

# Rocky Mountain Health Plans Small Group Rates

## U.S. Cleaning Professionals, Inc.

Group Number: 10457000

Effective Date: 6/1/04

### Renewal Options Summary

<u>RMHMO Plans</u>	<u>Employee</u>	<u>Employee &amp; Spouse</u>	<u>Employee &amp; Children</u>	<u>Employee &amp; Family</u>	<u>Total Premium</u>
HMO F1200, Rx: \$10 Generic Only					\$1,020.95
Age 00-19	\$107.76	\$215.52	\$247.88	\$355.64	
Age 20-24	\$117.83	\$235.65	\$270.95	\$388.78	
Age 25-29	\$128.04	\$256.09	\$281.64	\$409.68	
Age 30-34	\$138.11	\$276.22	\$290.00	\$428.10	
Age 35-39	\$148.17	\$296.34	\$296.34	\$444.52	
Age 40-44	\$168.46	\$336.91	\$320.03	\$488.49	
Age 45-49	\$202.05	\$404.11	\$353.63	\$555.68	
Age 50-54	\$245.87	\$491.74	\$393.42	\$639.29	
Age 55-59	\$293.09	\$586.19	\$439.72	\$732.81	
Age 60-64	\$350.23	\$700.45	\$507.84	\$858.07	
Age 65+	\$377.17	\$739.93	\$527.97	\$890.74	
Medicare	\$224.35	\$447.46	\$337.53	\$560.64	

### Census Summary

	<u>Employee</u>	<u>Employee &amp; Spouse</u>	<u>Employee &amp; Child</u>	<u>Employee &amp; Children</u>	<u>Employee &amp; Family</u>	<u>Total</u>
Age 00-19	0	0	0	0	0	0
Age 20-24	0	0	0	0	0	0
Age 25-29	0	0	0	0	0	0
Age 30-34	2	0	0	0	1	3
Age 35-39	1	0	0	0	0	1
Age 40-44	1	0	0	0	0	1
Age 45-49	0	0	0	0	0	0
Age 50-54	0	0	0	0	0	0
Age 55-59	0	0	0	0	0	0
Age 60-64	0	0	0	0	0	0
Age 65+	0	0	0	0	0	0
Medicare	0	0	0	0	0	0
<b>Total</b>	<b>4</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>5</b>

### Rating Information/Disclosures

Rating Type: Renewal (E), Age-Banded, Employer is located in zip code 81501, Mesa county.  
 Broker: Margaret Lifland Account Executive: Patty Clark Current Carrier:  
 Plan Choices: Dual Option Not Allowed, Indemnity Plan Not Allowed

The rates and premiums quoted are based on the census summary as shown on this proposal. Actual rates and premiums will be based on actual enrollment.

Effective October 1, 2003, RMHP is charging a state-mandated assessment of \$2.00 per member per month on all billing statements to help fund the CoverColorado program (HB 01-1319). RMHP reserves the right to modify this assessment fee as necessary based on changes in Colorado law.

Rates and coverage are subject to all terms and conditions of Rocky Mountain HMO/Health Care Options policies and procedures, group service agreements, health benefit contracts and requirements of applicable law.

Notes:

04/16/04 12:09 pm Sheri Alderton  
 q104q204c

**Colorado Health Plan Description Form**

**Rocky Mountain HMO**

**Rocky Mountain Direct HMO Plan F1200**

**PART A: TYPE OF COVERAGE**

<b>1. TYPE OF PLAN</b>	Health Maintenance Organization (HMO)
<b>2. OUT-OF-NETWORK CARE COVERED?<sup>1</sup></b>	Only for emergency and urgent care.
<b>3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE</b>	Plan is available throughout Colorado except in the following counties: Gunnison, Routt, Baca, Jackson, and portions of Larimer (plan is available in 80513, 80537, 80538, and 80539 zip codes).

**PART B: SUMMARY OF BENEFITS**

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

**Coinsurance options and percentage copayments reflect the amount the carrier will pay.**

	<b>IN-NETWORK ONLY (out of network care is not covered except as noted)</b>
<b>4. ANNUAL DEDUCTIBLE</b> a) Individual b) Family	a) \$1,200 b) \$3,600 Deductibles shall not be applied to satisfy the out-of-pocket maximum. Deductible must be satisfied before services will be covered, except as noted.
<b>5. OUT-OF-POCKET ANNUAL MAXIMUM<sup>2</sup></b> a) Individual b) Family	a) \$4,000 b) \$8,000 All copayments apply toward the out-of-pocket maximum, unless otherwise noted. Services for which the copayments do not apