medicare certified,
- the non-Network SNF agrees to follow the same terms and conditions that apply to Network Providers; and
- the services are Prior Authorized by Us.

L *We will not pay a non-Network SNF a higher rate than We pay Network Providers in the same geographic area for the same level and intensity of services.*

M *See Coverage Schedule*

⊗ *Custodial Care.*

⊗ *Nursing home and domiciliary care.*

(36) **Therapy Services**

- **Inpatient and Outpatient therapy**

Coverage is provided for rehab speech, physical and occupational therapy. Also see **Cleft Lip and Palate Services**.

M *See Coverage Schedule*

L *Rehab services must be expected to result in major improvement within the allowed time period or number of visits, whichever applies.*

- **Therapies for Congenital Defects and Birth Abnormalities**

Coverage is provided for physical, occupational and speech therapy for Members under age 6.

M *See Coverage Schedule*

⊗ *Services for Members under age 3 are only covered if:*

- the Member is not eligible for Early Intervention Services; or
- such services are not provided as part of a written individualized family service plan.

- **Pulmonary Therapy and Cardiac Rehab**

Coverage is provided for pulmonary therapy and cardiac rehab services, phases I and II.

⊗ *Therapies, self-help programs and other services not specifically covered under the Contract. This includes the following types of therapy:*

- *Recreational;*
- *Sex;*
- *Primal scream;*
- *Sleep;*
- *Z therapies;*
- *Self-help programs;*
- *Stress management programs;*
- *Transactional analysis, encounter groups, and transcendental meditation;*
- *Sensitivity or assertiveness training;*
- *Rolfing;*
- *Religious counseling;*
- *Holistic medicine and other wellness programs;*
- *Educational programs such as cardiac class or arthritis class;*
- *Orthomolecular medicine;*
- *Environmental medicine;*
- *Chelation therapy, except for treatment of metal poisoning;*

- *Cytotoxin testing;*
- *Gene manipulation therapy;*
- *Naturopathic medicine;*
- *Megavitamin therapy;*
- *School-based therapy;*
- *Acupuncture;*
- *Pain clinic services;*
- *Hypnotherapy;*
- *Educotherapy;*
- *Reflexology;*
- *Hair analysis;*
- *Pool therapy and submersion therapy;*
- *Massage therapy;*
- *Physical therapy performed by an individual when the therapy is not within the scope of his or her license or certification under Colorado law;*
- *Group physical therapy;*
- *Exercise programs;*
- *Isometric exercise;*
- *Phase III cardiac rehab;*
- *Health club fees;*
- *High colonics;*
- *Anodyne therapy;*
- *Extracorporeal shock wave treatment, except for removal of kidney stones;*
- *Behavior modification programs, including, weight loss programs and any related health service;*
- *Services of professional trainers;*
- *Special education, counseling, therapy or other services for learning deficiencies or behavioral problems;*
- *Myofunctional Therapy; and*
- *Biofeedback, except to treat urinary stress incontinence.*

(37) **Transplants**

Coverage is provided for the following:

- Solid organ transplant:
 - cornea;
 - kidney;
 - liver;
 - heart;
 - lung or lungs;
 - intestine;
 - pancreas;
 - simultaneous pancreas and kidney;

- Autologous or allogenic human bone marrow or peripheral stem cells for the following conditions:
 - leukemia or aplastic anemia;
 - Severe Combined Immunodeficiency Disease (SCID);
 - Wiskott-Aldrich Syndrome;
 - recurrent or refractory neuroblastoma; or
 - testicular, mediastinal, retroperitoneal and ovarian germ cell tumors.

L *Coverage for transplants is subject to the following:*

- (a) *We or providers will not be responsible to:*
 - *find a donor; or*
 - *assure the availability or capacity of approved referral facilities;*
- (b) *We will provide coverage for organ donation costs for a Member receiving a covered transplant, coverage includes:*
 - *costs for testing of the donor;*
 - *organ donation procedures;*
 - *facility charges; and*
 - *organ storage costs.*
- (c) *If the donor is covered by a Policy that covers organ donation, We will be the secondary payor; and*
- (d) *The transplant and related procedures must be the preferred method of treatment.*

L *Multiple organ transplants will be covered only if the organs transplanted are the human kidney, liver, heart, lung(s), intestine and pancreas. If a multiple organ transplant includes an organ that is not a human kidney, liver, heart, lung(s), intestine or pancreas, then none of the transplants will be covered.*

L *An organ transplant recipient must be a Member.*

L *Coverage is provided only for human organ transplants. Mechanical organs are not considered human organs for purposes of this Contract.*

⊗ *Transplants not listed as a Benefit in the Covered Benefits section.*

⊗ *Costs of maintaining a cadaver donor for organ retrieval.*

- ⊗ *Autologous or allogeneic bone marrow harvest and transplant and autologous or allogeneic peripheral stem cell removal and reintroduction, whether alone or with high dose chemotherapy. This does not apply to the extent such harvest and transplant or removal and reintroduction are listed as a Benefit in the Covered Benefits section.*

- ⊗ *Multiple organ transplants except as provided in the Covered Benefits section.*

C. Pilot Programs

At times, We may provide services for a certain Sickness, Injury or program as part of a pilot program or study. These services may be offered in a limited part of the Service Area or to certain Members or Network Providers.

D. Double Coverage and Coordination of Benefits

(1) Coordination of this Contract's Benefits with Other Benefits

The Coordination of Benefits (COB) rules apply when You are covered under more than one Plan.

These rules determine which Plan will pay a claim for benefits. The Primary Plan pays first. The Primary Plan pays even though another Plan may cover some expenses. A Secondary Plan pays after the Primary Plan. The Secondary Plan may reduce the benefits it pays so payments by all Plans are not more than 100% of the total Allowable Expense.

When this Contract is Primary, its Benefits are determined before the benefits of any other Plan and without considering any other Plan's benefits. When this Contract is the Secondary Plan, its Benefits are determined after the benefits are determined for the Primary Plan. When this Contract is the Secondary Plan, Benefits may be reduced because of the Primary Plan's benefits.

If You do not follow the rules of the Primary Plan, the benefit may be reduced. Examples of these rules are second surgical opinions and prior authorization. The amount the benefit is reduced by the Primary Plan is not an Allowable Expense.

We do not coordinate Benefits with:

- hospital indemnity or other fixed indemnity coverage
- accident only coverage
- specified disease or accident coverage
- limited benefit health coverage, as defined by state law
- school accident type coverage

- benefits for non-medical components of group long-term care policies
- Medicare supplement policies
- Medicaid policies
- coverage under other federal governmental plans, unless permitted by law.

(2) **Order of Benefit Payment Rules**

When 2 or more Plans pay benefits, the rules for deciding the order of payment are:

- (a) The Primary Plan pays or provides its benefits according to its terms and without regard to benefits of any other Plan.
- (b) A Plan that does not have a COB rule that follows Colorado Insurance Regulation 4-6-2 is always primary, unless both Plans state that the complying Plan is primary. An exception is if You are covered by another Plan by membership in a group that is designed to supplement a part of a basic package of benefits and provides that the coverage will be in excess to any other parts of the Plan. Examples include major medical coverage that is in addition to base Plan hospital and surgical benefits, and insurance type coverage that provides out of network benefits for a Closed Panel Plan.
- (c) A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
- (d) The first of the rules shown in **bold** below that describes which Plan pays its benefits before another Plan is the rule to use:
 - (i) **Non-Dependent or Dependent:** The Plan that covers You other than as a Dependent (for example: as an employee, member, subscriber or retiree), is primary. The Plan that covers You as a Dependent is secondary. If You are covered by Medicare, there is a different rule. If Medicare is secondary to the Plan covering You as a dependent, and primary to the Plan covering You as other than a dependent (example, a retired employee), the order between the two Plans is reversed. The Plan covering You as a dependent is primary and the Plan covering You as an employee, member, subscriber or retiree is secondary.
 - (ii) **Child Covered Under More than One Plan:** Unless a court order states otherwise, when a Dependent Child is covered by more than one Plan, the order of benefits is determined as follows:

- (a) For a Dependent Child whose parents are married or living together, whether or not they have ever been married:
- The Plan of the parent whose birthday is earlier in the year is the Primary Plan; or
 - If both parents have the same birthday, the Plan that covered a parent longer is the Primary Plan.
- (b) For a Dependent Child whose parents are divorced, separated or not living together (whether or not they have ever been married), the order of benefits is:
- If a court order states that one of the parents is responsible for the child's health expenses or coverage and the Plan of that parent has actual knowledge of the court order, that Plan is primary. This rule applies to plan years starting after the Plan is given notice of the court order;
 - If a court order states that both parents are responsible for the child's health care expenses or coverage, then subparagraph (a) above will determine the order of benefits;
 - If a court order states that the parents have joint custody without specifying one parent has responsibility for health care expenses or coverage of the child, then subparagraph (a) above will determine the order of benefits;
 - If there is no court order allocating responsibility for the child's health care expenses or coverage, the order of benefits are as follows:
 - The Plan of the Custodial Parent;
 - The Plan of the spouse of the Custodial Parent;
 - The Plan of the non-Custodial Parent; and then
 - The Plan of the spouse of the non-Custodial Parent.
- (c) For a Dependent Child covered under more than one Plan of individuals who are not parents of the child, subparagraph (a) or (b) above will determine the order of benefits as if those individuals were the parents of the child.

- (iii) **Active or Inactive Employee:** The Plan that covers You as an employee who is neither laid off nor retired is primary. This also applies if You are a dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule and the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule shown above labeled “Non-Dependent or Dependent” can determine the order of benefits.
- (iv) **Continuation Coverage:** If Your coverage is under COBRA or a right of continuation provided by federal or state law and You are also covered under another Plan, the Plan covering You as an employee, member, subscriber or retiree (or as that person’s Dependent) is primary, and the COBRA or other continuation coverage is secondary. If the other Plan does not have this rule and the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule shown above labeled “Non-Dependent or Dependent” can determine the order of benefits.
- (v) **Longer or Shorter Length of Coverage:** The Plan that covered You as an employee, member, subscriber or retiree longer is the Primary Plan and the one that covers you a shorter time is the Secondary Plan.
- (vi) **Sharing of Expenses:** If the previous rules do not determine the order of benefits, the Allowable Expenses will be shared equally between the Plans. This Contract will not pay more than it would have paid had it been the Primary Plan.

(3) **Effect on the Benefits of this Plan when COB Applies**

When this Contract is secondary, We may reduce Benefits so the total benefits paid or provided by all Plans during a Claim Period are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that amount to any Allowable Expense under its Plan that is not paid by the Primary Plan. The Secondary Plan may reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan will credit to its deductible any amounts it would have credited to its deductible in the absence of other health care coverage. If You are covered by two or more Closed Panel Plans, and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB will not apply between that Plan and other Closed Panel Plans.

(4) **Right to Get and Release Information**

Information about health coverage and services is needed to apply the COB rules and Our right of subrogation. Information is also needed to determine the Benefits to be paid under this Contract and other Plans. We may obtain the information We need from or give it to others to apply COB rules and determine benefits under this Contract and other Plans. We do not need to tell anyone or get permission from anyone to do this. Each person claiming benefits under this Contract must give us information we need to apply the COB rules and determine benefits payable.

(5) **Payment**

A payment made under another Plan may include an amount that should have been paid under this Contract. If it does, We may pay that amount to the organization which made that payment. The amount We pay will be counted as if it were a Benefit paid under this Contract. We will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

(6) **Right of Recovery**

If the payments made by Us are more than We should have paid under the COB rules, We may recover the amount We overpaid. We may recover the amount from one or more of the people We have paid or for whom We have paid, or any other person or group which may be responsible for the Benefits provided to You. The “payments made” includes the reasonable cash value of any Benefits provided in the form of services. If We are determined to be the Secondary Plan and paid for Benefits which should have been paid by the Primary Plan, then You must help Us and also complete and submit any documents We ask for to obtain payment from the Primary Plan.

(7) **Medicare COB**

If You have Medicare coverage while covered under this Contract, special COB rules apply. We will follow Medicare’s COB rules. Medicare will be primary except as explained below or required by law.

- (a) **Working Aged Members in Group Plans of Employers with More Than 20 Eligible Employees:** All employers (including government entities, agencies or units) with 20 or more eligible employees are required to offer the same health benefits to employees over age 65 and their spouses as they provide to eligible employees and their spouses who are under the age of 65. This does not apply to employee-pay-all and union-maintained plans (other than those for a union’s own employees). If the employer has 20 or more eligible employees, employees over age 65 have the right to choose whether they want their employers to provide them with the regular group

Policy or be covered by Medicare. If an employee elects coverage under the employer's regular group Policy, and the regular group Policy is Our Contract, this Contract will be determined to be primary in accordance with Medicare guidelines.

- (b) **Disabled Members in Large Group Health Plans, as Defined by Federal Law:** If the employer's regular group Policy is Our Contract, and the employee covered by this Contract or the employee's spouse is under age 65 and Medicare eligible because of handicap, disability or related condition, this Contract will be primary in accordance with Medicare guidelines as long as this Contract remains a "Large Group Health Plan" as defined by federal law.
- (c) **Members With End Stage Renal Disease:** If the employer's group Policy is Our Contract, and the employee who is covered by this Contract is Medicare eligible because such employee is medically determined to have end stage renal disease, then this Contract will be primary to the extent required by law.

(8) **Auto Insurance Benefits COB**

- (a) **Coordination With Auto Coverage:** Your Benefits under this Contract will be coordinated with any no fault coverage or other automobile insurance that provides medical payment coverage or medical expense coverage in any form as allowed by law (Auto Coverage).
- (b) **Payment:** If You are eligible for benefits under Auto Coverage, such coverage will be primary and responsible for all benefits payable under the Auto Coverage. If You are eligible for coverage under more than one automobile insurance policy, each policy will pay its maximum Auto Coverage before We will make any payments. We will apply payments made by Auto Coverage to any Cost Sharing payable under this Contract as required by law. We may request proof that Auto Coverage has paid all benefits required. If We request information, You must give it to Us before We are obligated to make any payments.
- (c) **Settlement of Auto Coverage Claims:** You may not release or settle any Auto Coverage claim without Our written consent if We paid or may have to pay Benefits for services that would be covered by the Auto Coverage. If You release or settle an Auto Coverage claim without Our consent, We may refuse to provide Benefits for services that would be provided to You by the Auto Coverage. We may also recover amounts You got under the Auto Coverage for any Benefits We provided that should have been provided to You by the Auto Coverage. Amounts You get or may get for future health care services that would be provided by the Auto Coverage will be placed in a trust account as directed by Us for payment of those services.

(d) **Applicability of Other States' Auto Coverage Laws:** The provisions of this subsection will apply to Auto Coverage.

(9) **Pursuit of Coverage**

If We are the Secondary Plan, You must actively pursue coverage from the primary Plan before receiving any Benefits from Us. You must follow all rules for coverage under the Primary Plan, including filing claims and providing notice and information needed by the Primary Plan. If You do not follow this rule, We will not provide coverage for any services or Benefits which were subject to coverage by the Primary Plan.

(10) **No Double Recovery**

In no event will You be entitled to obtain double recovery from Plans or Policies for health care services provided to You.

8. LIMITATIONS/EXCLUSIONS (What is Not Covered)

A. Limitations:

L *Failure to Work or Live in the Service Area: If the Subscriber does not work or live in the Service Area, the Subscriber and Dependents are not eligible for Benefits under this Contract. This includes Benefits for Medical Emergencies and Urgent Care Services. This Limitation does not apply to a Subscriber:*

- *if allowed by Us under Our rules, or*
- *enrolled under any continued coverage pursuant to COBRA.*

L *Payment of Premium: If a Network Provider, a Non-Network Provider or anyone affiliated with a Network Provider or Non-Network Provider who has provided or intends to provide Care to a Member pays Premium amounts due under this Contract, Members are not eligible for Benefits. This will not apply if We are required by law to accept such payment.*

B. General Exclusions. The following are not covered:

- ⊗ *Any services or supplies not listed in the Covered Benefits section even if We arrange the service except if Prior Authorized.*
- ⊗ *Any services or supplies not Medically Necessary.*
- ⊗ *Any services or supplies that do not follow the accepted standards of health care practice in the area where services are provided.*

- ⊗ *Personal comfort or convenience items.*
- ⊗ *Surrounding services and supplies used for any treatment not listed as a Benefit in the Covered Benefits section. The phrase “used for any treatment” includes, but is not limited to, services and supplies that are an integral part of, derived from, or supportive of, a service which is not a Benefit listed in the Covered Benefits section.*
- ⊗ *Confinement, treatment, services or supplies You get outside the U.S. that are not the type and nature available in the U.S.*
- ⊗ *Confinement, treatment, services or supplies if paid or provided by the government. This does not apply if You must pay for the treatment or service in the absence of coverage, or if the law requires You to pay.*
- ⊗ *Confinement, treatment, services or supplies needed for insurance, travel, employment, school, camp, or similar purposes.*
- ⊗ *Confinement, treatment, services or supplies that are not ordered and approved by a provider.*
- ⊗ *Confinement, treatment, services or supplies that are not under the care and treatment of a provider.*
- ⊗ *Treatment, services or supplies provided to the Member by the Subscriber, his or her spouse, a child, sibling or parent of the Subscriber or of the Subscriber’s spouse, or any other person who lives in the Member’s home for which the Member would ordinarily have no obligation to pay in the absence of health care coverage.*
- ⊗ *Any services or benefits not covered by Your primary Policy because You did not follow its terms, except as required by COB rules of this Contract.*
- ⊗ *Services, drugs, supplies or products that are experimental or investigational, unless provided to You as part of a Clinical Trial. We may determine if a service, drug, supply or product is experimental or investigational before or after You request that We provide or pay for such service. The decision will be based on a review of local standards as well as consideration of national or state standards that We find are applicable to making the decision. We may review information from available resources. This includes the United States Food and Drug Administration, the National Institutes of Health, the American Medical Association, Hayes Technology Assessment, National*

Library of Medicine, Medline, the Cochrane Library, and the Centers for Medicare and Medicaid Services.

- ⊗ *Treatment for work-related illnesses and injuries, unless Your employer does not have to provide workers' compensation insurance. If a workers' compensation policy is in place, that policy is responsible for health benefits for work-related illnesses and injuries. "Work-related illnesses and injuries" include, but are not limited to, work-related aggravations of existing illnesses and injuries.*
- ⊗ *Treatment for Injury or Sickness incurred in connection with a felony You committed.*
- ⊗ *Equipment, supplies and drugs that are not approved by the Food and Drug Administration for health purposes.*
- ⊗ *Fees and costs that are not for treatment. This includes copying charges, file set up charges, financing charges and interest and other billing charges imposed by providers. This does not apply to copying charges for records requested by Us, or to interest and late fees that We are required to pay.*
- ⊗ *Treatment and services at a bloodless surgery center or religious science center, holistic medicine or other religion-oriented program.*
- ⊗ *Services provided by a Network Provider, Non-Network Provider, or anyone affiliated with a Network Provider or Non-Network Provider who has paid Your Premium. This will not apply if We are required by law to accept such payment.*

C. **Specific Exclusions.** The following are not covered:

- ⊗ *If not set forth on the RMHP Formulary, allergy injections, injectable drugs, medications and adult immunizations.*
- ⊗ *Transportation that serves only as a convenience for You or Your family.*
- ⊗ *Court ordered treatment that would not otherwise be covered.*
- ⊗ *Blood and blood products that are not provided as part of a service covered under this Contract.*

- ⊗ *Any part of a Clinical Trial that is paid for by a government or biotechnical, pharmaceutical or medical industry.*
- ⊗ *Any drug or device used in a Clinical Trial that is paid for by the manufacturer, distributor or provider of the drug or device.*
- ⊗ *Extraneous expenses related to taking part in a Clinical Trial. This includes travel, housing and other expenses that You, or a person traveling with You, may incur.*
- ⊗ *Any items or care provided as part of a Clinical Trial only to satisfy a need for data collection or analysis that are not directly part of Your clinical management.*
- ⊗ *Costs for the management of research relating to a Clinical Trial.*
- ⊗ *Care that, except for the fact that it is being provided in a Clinical Trial, is otherwise specifically excluded from coverage.*
- ⊗ *Dental splints, implants or prostheses.*
- ⊗ *Treatment for periodontal disease.*
- ⊗ *Dental treatment and services on or to the teeth, gums or jaws. This Exclusion does not apply to treatment for Injuries to Sound and Natural Teeth.*
- ⊗ *Treatment for pain or infection known or thought to be due to a dental cause and near the teeth or jaw, unless not treating such an infection may result in a systemic illness.*
- ⊗ *Surgical correction of malocclusion, services, supplies or appliances provided to alter, correct, fix, improve, remove, replace, reposition, restore or treat the jaw, or any jaw implant. This Exclusion does not apply to services for cleft lip and cleft palate and reconstructive surgery services. (See section 7.B.(8))*
- ⊗ *Maxillofacial and/or mandibular orthognathic surgery, oral surgery and orthodontia treatment including all outpatient and related costs, if the services are related to a dental condition.*

- ⊗ *Treatment of craniomandibular joint disorders and TMJ by use of orthodontic appliances and treatment, crowns, bridges or dentures, if the disorder is not caused by an Injury for which coverage is provided.*
- ⊗ *Removal of a tooth. This does not apply to treatment for Injuries to Sound and Natural Teeth.*
- ⊗ *Treatment for Injury to Sound and Natural Teeth caused by biting or chewing.*
- ⊗ *Alveoplasty when performed with an excluded service.*
- ⊗ *Care provided with non-covered dental services, except for general anesthesia for dental procedures for Dependent Children.*
- ⊗ *Dental cleaning, in-mouth scaling, planing, or scraping.*
- ⊗ *Myofunctional Therapy.*
- ⊗ *Non-emergency transport, Respite Care, service coordination, and assistive technology (unless otherwise covered under the Covered Benefits section).*
- ⊗ *EIS services for children age 3 and older.*
- ⊗ *Follow-up care You get in an emergency room.*
- ⊗ *Coverage for out of Service Area Emergency Care, if You left the Service Area to seek medical treatment.*
- ⊗ *Vision therapy, including the use of lenses and/or prisms for the treatment of a traumatic brain Injury, learning disabilities, and dyslexia.*
- ⊗ *Refractive keratoplasty, including radial and laser keratotomy (Lasik surgery), and any procedure to fix a refractive defect.*
- ⊗ *Routine hearing exams, except those covered as preventive Care for newborns.*

- ⊗ *Hearing aids and devices, including bone anchored hearing aids and auditory devices or implants attached to the bone, and fitting for Members age 18 and older.*
- ⊗ *Cochlear implants for Members age 12 and older.*
- ⊗ *Private Duty Nursing.*
- ⊗ *Custodial Care.*
- ⊗ *Housekeeping, homemaker and meal services.*
- ⊗ *Therapy services provided:*
 - *only to retain functioning at the level to which You have been restored; or*
 - *when Your condition is not expected to improve (i.e., maintenance care).*
- ⊗ *Grief support services, except as provided as a part of hospice services.*
- ⊗ *Private room unless it is Medically Necessary.*
- ⊗ *Care for complications that arise after You leave a Hospital against medical advice.*
- ⊗ *Surgical treatment for obesity or conditions related to obesity.*
- ⊗ *The reversal of any obesity treatment.*
- ⊗ *Treatment of any complications caused by obesity treatment.*
- ⊗ *Services and supplies related to any care that is not covered. This includes services and supplies that are an integral part of a non- covered benefit.*
- ⊗ *Clinical pathology services unless the services are within the scope of practice of the individual providing the services and are either rendered personally by the pathologist or are performed under the pathologist's direct supervision.*

- ⊗ *Hair transplants or implants.*
- ⊗ *Pain clinic services.*
- ⊗ *Amniocentesis to find out if the baby is a boy or a girl.*
- ⊗ *Services performed by a direct-entry or lay midwife.*
- ⊗ *Over-the-counter contraceptive drugs or devices which do not require a prescription, except those listed as included in the RMHP Formulary.*
- ⊗ *Abortifacient drugs.*
- ⊗ *Reversal of voluntary sterilization.*
- ⊗ *Services and procedures to verify the success of reversal of voluntary sterilization.*
- ⊗ *Treatment for infertility or to cause pregnancy, including:*
 - *testing;*
 - *prescription drugs;*
 - *artificial insemination;*
 - *in vitro fertilization (IVF);*
 - *gamete intrafallopian transfer (GIFT);*
 - *zygote intrafallopian transfer (ZIFT); and*
 - *embryo transplants.*
- ⊗ *Costs to operate DME, orthotic devices and prosthetic devices.*
- ⊗ *Air filters, purifiers and/or humidifiers.*
- ⊗ *Changes made to Your home or vehicles to make them handicap accessible.*
- ⊗ *Home modification equipment.*
- ⊗ *Wigs or hairpieces.*
- ⊗ *Home exercise equipment.*

- ⊗ *Bionic prostheses.*
- ⊗ *Power enhancements or controls for prosthetic limbs and terminal devices.*
- ⊗ *Myoelectric prostheses.*
- ⊗ *Peripheral nerve stimulators.*
- ⊗ *Repairs and replacements of DME, orthotic devices and prosthetic devices due to Your misuse or loss.*
- ⊗ *Behavior modification, such as weight loss programs.*
- ⊗ *Medical foods are not covered for Members with cystic fibrosis or for Members who are lactose- or soy- intolerant.*
- ⊗ *Outpatient nutrition products, including Medical Foods, TPN and therapeutic formulas, except as provided in the “Nutrition” subparagraph.*
- ⊗ *Weight loss programs and services.*
- ⊗ *Charges for visits to a health care provider that are not kept.*
- ⊗ *Third party testing, such as lab and x-rays that are not part of suggested screening or routine physicals.*
- ⊗ *Costs for health reports, including presentations and preparation.*
- ⊗ *Third party physical and/or psychological exams for employment, licensing, insurance, adoption or any other non-health reasons.*
- ⊗ *Screening tests that are done in multiple phases.*
- ⊗ *Checkups not associated with any Injury or Sickness, except as stated in the Covered Benefits section.*
- ⊗ *Clinical ecology services and services for treatment of multiple chemical sensitivity and idiopathic environmental illness.*

- ⊗ *Genetic testing, except for:*
 - *diagnosing You with a condition or illness that will affect Your health;*
 - *treating a condition or illness that will affect Your health; or*
 - *preventive care recommended by the USPSTF or HRSA, including, for example, BRCA testing and counseling.*
- ⊗ *Routine foot care.*
- ⊗ *Trimming of corns and calluses.*
- ⊗ *Treatment of flat feet.*
- ⊗ *Partial dislocations in the feet.*
- ⊗ *Over the counter, nonprescription drugs or medicines, vitamins, nutrients and food supplements even if prescribed or given by a Physician. This does not apply to items that are listed as included in the RMHP Formulary.*
- ⊗ *Travel immunizations.*
- ⊗ *Cosmetic surgery or treatment for complications caused by non-covered cosmetic surgery.*
- ⊗ *Reversal of a cosmetic surgery or non-covered reconstructive surgery.*
- ⊗ *Reconstructive surgery that does not result in functional gain.*
- ⊗ *Reconstructive surgery primarily for cosmetic reasons.*
- ⊗ *Breast reduction, unless Medically Necessary or as part of a mastectomy. Breast reduction is not covered in connection with cosmetic implants or primarily for cosmetic reasons.*
- ⊗ *Sexual dysfunction services for any reason other than surgical or radiation treatment of prostate cancer. This Exclusion includes therapy, Physician services, surgical treatment, injectables, prescription drugs and any other treatment for impotency.*
- ⊗ *Nursing home and domiciliary care.*

- ⊗ *Therapies, self-help programs and other services not specifically covered under the Contract. This includes the types of therapies listed as Exclusions under subsection 7.B.(36) – **Therapy Services**.*
- ⊗ *Transplants not listed as a Benefit in the Covered Benefits section.*
- ⊗ *Costs of maintaining a cadaver donor for organ retrieval.*
- ⊗ *Autologous or allogeneic bone marrow harvest and transplant and autologous or allogeneic peripheral stem cell removal and reintroduction, whether alone or with high dose chemotherapy. This does not apply to the extent such harvest and transplant or removal and reintroduction are listed as a Benefit in the Covered Benefits section.*
- ⊗ *Multiple organ transplants except as provided in the Covered Benefits section.*
- ⊗ *Chiro Care for children 3 years of age and younger.*
- ⊗ *Chiro Care provided in excess of what is necessary for maximum improvement. This is the point at which the patient shows little or no improvement with additional therapy.*
- ⊗ *Chiro Care provided on an inpatient basis.*
- ⊗ *Chiro Care which is maintenance care. Maintenance care is defined as a treatment program designed to maintain optimal health in the absence of symptoms.*
- ⊗ *Neuromusculoskeletal manipulation under anesthesia.*
- ⊗ *Clinical laboratory services and any associated procedures related to Chiro Care involved in the collection and/or testing of biological or lab specimens.*
- ⊗ *Preventive care, educational programs, therapies, nonmedical self-care, self-help training and any related diagnostic testing. This does not apply if such services occur during the normal course of providing Chiro Care.*
- ⊗ *Vocational or long-term rehab related to Chiro Care.*

- ⊗ *Advanced diagnostic testing and imaging performed as part of Chiro Care, including:*
 - *MRI, CT or bone scans;*
 - *diagnostic ultrasound;*
 - *videoflouroscopy;*
 - *thermography;*
 - *electrodiagnostic testing, such as nerve conduction velocity (NCV); and*
 - *electromyography (EMG) or evoked potentials.*

- ⊗ *Radiological procedures related to Chiro Care performed on equipment not certified, registered or licensed by the state where the services are performed.*

- ⊗ *Radiological procedures that We determine cannot be safely utilized in diagnosis or treatment.*

- ⊗ *Chiro Care for or related to diagnosis and treatment of jaw joint problems. This includes TMJ or craniomandibular disorders.*

- ⊗ *Technique-specific radiographs exposed to support such techniques.*

- ⊗ *Transportation costs related to Chiro Care. This includes ambulance charges.*

9. MEMBER PAYMENT RESPONSIBILITY

A. Payment

You or the Subscriber must pay all Premiums, Cost Sharing, and all other fees or amounts owed to Us or the provider, as applicable, under this Contract when due. A Network Provider, a Non-Network Provider, or anyone affiliated with a Network Provider or Non-Network Provider who has provided or intends to provide You Care may not pay Your Premium. This will not apply if We are required by law to accept such payment. Premium is owed up to the date of termination. If Your coverage ends any day other than the last day of a month, this includes a pro-rated amount for the month in which this Contract ends. You must pay Your Cost Sharing directly to the provider at the time You get the Care. You or the Subscriber and Members must pay amounts for services that are not Benefits under this Contract.

B. Yearly Out-of-Pocket Maximum

Your Policy with Us may have both a Member and a Subscriber/Dependent Yearly Out-of-Pocket Maximum. Please refer to the Covered Benefits section and Your Coverage Schedule for Cost Sharing and Yearly Out-of-Pocket Maximum amounts.

When the Copays owed for certain Benefits provided in a Calendar Year equal the Yearly Out-of-Pocket Maximum amount, You will not have to pay additional Copays for those Benefits provided during the rest of the Calendar Year. Yearly Out-of-Pocket Maximums are subject to annual adjustments in accordance with federal law.

C. Change of Health Care Plans

If You change between Policies offered by Us, the Cost Sharing amounts You paid on Your prior Policy may count toward the new Policy's Cost Sharing amounts according to Our policies and procedures. Also, Benefits You got that count toward Maximum Benefit Levels will be applied to the new Policy's Maximum Benefit Levels.

D. Incentives

We may choose to pay travel costs or reduce Cost Sharing for specific types of Care You get from certain Network Providers. If We decide to offer an incentive to You, We will tell You in writing.

E. Third Party Liability

(1) Applicability

This section applies when We have paid or incurred costs for which You have a claim against a third party or insurer for any Injury, Sickness or condition ("Conditions"). This includes all current or future costs. "Third party" means any person, entity, Subscriber or Member other than the Member to whom We are subrogated. We are entitled to subrogation and reimbursement as allowed by law and as described below. Any dispute regarding subrogation or reimbursement will be resolved by arbitration. In case of arbitration, You and Rocky Mountain will each pay one half of the cost. Any arbitration related to subrogation or reimbursement will follow the rules for arbitration in section 13, Appeals/Complaints.

(2) Subrogation

We will have the benefit of and become the owner of all rights, claims, remedies, and security against a third party for Conditions for which:

- You have a legal claim against a third party for damages; or
- You have a right to get payment from any insurer, with or without regard to fault, to the extent of costs paid or incurred, or that may be paid or incurred, by Us on Your behalf.

We will have the full power and authority to enforce these claims in Our name as allowed by law.

We may seek to recover amounts from a third party or obtain information about Your claims against a third party. You will actively cooperate with Us by:

- securing and giving evidence as needed for recovery efforts. This includes attending, participating in and giving testimony at depositions, hearings and trials;
- giving information, documents, and written information to Us when requested; and
- helping secure other witnesses in the conduct of administrative or legal proceedings.

Our recovery through subrogation will not affect Your obligation to pay Premiums, Cost Sharing or other sums due under this Contract.

(3) Reimbursement of Proceeds

This section applies to a payment of a claim or judgment by a third party or other insurer. Any money, proceeds or property paid to You or recovered by You for Conditions will be considered held in trust by You for Us to the extent We pay current or future costs for related Benefits. This includes Auto Coverage or medical payments coverage. As allowed by law, You agree to promptly pay Us money, proceeds or property received to the extent of Our costs paid or incurred now or in the future. You agree that this payment will be made to Us whether:

- the money, proceeds or property are for a particular type of Conditions or claim;
- Your efforts to recover from a third party were known, approved or shared by Us; and
- the recoveries were the result of a lawsuit, a settlement, or otherwise.

(4) Settlement of Third-Party Liability Claims

You must give Us notice about any settlement with or recovery against:

- any third party or other insurer, including Your insurer;
- any liability insurer; or
- a third party insurer

of any claim or judgment for damages from Conditions that We have paid or may pay or incur in the future for Benefits provided to You. As allowed by law, We may recover from You any amounts paid to You up to the amount incurred or paid by Us or that in the future may be paid or incurred by Us for Benefits.

F. Interest

Cost Sharing owed to Us will be due and payable on the due date shown on the Member billing statement. Past due amounts will accrue interest up to the rate of 24% per year. Interest accrues from the date the amount is due until paid.

10. CLAIMS PROCEDURE (How to File a Claim)

A. Filing Claims

(1) Time Limit

Except for claims for Outpatient Prescription Drugs, when You pay for Care and ask Us to repay You, You will be liable for no more than the applicable Cost Sharing for the Care if:

- (a) You submit Your request within 12 months of getting the Care;
- (b) the Care did not need Prior Authorization; and
- (c) a contract was in place between the provider and Us when You got the Care.

In other cases, You or Your provider must submit all claims to Us within 180 days after You got the Care. If We do not get the claim timely, We may not pay the claim. You must send claims for Outpatient Prescription Drugs to Us within 120 days of the date that You receive the Outpatient Prescription Drug.

Clean Claims will be paid, settled or denied by Us within:

- 30 days if sent electronically; or
- 45 days if sent by other means.

All claims except Clean Claims will be paid, settled or denied by Us within 90 days after receipt if there is not Fraud.

(2) Required Information

You can download a claim form from our website, www.rmhp.org, or call Us. You or Your provider may submit a claim:

- by U.S. mail, first class or overnight delivery;
- electronically;
- by fax; or
- by hand delivery.

To get Your claim paid, You or Your provider must send Us an authorized claim form and original bill.

Send claims to Us at:

RMHP
Attention: Claims
2775 Crossroads Boulevard
Grand Junction, Colorado 81506
Fax: 970-244-7880

Claims must include the following:

- The Subscriber's Rocky Mountain identification number;
- The Subscriber's name and address;
- The name of the Member who got the Care;
- The age and relationship to the Subscriber of the Member who got the Care;
- The date(s) of the accident, Care or purchase;
- The diagnosis and type of treatment;
- An original itemized statement of expenses;
- The provider's name, address and federal tax ID number; and
- Expenses for prescription drugs must include:
 - pharmacy name and address;
 - drug name and prescription number; and
 - the original bill or receipt from the pharmacy.

If We do not timely get required information from You, We may not pay Your claim.

(3) Manner of Payment

We will decide if We will pay Benefits to You or to Your providers.

(4) Minor or Incompetency

We may pay an individual or institution directly if it appears to have assumed the custody or the principal support of a Member if:

- (a) the Member is a minor, or in Our opinion, the Member is not competent to give a valid receipt for payment due the Member under this Contract; and
- (b) We have not received a request from a duly appointed guardian or other legally-appointed representative.

B. Time Lines for Our Decisions

After You file a claim, We will tell You of Our decision within the time frames below. If We verbally tell You within the time frames set forth below, written or electronic notification will be given to You within 3 days.

- (1) Urgent Care Claims. Upon Our receipt of an Urgent Care Claim, We will tell You of Our decision as soon as possible, but no later than 72 hours after Our receipt of Your Urgent Care Claim. If there is not enough information to decide whether Benefits are covered or payable by Us, We will notify You as

soon as possible, but no later than 24 hours after Our receipt of Your Urgent Care Claim. We will tell You the specific information needed to complete such Urgent Care Claim. You will be given a reasonable time to provide the specified information, depending on the circumstances, but no less than 48 hours after You have been notified. We will tell You of Our decision as soon as possible, but no later than 48 hours after the earlier of:

- Our receipt of the specified information; or
- the end of the period given to You to provide the additional specified information.

(2) Pre-Service Claims. We will tell you of Our decision regarding a Pre-Service Claim within a reasonable time (appropriate to the medical circumstances), but no later than 15 days after Our receipt of Your Pre-Service Claim. We may extend the initial 15 day period for up to an additional 15 days if there are matters beyond Our control. In this case, We must notify You prior to the end of the initial 15 day period:

- of the circumstances requiring the extension, and
- the date on which We expect to make Our decision.

If the extension is necessary because You failed to submit the information needed to make a decision, the notice must describe the information required. You will have at least 45 days from the date of receipt of such notice to provide the requested information.

If You fail to follow Our procedures for filing a Pre-Service Claim, You will be notified as soon as possible, but no later than 5 days (24 hours in the case of a Pre-Service Claim that also qualifies as an Urgent Care Claim) after Our receipt of Your claim, that Your claim has been improperly filed. You will be given a description of the proper procedures for filing Your Pre-Service Claim. Such notice may be given verbally, unless You have specifically requested written notification.

(3) Post-Service Claims. For a Post-Service Claim, We will notify You of Our decision within a reasonable time period, but no later than 30 days after Our receipt of the Post-Service Claim. We may extend the initial 30 day period for up to an additional 30 days if there are matters beyond Our control. In this case, You will be notified, prior to the end of the initial 30 day period:

- of the circumstances requiring the extension, and
- the date on which We expect to make Our decision.

If such extension is necessary because You failed to submit the information required to make a decision, the notice must describe the information required. You will have 45 days from Your receipt of the notice to provide the requested information.

- (4) Concurrent Care Claims. We will notify You of Our decision with respect to a Concurrent Care Claim enough in advance of the termination of the pre-approved course of Care, or reduction in the specific number of treatments, to allow You to appeal and obtain a decision on review prior to such termination or reduction.

Your request to extend a course of Care beyond the prescribed period of time, or the specific number of pre-approved treatments, that also qualifies as an Urgent Care Claim must be decided as soon as possible, taking into account the medical needs. We will notify You of Our decision within 24 hours after Our receipt of the claim, if Your claim is made at least 24 hours prior to the end of the:

- prescribed course of Care; or
- specific number of pre-approved treatments.

C. **RMHP Formulary Exception Requests**

You, Your designee, or Your provider may request clinically appropriate drugs not otherwise covered by Us through a special process. If We grant Your request, We will cover the non-formulary drug for the duration of the prescription. If We deny Your request, You, Your designee, or Your provider may request an external review of the decision by an independent review organization.

For more information about the special process for drugs not on the RMHP Formulary, please contact RMHP Customer Service.

(1) **Standard Review**

You, Your designee or Your provider may request a standard review of Our decision to not include a drug in the RMHP Formulary.

We will make a decision on Your standard review request and notify You or Your designee and Your provider of Our decision no later than 72 hours after We receive Your request. If We grant Your standard review request, the drug will be covered for the duration of the prescription, including any refills.

(2) **Expedited Review**

If there are exigent circumstances, You, Your designee or Your provider may request an expedited review of Our decision to not include a drug in the RMHP Formulary. Exigent circumstances exist when:

- You have a health condition that may seriously jeopardize Your life, health or ability to regain maximum function; or
- You are currently undergoing a course of treatment with a drug not in the RMHP Formulary.

We will make a decision on Your expedited review request and notify You or

Your designee and Your provider of Our decision no later than 24 hours after We receive Your request. If We grant Your expedited review request, the drug will be covered for the duration of the exigent circumstances.

(3) **External Review**

If We deny a standard or expedited review request, You, Your designee or Your provider may request an external review of the denial by an independent review organization.

You or Your designee and Your provider will be notified of the decision no later than:

- 72 hours after We receive Your request, if it is a review of a standard review request; or
- 24 hours after We receive Your request, if it is a review of an expedited review request.

If Your standard review request is granted, the drug will be covered for the duration of the prescription, including any refills. If Your expedited review request is granted, the drug will be covered for the duration of the exigent circumstances.

11. GENERAL POLICY PROVISIONS

A. Reporting Rules for Subscribers and Members

(1) **Double Coverage**

You must tell Us when You have Double Coverage so We can determine which Policy pays first. (See section 7.)

(2) **Tell Us if You are Admitted to a Non-Network Hospital**

You or Your Physician must tell Us if:

- You deliver a baby in a non-Network Hospital; or
- You are admitted to a non-Network Hospital for Urgent Care or Emergency Care.

This notification must occur within 24 hours or the next business day. We will make an exception to the time limits if Your medical condition prevented timely notice.

(3) **Report Third-Party Claims**

You must promptly tell Us about any claims and potential claims against any third party. (See section 9.)

(4) If Your Eligibility Changes

You must send proof of eligibility to Us. We will decide if the proof meets all eligibility rules. (See section 5 for eligibility rules.) You must tell Us immediately if You have a change in status that may affect Your eligibility under this Contract. Eligibility status changes start on the first day of the next month after the date of change. If a change in status causes You to be ineligible, Your coverage will end the last day of the month You tell Us of the change.

(5) Tell Us if Your Address Changes

You must tell Us if Your address changes. We will change Your address in Our records if the United States Postal Service notifies Us that Your address changed.

B. Duration

This Contract is between Us, the Contracting Group and the Subscriber on behalf of each Member. This Contract begins on the Effective Date. The Contract will automatically Renew on the Renewal Date, unless this Contract is terminated. If there is no Renewal Date, this Contract will Renew on January 1 of each Calendar Year.

C. Application and Effective Date

The Effective Date of this Contract is the date designated by Us after:

- You submit a complete and accurate request for enrollment which complies with the GSA;
- You give Us any additional information We request;
- We accept and approve Your request; and
- the Premium has been paid.

Benefits begin on the Effective Date.

D. Confidentiality of Records

We will keep Your information confidential. However, You agree to let Us obtain, use, and share health records and information about Care provided to You:

- as allowed or required by law;
- for use in medical research and education (without identifying You); or
- as needed to administer this Contract.

You also agree to promptly give Us, Our Network Providers and other providers written consent for release of records related to Your Care if requested.

E. Relationship with Providers

It is the intent of You and Rocky Mountain that:

- Network Providers and Non-Network Providers will be independent contractors and are not Our agents or employees; and
- Our employees will not be the employer or agent of any Network Provider.

We do not insure against and are not liable for, the negligence or other wrongful act or omission of any Network Provider or Non-Network Provider, their employees or other persons or agencies, or for any act or omission of any Member. Network Providers, Non-Network Providers, or their employees or agents, are solely responsible for Care provided to You. You agree that We cannot and do not practice medicine.

F. Controlling Costs

We use cost control tools including the following:

- regular utilization review of Network Providers;
- second opinions (See subsection 7.B.(29));
- Prior Authorization;
- managed care including:
 - education
 - use of a drug formulary;
 - support of community health programs;
 - quality improvement review;
 - the Primary Care Procedures;
- dispute resolution process (See section 13);
- incentives (See subsection 9.D.); and
- pilot programs or studies (See subsection 7.C.)

G. Notice

Except as noted in section 13 and this subsection, any required notice, including change of address, will be in writing. Notices are effective upon mailing, postage prepaid, to Our address in section 3, or to the Contracting Group or Subscriber and Members at the address that appears in Our records. (See section 13 for additional notice requirements.)

This Contract may be made available to You electronically. It has very important information about Your Benefits that should be shared with all Dependents covered under this Contract. If You chose an electronic copy, We will email You when an electronic copy of this Contract is ready. You must give Us Your email address and notify Us if it changes. If We cannot send this Contract to the email address You gave Us, We will send You a paper copy. You can ask for a paper copy of this Contract at any time by asking customer service. You can also ask that We only send You paper copies.

H. Assignment

The rights of the Contracting Group, Subscriber, or Member under this Contract may not be assigned or delegated. However, a Member is allowed to assign payments due for Benefits under this Contract to a licensed Hospital, licensed health care provider, occupational therapist or massage therapist. We have the right to assign this Contract.

I. Enforcement

If We seek to enforce or interpret this Contract, except for matters submitted for review by the internal review committee and arbitration, We will be awarded Our costs, including reasonable attorneys' fees.

J. Offset

We have the right to recover sums owed to Us by a Contracting Group, Subscriber, or Member by withholding sums We owe to the Contracting Group, Subscriber, or Member. No terms of this Contract will restrict this right.

K. Binding Effect

Subject to the terms restricting assignment or delegation, the terms of this Contract will be binding upon and confer to the benefit of the Rocky Mountain, the Contracting Group, the Subscriber and Members, and their successors and assigns.

L. Headings

The headings are for reference only and are not to be used to interpret this Contract. The headings do not in any way qualify, modify or explain any terms or their effect.

M. Unexpected or Uncontrollable Events

Rocky Mountain and Network Providers will not have any liability or obligation, beyond a good faith effort, for delay or failure to provide any services if the delay or failure is caused by conditions beyond their control. This may include lack of available facilities, personnel or financial resources because of:

- disaster;
- epidemic;
- riot;
- civil insurrection;
- labor disputes;
- complete or partial destruction of facilities;
- disability of a significant number of Network Providers; or
- any other emergency or similar situation.

N. Entire Agreement

This Contract constitutes the entire agreement between the parties. This Contract will not be changed except as provided in this Contract.

O. Interpretation

The interpretation of this Contract will be guided by:

- the Affordable Care Act;
- the Internal Revenue Code;
- the Colorado Health Care Coverage Act;
- the federal Health Maintenance Organization Act of 1973, as applicable; and
- other applicable Colorado and federal law.

Any provision of this Contract that does not conform with the Affordable Care Act, the Internal Revenue Code, the Colorado Health Care Coverage Act and other applicable law will not be invalid, but will be construed and applied as if it was in full compliance with the act and regulations.

12. TERMINATION/NON-RENEWAL/CONTINUATION

A. Termination for Cause

As allowed by law, We may end or not Renew coverage under this Contract for these reasons:

- (1) Premiums due to Us have not been paid.
 - If Premiums are being paid by a Contracting Group, nonpayment may also result in loss of coverage for the Group. As stated in the GSA, Premiums are owed until We are told coverage for a Member has ended.
 - If Premiums are being paid by a Subscriber, nonpayment will result in loss of coverage for Subscriber and Dependents.
 - Payment of Premiums will not entitle a Member to coverage if the Member is no longer eligible.
- (2) Fraud by You about Your eligibility, enrollment or in any other matter.
- (3) Allowing someone else to fraudulently use Your Member ID Card to get Benefits.
- (4) Any other reason allowed by law.

B. Procedure to Terminate for Cause

If We end this Contract for cause, We will notify the Subscriber on behalf of the Member. The notice will explain why the Contract is ending. The Subscriber will

have 30 days from the date of the notice to resolve the cause of termination. This chance to resolve the issue does not apply if the Contract ended due to Fraud. If the cause for ending the Contract is not resolved, the Contract will end 30 days from the date of notice. You will not be entitled to Benefits as of the date the Contract ends. You must pay for any health care services You get after that date. We may end this Contract immediately for Fraud.

If We end the Contract for nonpayment and the Contracting Group is responsible to pay the Premium, We will notify the Contracting Group. The notice will explain the reason the Contract is ending. The Contracting Group must pay the past due Premium by the date stated in the notice. If payment is not made by the date in the notice, You will no longer be entitled to Benefits. You must pay for any health care services You get after this date.

C. **Other Terminations**

As allowed by law, coverage under this Contract may end or not be Renewed for these reasons:

- (1) If We are notified You are no longer eligible.

The termination will be 30 days after We give notice to You.

If the Subscriber no longer works or lives in the Service Area, this will not cause a Member to lose eligibility. However, a Member will not be entitled to Benefits except as provided in this Contract.

- (2) The Subscriber decides to end the Subscriber's coverage or the coverage for any Dependent.

You must notify Us to end coverage. Ending the Subscriber's coverage ends coverage for all the Subscriber's Dependents under this Contract. The termination date will be:

- the date specified by You, if You provide at least 14 days' notice to Us;
- 14 days after the termination is requested by You, if You do not provide at least 14 days' notice to Us;
- the date determined by Us, if We are able to terminate this Contract in less than 14 days and You request an earlier termination effective date;
- if the Subscriber is newly eligible for Medicaid, CHP+, or a basic health plan, the last day of coverage is the day before such new coverage begins; or
- the date of death of the Subscriber or any Member.

A Subscriber cannot end coverage for a Dependent Child if there is a court order to provide coverage for the Dependent Child, unless the Subscriber gives Us written proof that:

- the court order is no longer in effect; or
- the Dependent Child is or will be covered by a comparable Policy through another insurer. The effective date of the new Policy can be no later than the end date of the coverage under this Contract.

(3) A Dependent decides to end the Dependent's coverage.

If You are a Dependent, You must notify Us to end coverage. Coverage ends the last day of the month that We get notice.

(4) The Contracting Group may end coverage of some or all of the Subscribers within the Group. The Group must notify Us to end coverage.

(5) We stop offering or do not Renew all of Our small or large group Policies delivered or issued for delivery in Colorado. If this happens, We will send notice to the Contracting Group and Members and to the insurance commissioner in each state in which an affected Member is known to live. This notice will be sent at least 180 days before the non-Renewal. Notice to the insurance commissioner will be sent at least 3 business days before the notice to the affected Members.

(6) We stop offering the Policy under which You are enrolled. If this happens, We will act uniformly without regard to the claims experience of the policyholders or any health-status-related factor of any individual, participant, or beneficiary covered by the Policy or new individuals, participants, or beneficiaries who may become eligible for coverage. We will notify the insurance commissioner and certify:

- (a) the premiums for other Policies We offer are not excessive, inadequate, or unfairly discriminatory relative to the plan that We are discontinuing; and
- (b) the benefit levels We offer in the other Policies comply with the requirements of law applicable to individual and small employer Policies.

We will send notice to the Contracting Group and each Member. Such notice will be sent at least 90 days before the date We stop offering the Policy. We will offer the Contracting Group the choice to buy any other Policy currently being offered by Us in the same group market, and specify the applicable special enrollment periods.

(7) This Contract will end when the GSA ends.

(8) Any other reason allowed by law.

D. Reinstatement of Contract

We may reinstate a Group, Subscriber or Member whose enrollment was ended in error.

E. Requests for Retroactive Termination

We may approve retroactive requests to end this Contract at Our discretion.

F. Effect of Ending Subscriber's Coverage

If a Subscriber's coverage ends, coverage for all the Subscriber's Dependents ends without further action by Us. No additional notice will be given.

G. Termination for Any Reason

You will not have coverage for Benefits after the date the Contract ends. There is an exception for continued inpatient Care. (See subsection I below.)

H. Renewability of this Contract

Unless this Contract has ended, We will not discontinue coverage or refuse to Renew this Contract, except for one of these reasons:

- (1) Nonpayment of, or failure to timely pay, Premiums owed to Us.
- (2) The Contracting Group's Fraud.
- (3) We stop offering or do not Renew all of Our small or large group Policies delivered or issued for delivery in Colorado. We will send notice to the Contracting Group and Members and to the insurance commissioner in each state in which an affected Member is known to live. This notice will be sent at least 180 days before the non-Renewal. Notice to the insurance commissioner will be sent at least 3 working days before the notice to the affected Members.

If We stop offering Policies of one market type but still offer Policies of other market types, We will still provide Benefits up to the date this Contract would Renew, but not more than 12 months after We send notice.

- (4) The Contracting Group does not follow participation or contribution rules in the GSA.
- (5) No Group Member lives, resides or works in Our Service Area.
- (6) If coverage is offered by a Small Employer, the Employer Entity is no longer actively engaged in the business in which the Employer Entity was engaged on the effective date of the GSA.

- (7) If coverage of an Employer Entity is made available only through one or more bona fide associations, the membership of the Employer Entity in such an association ends.
- (8) Any other reason allowed by law.

I. Continued Inpatient Care

If You are in an inpatient facility on the date this Contract ends, Your coverage will continue until You are discharged. “Discharge” includes a discharge or transfer to a lower level of Care or Your home. This continued coverage does not apply if this Contract ends due to:

- nonpayment of Premium due under this Contract; or
- fraud or abuse.

J. Continuation of Coverage

The purpose of this section is to follow Title X of COBRA and the Colorado Continuation of Coverage (CCOC) rules that apply to HMOs. COBRA is for groups with 20 or more employees. CCOC is generally for non-employer groups and groups with less than 20 employees. This section describes the continuation of coverage rights of Members.

We will apply COBRA and CCOC rules to follow federal and state law. This section will not impose more duties on Us or give You more rights than required by law. Due to the requirements of federal law, a Partner in a Civil Union is not entitled to COBRA benefits as a Qualified Beneficiary with respect to a Covered Employee. For purposes of CCOC, a Partner in a Civil Union may be entitled to CCOC benefits as a Dependent Spouse.

(1) COBRA

This section applies to You only if You are a Qualified Beneficiary. At the time of a Qualifying Event, You may choose COBRA coverage.

COBRA coverage will continue for a period of no longer than:

- (a) 18 months after the Qualifying Event if:
 - (i) the Covered Employee’s employment ended for any reason other than gross misconduct; or
 - (ii) the Covered Employee’s hours were reduced.
- (b) 29 months after the Qualifying Event for all Qualified Beneficiaries, if a Qualified Beneficiary is determined to be disabled under Title II or XVI of the Social Security Act at:
 - (i) the time of Qualifying Event; or

- (ii) any time during the first 60 days of COBRA coverage.

You must give the notice to the employer within 60 days of the disability determination and before the end of the 18-month period described above.

- (c) 36 months after the Qualifying Event if the Qualifying Event is due to:
 - (i) the death of the Covered Employee;
 - (ii) a divorce or legal separation of the Covered Employee's spouse;
 - (iii) the Covered Employee becoming entitled to Medicare; or
 - (iv) a Member is no longer eligible to be a Dependent Child.

(2) Electing COBRA

You must tell Your employer within 60 days if:

- the Covered Employee is divorced or legally separated; or
- a Member is no longer eligible to be a Dependent Child.

If You want COBRA coverage, You must tell Your employer in writing within specific timeframes. You must give Your employer the notice within 60 days of the later of:

- the date coverage would end because of a Qualifying Event; or
- the date You get the notice explaining Your right to COBRA coverage.

(3) Premiums for COBRA

You may be charged up to 102% of the monthly Premium unless You are entitled to the 18-month disability period.

If You are entitled to the 18-month disability period of COBRA explained in this section 12, You may be charged up to 150% of the monthly Premium after the 18th month of COBRA coverage.

(4) Termination of COBRA

COBRA coverage will end before the 18-month, 29-month or 36-month period if any one of the events listed below occurs. It will end on the date of the earlier of one of these events:

- (a) the Covered Employee's employer ends coverage with Us for all employees;

- (b) You become covered under a different group health Policy that does not exclude coverage for a pre-existing condition that You have;
- (c) You become entitled to Medicare;
- (d) You do not pay Premiums,
- (e) for other reasons described in this Contract; or
- (f) if You are a disabled Qualified Beneficiary as described in this section 12, the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that You are no longer disabled (if this determination happens after the first 18 months of COBRA coverage).

(5) **Colorado Continuation of Coverage (CCOC)**

This section applies to You only if You qualify for CCOC.

CCOC is available to Covered Employees and their Dependents for a period not longer than 18 months after loss of coverage because the Covered Employee's:

- employment ends;
- death; or
- marital or Civil Union status changes.

You may choose CCOC coverage if:

- (a) the Covered Employee's eligibility ended for any reason other than:
 - the GSA ends; or
 - a class of Members is no longer covered;
- (b) all amounts owed to Us for the Covered Employee have been paid through the Covered Employee's termination date; and
- (c) the Covered Employee has been covered under this Contract (or any group Policy with similar benefits which this Contract replaces), for at least the 6 months prior to the Covered Employee's termination date. The Covered Employee must have been covered the entire 6-month period without a break in coverage.

We are not required to offer CCOC to any person who is covered by Medicare or Medicaid.

(6) **Electing CCOC**

If You want CCOC coverage, You must tell Your employer in writing within specific timeframes. You must give Your employer the notice on or before 30 days after:

- the Covered Employee's employment ends;
- the Covered Employee dies; or
- the Covered Employee's marital or Civil Union status changes.

If the employer does not give the Covered Employee information about the right to CCOC coverage, then You will have 60 days from the date the Covered Employee's employment ends to elect CCOC.

The employer must get full payment of Your first monthly Premium with the notice.

(7) **Premiums for CCOC**

You may be charged up to 100% of the monthly Premium.

(8) **Termination of CCOC**

CCOC will end before the 18-month period if any one of the events listed below occurs. It will end on the date of the earlier of one of these events:

- (a) The employer ends coverage with Us for all employees;
- (b) Premiums are not paid timely;
- (c) for other reasons described in this Contract; or
- (d) You become eligible for another group Policy. If the new Policy excludes a condition covered under this Contract, coverage for the excluded condition may continue for 18 months or until the new Policy covers the condition, whichever happens first.

(9) **Leaving the Service Area**

If You leave the Service Area, COBRA and CCOC coverage will not end unless allowed by law. If You leave the Service Area, Benefits will be limited as described in this Contract.

(10) **Members Who Are Minors**

If a minor Child qualifies for COBRA or CCOC coverage, the Child's legal guardian will represent the Child as the Subscriber on the plan, even though the guardian may not be a Member.

(11) **No Other Continuation Rights**

The only continuation of coverage rights available to You are specifically explained in this Contract and/or required by law.

13. APPEALS AND COMPLAINTS

We want You to be satisfied with the Care You get and the services We provide. We give You many ways to tell Us about any questions, concerns or complaints (“Complaint Process”). We list each of these options below.

If You need help with the Complaint Process, You may choose a Designated Representative to help You. You must notify Us if You choose a Designated Representative. If a health care provider who knows about Your health condition asks for a Fast Review, We will assume this person is Your Designated Representative.

In this section only, the terms “You,” “Your” and “Member” include a Designated Representative.

A. Informal Procedure

If You have questions or concerns, You may call or write Us. You may hand deliver, mail, or fax Your written questions or concerns to Us. If We cannot resolve Your questions or concerns at that time, You must follow the Complaint Process steps below.

B. Review Time Lines

There are two time lines for review – Standard Review and Fast Review. Standard Review is the review procedures and time lines that We follow if a Fast Review or a Fast External Review do not apply.

(1) **Fast Review**

You can ask for a Fast Review if the standard time lines for First Level Review would:

- (a) seriously risk Your life or health;
- (b) seriously risk Your ability to recover maximum function;
- (c) if You have a disability, create an imminent and substantial limit on Your existing ability to live on Your own; or
- (d) if a Physician who knows about Your condition believes that lack of treatment will subject You to severe pain that You cannot adequately control.

You can also ask for a Fast Review if You got Emergency services and have not been released from the facility. A Fast Review is not available for Our denial of a waiver or an alternate standard for a wellness program.

Our Medical Director will review Your request for a Fast Review. If We decide to use the Standard Review time line, We will notify You within 72 hours after We get Your request. If Your Physician determines You need a Fast Review, We will do a Fast Review.

We will decide a Fast Review within 72 hours after We get the request. If We tell You Our decision by phone, We will also send it to You in writing within 3 calendar days.

(2) **Fast External Review**

You can ask for a Fast External Review if the standard time line for External Review would:

- (a) seriously risk Your life or health;
- (b) seriously risk Your ability to recover maximum function; or
- (c) if You have a disability, create an imminent and substantial limit on Your existing ability to live on Your own.

You can ask for a Fast External Review at the same time that You request a Fast Review.

C. **Review Procedure**

The Complaint Process includes:

- a First Level Review;
- an optional Second Level Review; and
- In some cases, an optional External Review.

You may request an External Review without completing Our internal review process if We do not follow law regarding internal or external review. In such case, You may also seek judicial relief under state or federal law. (See subsections 13.E and 13.F)

(1) **Filing a Complaint**

You must follow the Complaint Process below if You:

- do not agree with and want to appeal Our decision to deny all or part of a claim, reduce or terminate services, or to not provide or pay for services, including a denial of a Prior Authorization;
- were harmed when Care was provided and You think We are responsible for the adequacy or competency of the Care You got;

- claim We did not provide services or did not perform duties owed to You;
- do not agree with Our decision to Rescind a Member's enrollment under this Contract; or
- do not agree with Our denial of Your request for a waiver or alternate standard for a wellness program that offers a reward for meeting a health related standard.

Decisions that You may appeal include:

- if We deny, reduce, terminate, or fail to provide or make payment, in whole or in part, for Care resulting from any utilization review We apply;
- if We do not cover an item or service because We decided the item or service was experimental, investigational or not Medically Necessary or appropriate; and
- if We do not cover an item or service because we decided the item or service was not provided in the right setting or at the right level of care.

Complaints about the privacy of Your information under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") follow different steps described later in this section. Concerns about the quality of care You get from providers also follow different steps described later in this section.

You must submit Your complaint to Us in *writing* by mail, hand delivery, e-mail or fax to:

Address: RMHP
 Attention: Member Appeals
 2775 Crossroads Boulevard
 Grand Junction, Colorado 81506
 Fax: 970-244-7828
 Email: customer_service@rmhp.org

You may request a Fast Review by phone (970-243-7050 in Mesa County or 800-346-4643 toll-free).

We must get Your complaint within 180 days of the earliest of:

- the date We notify You of Our decision; or
- the denial of Benefits, or failure to provide services or perform duties owed to You; or
- the date on which You knew, or should have known, of the event giving rise to Your claim about the adequacy or competency of Care.

We will not review Your complaint if We do not get it by the deadline above.

- (2) **First Level Review:** Your complaint will be reviewed and the decision made by someone who was not involved in the initial decision. You may review Your appeal file as part of the First Level Review appeal. You will have the chance to give testimony and give Us written comments, documents, records, and other evidence to consider.

If Your complaint is about one of the items listed below, a medical professional will decide the outcome:

- Medical Necessity of a treatment or service;
- if a treatment or service is experimental or investigational;
- if a treatment or service is not provided in the right setting or at the right level of care; or
- there is a reasonable medical basis that an Exclusion does not apply to the treatment or service You requested. If You claim that an Exclusion does not apply, You must give Us evidence from a medical professional to support a reasonable medical basis for Your claim.

The decision will be made only after the medical professional consults with someone in the same or similar specialty typically needed to manage Your case.

We will notify You of Our decision within 30 days of receiving Your request, unless the Fast Review time line applies. We will give notice of the decision to any providers You designated.

Our decision will be final and binding unless:

- (a) We get a timely request for:
- a Second Level Review;
 - an External Review (if available to You);
 - arbitration (if ERISA does not apply to Your claim for Benefits); or
- (b) You timely assert a claim in court under section 502(a) of ERISA; or
- (c) You seek de novo review by a court of a claim for benefits that We denied in whole or in part.

- (3) **Second Level Review:** If You do not agree with the First Level Review decision, You may request a Second Level review. The Second Level Review is optional.

You must ask for a Second Level Review in writing by mail, hand delivery, e-mail or fax at the addresses shown above. The request must be made within 30 days after We give You notice of the First Level Review decision. You may review Your appeal file as part of the Second Level Review.

An internal review committee will hold a Second Level Review hearing within 60 days after We get the request. The committee will include at least 3 people. The internal review committee will not include anyone who was involved in the initial decision. We will notify You of the date of the review at least 20 days before it is scheduled. If You ask that We delay the Second Level Review hearing, We will not unreasonably deny Your request.

The review committee will be made up of medical professionals with expertise related to the complaint if Your complaint is about:

- the Medical Necessity of a treatment or service;
- if a treatment or service is experimental or investigational;
- if a treatment or service is not provided in the right setting or at the right level of care; or
- if there is a reasonable medical basis that an Exclusion does not apply to the treatment or service You requested. If You claim that an Exclusion does not apply, You must give Us evidence from a medical professional to support a reasonable medical basis for Your claim.

No review committee member will have a direct financial interest in the appeal or its outcome. A medical professional who was involved in the initial decision or appeal will not evaluate or be consulted regarding the Second Level Review. A person who was previously involved with the initial decision or appeal may answer questions.

You and Your attorney, advocates, health care professionals and other witnesses may be at the Second Level Review hearing in person or by phone or by using other technology, if it is available and not unduly costly for Us to use.

At the Second Level Review hearing, You and Rocky Mountain will have the chance to:

- bring counsel, advocates and health care professionals;
- give testimony and materials to the review committee. (A copy of the materials must be given to each party at least 5 days in advance. If new information arises after the deadline, this material may be presented at the hearing, if feasible); and
- have an audio or visual recording made by Rocky Mountain. (If a recording is made, You may have a copy. If You appeal this decision, a copy will be sent to the External Review group, if You or We request it.)

The review committee will issue a written decision to You within 7 days after the Second Level Review hearing. The review committee will give notice of the decision to any providers You designated.

The Second Level decision will be final and binding unless:

- (a) We get a timely request for:
 - an External Review (if available to You); or
 - for arbitration (if ERISA does not apply to Your claim for Benefits); or
- (b) You timely assert a claim in court under section 502(a) of ERISA; or
- (c) You seek de novo review by a court of a claim for benefits that We denied in whole or in part.

(4) **External Review:**

You may ask Us in writing to submit the First Level Review or the Second Level Review decision to an External Review group if Your complaint is about:

- the Medical Necessity of a treatment or service;
- if a treatment or service is experimental or investigational;
- if a treatment or service is not provided in the right setting or at the right level of care; or
- if there is a reasonable medical basis that an Exclusion does not apply to a treatment or service.

You may also request an External Review or a Fast External Review of Our initial decision denying coverage of a recommended or requested service that is experimental or investigational. In such case, your treating Physician must tell Us in writing that the requested service would be less effective if not begun immediately and at least one of the following applies:

- standard health care services or treatments have not improved Your condition or are not medically appropriate for You; or
- there is no available standard health care service or treatment covered by Us that is more beneficial to You than the recommended or requested service, and the Physician is a board-certified or board-eligible Physician qualified to practice in the area of medicine appropriate to treat Your condition.

The Physician must also tell Us that scientifically valid studies support the requested service that is the subject of the denial is likely to be more beneficial to You than any available standard health care services or treatments.

There is no minimum dollar amount for a claim to be eligible for External Review or Fast External Review.

You can also ask Us for External Review if We deny Your request for a waiver or an alternate standard for a wellness plan. This External Review cannot be a Fast External Review.

You can also ask Us for External Review if We fail to follow the review process required by law.

Complaints or appeals that do not involve these types of decisions may not be submitted to External Review.

If You ask Us to submit a First Level Review decision to External Review, there will not be a Second Level Review.

You must ask in writing that the External Review be either a Standard Review or a Fast External Review, by mail, hand delivery, e-mail or fax to one of the addresses above within four months from the date You get the First Level Review decision or notice of exhaustion of First Level Review or Second Level Review decision.

If the deadline falls on a weekend or holiday, You will have until the next business day to request an External Review. We will consider Your receipt to be not less than 3 business days after We postmark the notice. Requests for a Fast External Review must include a certification from a Physician that Your condition meets the criteria for a Fast External Review, as explained above. You can ask for a Fast External Review at the same time You request a Fast Review.

You can include new information with Your request if that information is significantly different from the information in Your appeal file. We will tell You if We change Our decision based on the new information within 1 business day of Our decision by email, phone, or fax. We will also tell You by mail.

If We deny Your request for External Review or Fast External Review, We tell You why and how You can appeal to the Colorado Division of Insurance (DOI). We will also send a copy of the denial to the DOI.

If We do not deny Your request for External Review, We will send it to the DOI within 2 business days after We get it. If We change Our decision before then, We will tell You within 1 business day by email, phone, or fax. We will also tell You by mail. If We change Our decision after We send Your request to the DOI, We will tell You, the DOI and the External Review group within 1 business day of the changed decision by email, phone, or fax. We will also tell You by mail.

If We do not deny Your request for Fast External Review, We will send it to the DOI within 1 business day after We get it.

The External Review or the Fast External Review will be done by a group selected by the DOI and will follow the law. We will tell You the External Review group selected by the DOI within 1 business day after the DOI tells Us. Within 2 business days, You must tell the DOI of any possible conflict of interest with the External Review group. We will give the External Review

group Your appeal file within 5 business days after We are told of the External Review group (immediately if it is a Fast External Review). If You ask Us, We will give You all relevant information supplied to the External Review group that is not confidential or privileged.

If it is not a Fast External Review, You may submit additional information up to 5 business days after You receive notice of the External Review group. The External Review group may, but is not required to, consider additional information that You provide after the 5 day period. If We change Our decision based on the new information, We will tell You, the External Review group and the DOI within 1 business day of Our decision by email, phone, or fax. We will also tell You by mail.

We will pay the cost of the External Review or the Fast External Review.

The External Review group will give its decision in writing within 45 calendar days after it received the request for External Review. In the case of a Fast External Review, the External Review group will give its decision as soon as possible, but no later than 72 hours after it received the request for Fast External Review. If notice of the Fast External Review decision is not written, the External Review group will provide a written confirmation within 48 hours after notice is given to You, the Physician or other health care professional.

If the External Review group decides a retrospective request for Benefits in Your favor, We will approve Your request for Benefits or for a waiver or alternate standard within 5 business days. For a concurrent or prospective request for Benefits, We will approve Your request for Benefits or for a waiver or alternate standard within 1 business day after the External Review group decides in Your favor. We will notify You within 1 business day of Our approval. The decision of the External Review group will be final and binding unless:

- either You or Rocky Mountain appeal the decision by timely submitting the decision to arbitration (if ERISA does not apply to Your claim for Benefits); or
- You timely assert a claim in court under section 502(a) of ERISA.

D. Arbitration

- (1) You may submit any review decision, except ERISA claims, to arbitration. We may submit an External Review decision to arbitration.

Any request for arbitration must be made within 30 days of the decision. Requests must be made by personal service of a demand for arbitration on the other party, or by giving notice of the demand for arbitration to the other party using certified mail, return receipt requested addressed as required by subsection 11.G.

If You request arbitration of a First Level Review decision, You may not request a Second Level Review.

Except for ERISA claims, all claims that You may assert against Us are subject to arbitration. Arbitration will be governed by the Colorado Uniform Arbitration Act (Act), except as stated in this Contract. Consolidation of arbitration proceedings and/or class action arbitrations are not allowed under this Contract.

- (2) The arbitration will be decided by one or more arbitrators.
 - (a) If We decide that the amount at issue is less than \$100,000.00, the arbitration will be held before a neutral person selected by You and Rocky Mountain. If You and Rocky Mountain are unable to agree to a neutral person, the arbitrator will be selected using the rules in the Act.
 - (b) If We decide that the amount at issue is \$100,000.00 or more, the arbitration will be held before 3 arbitrators. One will be selected by Us, one will be selected by You, and the third will be a neutral person selected by the first two arbitrators. If the two arbitrators are unable to agree on a third neutral person, the third person will be selected using the rules in the Act.
 - (c) The arbitrator or arbitrators will be called the “Panel”.
- (3) If We decide that the amount at issue is more than \$200,000.00, the parties may take pre-hearing depositions. Such depositions are limited to a maximum of 3 per party, of no more than 6 hours’ time each. If We decide that the amount at issue is less than \$200,000.00, no depositions are allowed.
- (4) The Panel will hold a scheduling conference which will be attended by the parties.
- (5) The Panel will issue an “arbitration case management order” which will be consistent with Colorado Rule of Civil Procedure (CRCP) 26, or as otherwise agreed on by the Panel and the parties. Unless otherwise agreed upon, each party must:
 - make the disclosures required by Colorado Rule of Civil Procedure (CRCP) 26(a)(1) within 10 days after a date is selected for the arbitration hearing; and
 - disclose expert testimony as required by CRCP 26(a)(2)(A) and 26(a)(2)(B) at least 10 days before the date of the hearing.
- (6) The arbitration will be held in Mesa County, Colorado, or in the county where You reside, if in Colorado. If the parties are unable to agree on the venue, the Panel will decide if the arbitration will be held in Mesa County or in the

Colorado county where You reside. If You reside outside of Colorado, the venue for the arbitration will be only in Mesa County, Colorado.

- (7) The Panel will follow Colorado law in making an award. The Panel will issue written findings of fact and conclusions of law.
- (8) We will pay the Panel's fees and costs. You must pay for Your costs, including travel, food, lodging and other costs for You. You must also pay for the fees and costs for Your attorney and witnesses, if any, unless Colorado law allows for, and the Panel awards You, attorneys' fees and costs.

The decision or award of the Panel will be final and binding upon the parties to the same extent as if the matter had been decided by a court, except as provided in subsection 13.E. The party in whose favor any award will be made may file the award with the Clerk of the Mesa County, Colorado District Court or the clerk of the district court in the county in which the arbitration is held, which may enter judgment. If the award requires payment of money, the clerk may issue execution on the judgment.

E. De Novo Review

After You have exhausted Your remedies under this Contract, not including arbitration, You have the right to have a de novo review by any court with jurisdiction of a claim for Benefits that We denied in whole or in part, except for ERISA claims. You also have the right to a trial by a jury for that review. All other kinds of complaints subject to section 13 are not subject to de novo review or trial by jury.

You can file a claim for Benefits in court if We fail to follow the review process required by law unless Our failure:

- is a minimal error;
- does not, and is not likely to, harm or prejudice You;
- was for good cause or was beyond Our control;
- happened while We were exchanging information with You in good faith; and
- is not part of a pattern or practice of violations by Us.

F. ERISA Claims

Claims under section 502(a) of ERISA are not subject to arbitration, if ERISA applies to Your claim for Benefits. However, You must arbitrate any other claims against Us that are not claims under section 502(a) of ERISA. (See subsection 13.N. for a description of ERISA.)

If ERISA applies to Your claim, You can file an ERISA section 502(a) claim in court if We fail to follow the review process required by law unless Our failure:

- is a minimal error;

- does not, and is not likely to, harm or prejudice You;
- was for good cause or was beyond Our control;
- happened while We were exchanging information with You in good faith; and
- is not part of a pattern or practice of violations by Us.

G. Jurisdiction and Venue

No court will have subject matter jurisdiction of any disagreement or complaint referred to in this section 13. This includes any disagreements, disputes or claims that are or may be the subject of a class action, other than as expressly stated in this section 13. The Complaint Process is the exclusive and mandatory dispute resolution procedure under this Contract. In the event any disagreement or dispute, other than de novo review, is attempted to be resolved in any court, the venue of the matter will only be in Mesa County, Colorado. This section 13 will not apply to claims by Us for amounts You may owe to Us.

H. Time is of the Essence

All time periods to take or request action provided or required under this section will be strictly construed and will be of the essence of this Contract.

I. Contact the Insurance Commissioner

You have the right to call or write the DOI about any complaint, dispute or disagreement at any time at:

Colorado Division of Insurance
 Department of Regulatory Affairs
 1560 Broadway, Suite 850
 Denver, CO 80202
 800-930-3745

J. HIPAA Privacy Complaints

If You have a complaint controlled by Our HIPAA Notice of Privacy Practices, or about Our or any of Our Network Provider’s privacy practices under HIPAA, You must send the HIPAA complaint in writing by mail, hand delivery or fax to:

RMHP
 Attention: Privacy Complaint
 2775 Crossroads Boulevard
 Grand Junction, Colorado 81506
 Fax: 970-244-7880

We will investigate the complaint. We will respond in writing within 30 calendar days after We get Your complaint. You will not be entitled to any further review of this complaint after We respond to You. You may make a complaint to the Office of

Civil Rights of the United States Department of Health and Human Services at any time.

K. Quality of Care Concerns

If You tell Us of a concern about the quality of Care You got from a provider, Our Quality Improvement Department may investigate Your concern. The matter may be referred to a medical practice review committee. The records of such committees are confidential under Colorado law.

L. Release of Records

By submitting a complaint, You authorize Us to obtain and review all necessary medical records, similar documents and information related to the complaint. You also authorize Us to release the necessary medical records, similar documents and information to the internal review committee and to the External Review group.

M. Changes to the Complaint Process

We reserve the right to change the Complaint Process at any time by amending this Contract, according to the terms of this Contract.

N. ERISA

Members of some types of Group Benefit Plans have certain rights and protections under ERISA (Participants). This section applies to You only if You are a Participant.

If You have any questions about the Group Benefit Plan, call or write the Employer Entity or the Group Benefit Plan administrator (Plan Administrator). If You have questions about this statement or about rights under ERISA, call or write the office of the U.S. Labor-Management Services Administration, Department of Labor. In no event will We be considered a Plan Administrator.

Section 502(a) of ERISA requires that ERISA-type Policies follow certain steps when processing claims for Benefits. Our Complaint Process meets these federal rules. If We deny either part, or all, of a claim for Benefits, We will tell You in writing. The notice will explain the reason for the denial. You have the right to have the claim reviewed and reconsidered.

You agree that We may make reasonable decisions in applying this Contract. This includes, but is not limited to:

- decisions about eligibility;
- the amount and payment of Benefits; and
- whether services, Care, treatment or supplies are Medically Necessary.

These decisions will be binding and conclusive. We do not reserve discretion as a Group Benefit Plan or as a claim administrator to interpret the terms of this Contract

or to determine eligibility for Benefits when not allowed by Colorado law (unless that law is pre-empted by ERISA).

There are steps that You can take to put Your ERISA rights into effect. For example, if You ask the Plan Administrator for materials and do not get them within 30 days, You may file suit in federal court. However, if We are determined to be the Plan Administrator, then You must follow the Complaint Process in section 13. The Plan Administrator may need to give You the materials and pay You up to \$110 per day until You get the materials. This does not apply if the materials were not sent for reasons outside the Plan Administrator's control.

If We deny or ignore either part or all of Your claim for Benefits, You may appeal by following the Complaint Process in section 13. If Group Benefit Plan fiduciaries misuse the Group Benefit Plan's money or discriminate against You for asserting Your rights, You may ask for help from the U.S. Department of Labor. You may also file suit in a federal court unless a remedy is sought from Us. If a remedy is sought from Us, You must follow the Complaint Process in section 13. A court will decide who should pay the court costs and legal fees. If You are successful, the court may order the person sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees (for example, if a court finds Your claim has no legal merit).

If You have any questions about Your rights under ERISA, You may contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor or visit www.dol.gov/ebsa. The number is listed in the telephone book or on the website. You could also contact:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration, U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

14. INFORMATION ON POLICY AND RATE CHANGES

A. Amendment

We may change this Contract as allowed by law:

- (1) At any time to comply with state or federal law, statutes or regulations;
- (2) On the Renewal Date, to change any terms of the Contract, which may include increasing, reducing or eliminating Benefits; or
- (3) With 30 days' notice to change any terms of the Contract which do not increase, reduce or eliminate Benefits, except that a material change will require 60 days' notice.

Notice of changes will be given to Your Contracting Group in writing. Any change to this Contract which changes the terms of coverage or Benefits will apply to all Members. This includes Members who got Benefits that are no longer provided.

B. Premium Changes

We set Premiums as stated in the GSA. Premiums may change as allowed in the GSA.

15. DEFINITIONS

A. Definitions

The words used in this Contract will have their usual meanings, except for the words defined below that are capitalized in this Contract.

- (1) “Accident Supplement” means the document that lists the Care, Cost Sharing, Limitations and Exclusions for accidents. (If included with this Contract)
- (2) “Adoption” means the earlier of a placement for adoption or the adoption itself.
- (3) “Affordable Care Act” or “ACA” means the final, amended version of the comprehensive health care reform law enacted in March 2010, commonly known as the Patient Protection and Affordable Care Act.
- (4) “Allowable Expense” for purposes of section 7 only, means a health care expense, including deductibles, coinsurance and copays, that is covered at least in part by any of the Plans. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an Allowable Expense. Also, any expense that a provider by law or contract cannot charge You is not an Allowable Expense. The following are examples that are not Allowable Expenses:
 - The difference between the cost of a semi-private Hospital room and a private room is not an Allowable Expense. An exception is when one of the Plans routinely provides coverage for private Hospital rooms.
 - If You are covered by 2 or more Plans that base their benefit payments on the basis of usual and customary fees, or relative value reimbursement or other similar reimbursement method, any amount over the highest of the reimbursement amount for a specific benefit is not an Allowable Expense.
 - If You are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, any amount over of the highest of the negotiated fees is not an Allowable Expense.
 - If You are covered by one Plan that bases its benefits or services on the basis of usual and customary fees or relative value reimbursement

or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangements will be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a negotiated amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated payment will be the Allowable Expense used by the Secondary Plan to determine its benefits.

- The amount a benefit may be reduced by the Primary Plan because You do not comply with Plan provisions is not an Allowable Expense. Examples are second surgical opinions and pre-certification of admissions.
- If You tell Us that all Policies covering You are high deductible health plans ("HDHPs") and You intend to contribute to a health savings account, the primary HDHP's deductible is not an Allowable Expense. This does not apply to any expense that is not subject to the HDHP's deductible, for example, preventive services.

- (5) "Allowed Charges" means charges for services allowed by Our agreement with the Network Providers or an amount determined under a fee schedule used by Us in a part of Our Service Area. Allowed Charges are not reduced by amounts withheld by Us from payments for Care provided by Network Providers or due to any other provider incentive plan, or by any rebates We may get.
- (6) "Applied Behavior Analysis" or "ABA" means the use of behavior analytic methods and research findings to change socially important behaviors.
- (7) "Autism Services Provider" means any person who provides direct services to a person with Autism Spectrum Disorder. The person giving services must be licensed, certified, or registered by the state licensing board or by a nationally recognized group, and meet one of the following:
- (a) has a doctoral degree with a specialty in psychiatry, medicine, or clinical psychology, is actively licensed by the state board of medical examiners, and has one year of direct experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with ASD;
 - (b) has a doctoral degree in one of the behavioral or health sciences and has completed one year of experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with ASD;
 - (c) has a master's degree or higher in behavioral sciences and is nationally certified as a "Board Certified Behavior Analyst" or certified by a similar nationally recognized group;
 - (d) has a master's degree or higher in one of the behavioral or health sciences, is credentialed as a Related Services Provider and has completed one year of direct supervised experience in behavioral

- therapies that are consistent with best practice and research on effectiveness for people with ASD. For the purpose of this subparagraph (d), “Related Services Provider” means a physical therapist, occupational therapist, or speech therapist;
- (e) has a baccalaureate degree or higher in behavioral sciences and is nationally certified as a “Board Certified Associate Behavior Analyst” by the behavior analyst certification board or certified by a similar nationally recognized group; or
- (f) is nationally registered as a “Registered Behavior Technician” by the behavior analyst certification board or by a similar nationally recognized group and provides direct services to a person with ASD under the supervision of an autism services provider described in (a), (b), (c), (d), or (e).
- (8) “Autism Spectrum Disorders” or “ASD” has the same meaning as in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time of the diagnosis. It includes the following:
- autistic disorder;
 - Asperger’s disorder; and
 - atypical autism as a diagnosis within pervasive developmental disorder not otherwise specified.
- (9) “Benefits” means Hospital, medical and other services or supplies Members are entitled to under this Contract.
- (10) “Biologically-Based Mental Illness” means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive compulsive disorder and panic disorder.
- (11) “Calendar Year” means the dates from January 1 to December 31 of any year.
- (12) “Care” means the same as the term “Benefits.”
- (13) “Children’s Basic Health Plan” or “CHP+” means the health insurance plan designed by the Colorado Department of Health Care Policy and Financing.
- (14) “Civil Union” means a relationship between two eligible persons pursuant to the laws of the State of Colorado that entitles them to receive the benefits and protections and be subject to the responsibilities of spouses.
- (15) “Claim Period”, for purposes of section 7 only, is usually a Calendar Year, but a Plan may use some other period that fits the coverage of its Policy. You are covered by a Plan during a part of a Claim Period if Your coverage starts or ends during the Claim Period. Claim Period does not include any part of a year that You did not have coverage under this Contract, or before the date a COB provision, or a similar provision takes effect.

- (16) “Clean Claim” means a claim for payment for Benefits that is submitted to Us on the uniform claim form with all required fields completed with correct and complete information, including required documents. Clean Claim does not include a claim for payment of expenses incurred when Premiums are delinquent, except as required by law.
- (17) “Clinical Trial” means an experiment in which a drug or device is administered to, given to or used by one or more people. An experiment may include the use of a combination of drugs as well as the use of a drug with an alternative therapy or dietary supplement.
- (18) “Closed Panel Plan”, for purposes of section 7 only, means a Plan that provides health benefits primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- (19) “COBRA” means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985.
- (20) “Colorado Continuation of Coverage” or “CCOC” means continuation of coverage requirements of Colorado law applicable to health maintenance organizations.
- (21) “Complaint Process” means the process to resolve Your questions, concerns or complaints under this Contract.
- (22) “Complications of Pregnancy” means:
- Conditions (when the pregnancy is not terminated) whose diagnoses are separate from pregnancy but are negatively affected or caused by pregnancy, including:
 - acute nephritis;
 - nephrosis;
 - cardiac decompensation;
 - missed abortion; and
 - similar medical and surgical conditions of comparable severity.
- Conditions not within the definition of Complications of Pregnancy include:
- false labor;
 - occasional spotting;
 - Physician-prescribed rest during the period of pregnancy;
 - morning sickness;
 - hyperemesis gravidarum;
 - preeclampsia; and

- similar conditions associated with the management of a difficult pregnancy not rising to the level of a classifiable, distinct complication of pregnancy.
 - Non-elective c-section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs at a point during the pregnancy in which a viable birth is not possible.
- (23) “Concurrent Care Claim” means any decision in which We, after having previously approved an ongoing course of Care provided over a period of time or a specific number of treatments, either:
- now seek to reduce or terminate the course of treatment (other than by plan amendment or termination) or to reduce the specific number of treatments, or
 - You request an extension of such course of Care, or to increase the specific number of treatments, subsequent to the initial approval of the original course of Care, or specific number of treatments.
- (24) “Contract” means this document and the following, if included with this Contract:
- amendments;
 - Coverage Schedule;
 - Accident Supplement;
 - Prescription Drug Supplement;
 - the enrollment application form;
 - the Member ID Card; and
 - attachments, if any.
- (25) “Contracting Group” means the group or Employer Entity that has executed a GSA with Us to have Us provide Benefits under this Contract.
- (26) “Copay” means the amount or percentage of Allowed Charges to be paid by the Subscriber for Members for a Benefit, as described in the Coverage Schedule.
- (27) “Cost Sharing” means Copays and Deductibles.
- (28) “Coverage Schedule” means the document that lists the Cost Sharing, Limitations, Maximum Benefit Levels and Yearly Out-of-Pocket Maximums for a Policy offered by Us.
- (29) “Covered Benefits” means those services and supplies listed in subsection 7.B of this Contract.
- (30) “Covered Employee” means a person who is covered under this Contract through their current or former employment.

- (31) “Creditable Coverage” or “CC” means benefits or coverage provided under:
- Medicare, Medicaid or CHP+;
 - an employee welfare benefit plan or group health insurance or health benefit plan;
 - an individual health benefit plan;
 - a state health benefits risk pool (including CoverColorado); or
 - Chapter 55 of Title 10, United States Code,
 - a medical care program of the federal Indian Health Service or of a tribal group,
 - a health plan offered under Chapter 89 of Title 5, United States Code,
 - a public health plan, or
 - a health benefit plan under section 5(e) of the federal “Peace Corps Act” (22 U.S.C. § 2504(e)).

- (32) “Custodial Care” means services to help a person with daily living activities. This includes help with:

- walking;
- getting in and out of bed;
- bathing;
- dressing;
- feeding;
- using the toilet;
- preparing special diets; and
- taking medicine.

Custodial Care is personal care that does not require trained health care personnel. We will look at the level of services and help needed and provided to decide if it is Custodial Care. We do not consider the diagnosis, medical condition, a person’s physical limits or whether a person may overcome physical limits with therapy when making the decision. Custodial Care services may be provided in a facility or at home.

- (33) “Custodial Parent”, for purposes of section 7 only, means a parent awarded custody by a court order. If there is no court order, it is the parent the child lives with for more than one-half of the Calendar Year, not counting temporary visitation.

- (34) “Deductible” means the amount paid by a Member for most Allowed Charges before the Member is entitled to Benefits, as described in the Coverage Schedule.

- (35) “Dependent” means a Dependent Spouse or Dependent Child unless the GSA provides a different meaning. A DB or a Domestic Partner may also be a Dependent if:

- he or she meets the General Eligibility Rules;

- he or she meets the eligibility rules of the GSA; and
- the Contracting Group elects to cover them.

(36) “Dependent Child” means anyone who is:

- a natural born or adopted child of the Subscriber, Dependent Spouse, Domestic Partner or DB. The child will be “adopted” when the state or an adoption agency places the child for adoption with Subscriber, Dependent Spouse, Domestic Partner or DB. The Subscriber, Dependent Spouse, Domestic Partner or DB assumes a legal duty to support the child in hope of the child’s adoption. A placement ends at the time the legal duty ends;
- under the legal guardianship of the Subscriber and in a parent-child relationship with the Subscriber; or
- placed in foster care with the Subscriber, Dependent Spouse, Domestic Partner or DB. “Placed in foster care” means placement in foster care by an authorized agency or court with jurisdiction.

For purposes of this definition, the child of a Domestic Partner or DB will only be a Dependent if the Domestic Partner or DB is a Dependent.

(37) “Dependent Spouse” means a person who is the:

- spouse of the Subscriber in a marriage recognized by the State of Colorado; or
- Partner in a Civil Union with the Subscriber.

The person cannot be legally separated or divorced from the Subscriber. A Dependent Spouse must meet all of the General Eligibility Rules.

(38) “Designated Beneficiary” or “DB” means a person who has entered into a DBA. A DB is not a Domestic Partner or a Partner in a Civil Union.

(39) “Designated Beneficiary Agreement” or “DBA” means an agreement that is entered into pursuant to Colorado law by the Subscriber and another person for the purpose of designating each person as the beneficiary of the other person and for the purpose of ensuring that each person has certain rights and financial protections based upon the designation.

(40) “Designated Representative” means a person, including a health care professional who is treating You and is chosen by You in writing to represent You in a dispute under this Contract. It also includes other persons who can act for You or give consent on Your behalf under the law. If a dispute is under a Fast Review time line, a health care professional who knows about Your health condition will be assumed to act as Your Designated Representative.

(41) “Disposable Medical Supplies” means medical supplies (such as syringes, wound Care supplies, and catheters) needed to treat an Injury or Sickness.

- (42) “Double Coverage” means You can get Benefits under this Contract and also have coverage under another Policy for the same services.
- (43) “Durable Medical Equipment” or “DME” means equipment that can withstand repeated use and is needed for medical reasons because of Injury or Sickness, or because You are disabled. DME includes wheelchairs, Hospital beds and traction equipment.
- (44) “Early Intervention Services” means those services available under Part C of the federal “Individuals with Disabilities Education Act” (20 U.S.C. § 1400, et seq.)
- (45) “Effective Date” means the date the Benefits begin under this Contract.
- (46) “Eligible Employee” means a full time employee in a bona fide employer-employee relationship with an Employer Entity. The term does not include:
- An employee who works on a temporary or substitute basis;
 - A person and his or her Dependent Spouse as to a trade or business, incorporated or unincorporated, that is wholly owned by the person or by the person and his or her Dependent Spouse. A sole owner of a trade or business and the owner's Dependent Spouse may participate in a group plan established to cover one or more Eligible Employees of the trade or business who are not owners; or
 - A partner in a partnership and his or her Dependent Spouse as to the partnership. However, a partner and Dependent Spouse may participate in a group plan established to cover one or more Eligible Employees of the partnership who are not partners.

An eligible employee of a Small Employer who could also be considered a dependent of the Small Employer must receive taxable income from the Small Employer in an amount equal to minimum wage for working full-time on a permanent basis to be considered an employee of the Small Employer.

- (47) “Emergency” means an event that a prudent lay person would believe threatens his or her life or limb in a way that immediate health care services are needed to prevent death or serious impairment of health.
- (48) “Emergency Care” is Care due to an Emergency.
- (49) “Emergency Contraception” means an FDA-approved drug that prevents pregnancy after sexual intercourse. Emergency Contraception does not include abortifacient drugs.
- (50) “Employer Entity” means an employer that has executed a GSA with Us to have Us provide Benefits under this Contract.
- (51) “Episode” means a specific event that caused the need for speech, physical or occupational therapy. You may have and be covered for more than one

Episode for the same health condition when a new event or accident causes a change in therapy or a new course of treatment.

- (52) “ERISA” means the Employee Retirement Income Security Act of 1974, as amended.
- (53) “Evidence of Coverage” or “EOC” means the same as “Contract.”
- (54) “Exclusion” means care that is not covered under this Contract.
- (55) “External Review” means review of a First Level Review or Second Level Review decision by an independent group. (See section 13.)
- (56) “Fast External Review” means an External Review which is done within 72 hours of Our receiving Your completed request. (See section 13.)
- (57) “Fast Review” means a First Level Review which is done within 72 hours of Our receiving Your completed request. (See section 13.)
- (58) “First Level Review” means either a Standard Review or a Fast Review of Our initial decision. (See section 13.)
- (59) “Fraud” means a statement, act or omission that amounts to fraud or intentional misrepresentation of material fact.
- (60) “Group” means individuals who are eligible to enroll in a Policy offered by Us through a Contracting Group or Employer Entity.
- (61) “Group Benefit Plan” means the same as the term “Group Benefits Plan” as used in ERISA.
- (62) “Group Service Agreement” or “GSA” means the document used to detail the Policy(s), Premiums, eligibility and Benefits covered by this Contract, and which is signed by the Contracting Group.
- (63) “Health Plan Guide” means a document We provide that assists You in the use of this Contract.
- (64) “Home Health Agency” means an agency which:
- has been certified by the Colorado Department of Public Health and Environment as meeting the provisions of Title XVIII of the Federal “Social Security Act,” as amended, for home health agencies; and
 - arranges and provides nursing services, home health aide services and other therapeutic and related services.
- (65) “Home Health Care Plan” means a program of home care that:
- (a) is needed as the result of a Sickness or Injury; and

- (b) is certified by the Your Physician as a replacement for Hospital confinement that would otherwise be needed.
- (66) “Home Health Services” means skilled nursing services and related Care provided in Your home under Your Physician’s order.
- (67) “Hospice” means a provider that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people.
- (68) “Hospice Care Program” means a program that:
- is managed by a Network Hospice; and
 - set up by a Network Hospice, Hospice Care Team, and a Network Physician to meet the special physical, psychological, and spiritual needs of dying Members and their Immediate Family.
- (69) “Hospice Care Team” means:
- a Network Physician;
 - a patient Care coordinator (Network Physician or nurse who serves as go between for the Hospice Care Program and the Network Physician);
 - a nurse;
 - a mental health specialist;
 - a social worker;
 - a chaplain; and
 - lay volunteers.
- (70) “Hospital” means an inpatient acute care facility (not including any nursing or rest home, intermediate care facility, rehab facility or Skilled Nursing Facility) licensed or certified as a hospital which:
- (a) is primarily engaged in providing facilities for surgery and medical diagnosis and treatment of injured or ill persons under the supervision of Physicians;
- (b) is accredited by the Joint Commission on Accreditation of Healthcare Organizations or certified by Medicare; and
- (c) is recognized as a hospital by the American Hospital Association or the American Osteopathic Association.

A facility providing residential treatment services, whether as a stand-alone facility or as a part of a larger facility, will not be considered a Hospital.

- (71) “HRSA” means the Health Resources and Services Administration.
- (72) “Immediate Family” means Your mother, father, sister, brother, spouse, Partner in a Civil Union, Domestic Partner, DB and child.

- (73) “Inherited Enzymatic Disorder” means a disorder caused by single gene defects involved in the metabolism of amino, organic and fatty acids, including treatment for the following diagnosed conditions:
- phenylketonuria (PKU);
 - maternal PKU;
 - maple syrup urine disease;
 - tyrosinemia;
 - homocystinuria;
 - histidinemia;
 - urea cycle disorders;
 - hyperlysinemia;
 - glutaric acidemias;
 - methylmalonic acidemia; and
 - propionic acidemia.
- (74) “Injury” means accidental bodily harm.
- (75) “Intractable Pain” means pain for which the cause of pain cannot be removed, and:
- which in the generally accepted course of medical practice no relief or cure for the cause of the pain is possible; or
 - no relief or cure of the cause of the pain has been found after reasonable efforts, including evaluation by the attending Physician and one or more Physicians specializing in the treatment of the area, system or organ of the body thought to be the source of the pain.
- (76) “Limitation” means a restriction on a Benefit.
- (77) “Maximum Benefit Level” means limits on the amount of coverage We will provide for a Benefit.
- (78) “Medicaid” means the state-administered health insurance program for people with limited income.
- (79) “Medical Director” means the person employed or contracted by Us as a Medical Director or persons designated to act for him or her.
- (80) “Medical Foods” means prescription metabolic formulas and their modular counterparts, which:
- You get through a pharmacy;
 - are specifically designated and manufactured for the treatment of Inherited Enzymatic Disorders; and
 - have medically standard methods of diagnosis, treatment and monitoring.

These formulas are specifically processed or formulated to be deficient in one or more nutrients. They are to be taken or administered enterally either via tube or oral route under the direction of a Physician.

- (81) “Medically Necessary” means services or supplies required to preserve Your health according to the standards of medical practice in the Service Area, and are not given only as a convenience. A service or supply recommended, ordered or approved by a Network Provider or any other provider may not be Medically Necessary. If there is not agreement on the standards of medical practice used to decide if particular services or supplies are Medically Necessary, the Medical Director will decide which standards apply.
- (82) “Medicare” means the federal health insurance program for people age 65 or older, certain disabled people, and people with end stage renal disease.
- (83) “Member” means a person whose request to enroll has been accepted by Us, and who is entitled to Benefits under this Contract.
- (84) “Member ID Card” means the card issued by Us which gives basic information about eligibility and Benefits and identifies You as a Member.
- (85) “Mental Disorders” means:
- post-traumatic stress disorder;
 - drug and alcohol disorders;
 - dysthymia;
 - cyclothymia;
 - social phobia;
 - agoraphobia with panic disorder;
 - general anxiety disorder;
 - anorexia nervosa and bulimia nervosa; and
 - Autism Spectrum Disorders.
- (86) “Myofunctional Therapy” means muscle or other training to correct or control bad or harmful habits.
- (87) “National Network” means the program available under some of Our Policies which provides access to a network of providers outside the State of Colorado.
- (88) “Network Home Health Agency” means a Home Health Agency that is a Network Provider.
- (89) “Network Hospice” means a Hospice that is a Network Provider.
- (90) “Network Hospital” means a Hospital that is a Network Provider.
- (91) “Network Physician” means a Physician who is a Network Provider.

- (92) “Network Provider” means any physician, dentist, optometrist, anesthesiologist, hospital, x-ray, laboratory and ambulance service, or other person who:
- is licensed or authorized in Colorado to provide health care services;
 - has a written agreement with Us or a contractor or subcontractor;
 - agrees to provide Care to Members as described in the written agreement; and
 - has been approved by Us to provide Care under this Contract.
- (93) “Network SNF” means a SNF that is a Network Provider.
- (94) “Network Specialist” means any Network Physician who is selected by Us to provide specialty Care for Members according to the Primary Care Procedures.
- (95) “Neuromusculoskeletal Disorders” means:
- misalignments of the skeletal structure;
 - muscular weakness;
 - osteopathic imbalances; and
 - disorders related to the spinal cord, neck and joints.
- (96) “Non-Network Provider” means any physician, dentist, optometrist, anesthesiologist, hospital, x-ray, laboratory and ambulance service, or other person who:
- is licensed or authorized to provide health care services; and
 - does not have a written agreement with Us or a contractor or subcontractor to provide Care under this Contract.
- (97) “Our” means Rocky Mountain Health Maintenance Organization, Inc.
- (98) “Partner in a Civil Union” means a person who has established a Civil Union under laws of the State of Colorado. A Partner in a Civil Union is not a Domestic Partner or a DB.
- (99) “Physician” means a person who holds a degree of Doctor of Medicine or Doctor of Osteopathy, is licensed to practice medicine and provides services as a PCP or specialist.
- (100) “Plan”, for purposes of section 7 only, is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
- “Plan” includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of

group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or other federal governmental plans, as permitted by law.

- “Plan” does not include hospital indemnity or other fixed indemnity coverage, accident only coverage; specified disease or accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies; Medicaid policies and coverage under other governmental plans, unless permitted by law.

Each contract for coverage under the bullets above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

- (101) “Policy” means any arrangement, including health care insurance, for the payment or reimbursement of health care services to You, whether offered by an employer, group or organization, or arranged directly by You. A Policy may include coverage arranged, required or provided under state or federal law.
- (102) “Post-Service Claim” means any claim other than a Concurrent Claim or Pre-Service Claim, including a claim for reimbursement for unreimbursed health care expenses and that involves payment or reimbursement for a benefit that has already been provided.
- (103) “Premium” means all monies paid, including any fees or other contributions, by a Contracting Group or Subscriber as a condition of Our agreement to provide Benefits during the Premium Period under this Contract.
- (104) “Premium Period” means the calendar month or the 28 to 31 day period for which the Premium has been paid.
- (105) “Prescription Drug Supplement” means the document that describes the Benefits, Cost Sharing, Limitations and Exclusions for outpatient prescription drugs.
- (106) “Pre-Service Claim” means any claim for a benefit that must be approved in advance of receiving Care (for example, requests to pre-certify a hospital stay or for pre-approval under a utilization review program).
- (107) “Primary Care Physician” or “PCP” means any Network Physician who is designated by Us or by the Member, subject to Our policies and procedures.
- (108) “Primary Care Procedures” means the rules a Member must follow when obtaining Care under this Contract.

- (109) “Primary Plan/Secondary Plan”, for purposes of section 7 only, refers to the order of benefit determination rules which determine whether this Contract is a “Primary Plan” or “Secondary Plan” when compared to another Plan covering the person.

When this Contract is the Primary Plan, its benefits are determined before those of any other Plan and without considering any other Plan’s benefits. When this Contract is the Secondary Plan, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan’s benefits.

- (110) “Prior Authorization” or “Prior Authorized” means written approval for Your Care issued by Us or Our designee before You get the Care.

- (111) “Prior Coverage” means the Contracting Group’s Policy that this Contract replaced within 31 days after the termination, cancellation or expiration of the prior group Policy.

- (112) “Private Duty Nursing” means individual and continuous full shift nursing services, including those given to people who:

- are dependent at least part of each day on a mechanical ventilator;
- require prolonged intravenous nutritional substances or drugs; or
- depend daily on other respiratory or nutritional support, including tracheostomy tube Care, suctioning, oxygen support or tube feeding.

- (113) “Provider Directory” means a list of Network Providers We contract with to provide Care to Our Members.

- (114) “Qualified Beneficiary” means:

- a person entitled to Benefits as a Dependent Spouse, not including a Partner in a Civil Union, or Dependent Child of a Covered Employee, on the day before a Qualifying Event;
- the Covered Employee if the Qualifying Event is the result of reduced hours or loss of employment (other than for gross misconduct); or
- a child born to or placed for adoption with the Covered Employee while covered under COBRA.

- (115) “Qualifying Event” means:

- the Covered Employee lost employment for any reason other than gross misconduct;
- the Covered Employee’s hours were reduced;
- the death of the Covered Employee;
- the divorce or legal separation of the Covered Employee;
- the Covered Employee becomes entitled to Medicare; or
- a Dependent Child loses eligibility under this Contract.

- (116) “Renew” means the current Contract will end and a new Contract with the same terms You have now as amended by Us under subsection 14.A, begins without the parties needing to sign or re-issue Contract documents.
- (117) “Renewal Date” means the date stated in the GSA as the date each year that this Contract Renews.
- (118) “Rescind” or “Rescission” means a cancellation or discontinuance of coverage that has retroactive effect.
- (119) “Residential Treatment Facility” means a facility that provides 24 hour, 7 day a week facility-based programs. Such programs must provide individualized treatment with a high degree of supervision and structure to persons who have severe and persistent mental disorders. Other services that a Residential Treatment Facility may provide, such as education and recreation, are not Benefits. Residential Treatment Facility services are not a substitute for long term or custodial care and are not appropriate for persons who can be effectively treated as an outpatient. The services must be designed to treat the patient with an appropriate level of care. Residential Treatment Facilities serve persons who have the potential to respond to active treatment, and need a protected and structured environment. Realistic discharge goals must be set at admission. A Residential Treatment Facility must be licensed by all applicable federal, state and local agencies, and have a certificate to participate in Medicare.
- (120) “Respite Care” means services provided in Your home or in a licensed health care facility to give temporary relief to Your family or other providers.
- (121) “RMHCO” means Rocky Mountain HealthCare Options, Inc.
- (122) “RMHP Formulary” means the RMHP Outpatient Formulary Guidelines which includes the list of prescribed drugs and medicines approved by Us. The RMHP Formulary can be found at www.rmhp.org.
- (123) “RMHP Preferred Model” means the specific breast pump designated by RMHP as Our preferred model.
- (124) “Rocky Mountain” means Rocky Mountain Health Maintenance Organization, Inc.
- (125) “Same-Sex Domestic Partner” or “Domestic Partner” means a same-sex partner who resides with the Subscriber and who is eligible to be covered as a Dependent under the GSA. A Domestic Partner is not a Partner in a Civil Union or a DB.
- (126) “Second Level Review” means a review of a First Level Review decision by an internal review committee. (See section 13.)

- (127) “Service Area” means the area designated by Us and, approved by the Colorado Division of Insurance, where We do business and conduct operations.
- (128) “Sickness” means illness, disease, congenital defects or birth abnormalities of a Member.
- (129) “Skilled Nursing Facility” or “SNF” means a facility or a part of a facility that provides skilled nursing services needed after or instead of a Hospital stay and which:
- is certified or licensed as a skilled nursing facility by the appropriate governmental authority; and
 - meets all requirements of the Medicare Program for skilled nursing facilities.

A Skilled Nursing Facility only includes those beds in a facility that are certified by Medicare as skilled nursing facility beds.

- (130) “Small Employer” means any person, firm, corporation, partnership, or association that:
- is actively engaged in business;
 - employed an average of at least 1, but no more than 100, including full-time equivalents, Eligible Employees on business days in the prior calendar year; and
 - was not formed in order to buy insurance.

To count the number of Eligible Employees, We will consider affiliated companies under the Internal Revenue Code as one employer. If an employer did not exist during the prior calendar quarter, there is another test. We look at the average number of employees the employer reasonably expects to employ on business days in the current calendar year.

- (131) “Sound and Natural Teeth” means Your own healthy teeth (not artificial or imitation), free from defect or damage. A tooth is considered sound and natural if:
- the tooth does not have more than one surface restoration, does not have a crown or a root canal, and does not have decay on one more than one surface;
 - the tooth is not a denture, an implant or part of a partial plate;
 - the tooth does not have periodontal disease or other conditions; and
 - the tooth does not need treatment for any reason other than the accidental Injury.

- (132) “Standard Review” means a review by Us of Your complaint of Our initial decision. (See section 13.)

- (133) “Subscriber” means the person whose employment or other status, except for Dependent status, is the basis for eligibility to enroll, and who is enrolled with Us.
- (134) “Supplements” means the Accident Supplement and the Prescription Drug Supplement, if offered by Us and a part of this Contract.
- (135) “Temporarily Absent” means the Member has left the Service Area but intends to return within a reasonable period of time.
- (136) “TMJ” means temporomandibular joint disorder.
- (137) “Urgent Care” means Care needed in order to avoid a serious deterioration of health.
- (138) “Urgent Care Claim” means any claim for medical care or treatment that has to be decided more quickly:
- because the normal timeframes for decision-making could seriously jeopardize Your life or health, or Your ability to regain maximum function, or
 - in the opinion of a physician with knowledge of Your condition, subject You to severe pain that cannot be adequately managed without the care or treatment addressed in the claim.
- An Urgent Care Claim also includes any claim that a physician with knowledge of Your medical condition determines is a claim involving urgent care.
- (139) “Us” means Rocky Mountain Health Maintenance Organization, Inc.
- (140) “We” means Rocky Mountain Health Maintenance Organization, Inc.
- (141) “Well Child Visit” means an age appropriate visit that includes any examination or preventive service called for in guidelines supported by the HRSA or recommended by the American Academy of Pediatrics.
- (142) “Yearly Open Enrollment Period” means the calendar month specified for open enrollment in the GSA.
- (143) “Yearly Out-of-Pocket Maximum” means the total amount, including Cost Sharing, paid by the Member for certain Benefits provided during a Calendar Year for a Member or for a Subscriber and Dependent(s), as provided in the Coverage Schedule and the Accident Supplement (if included with this Contract).
- (144) “You” or “Your” means “Member”.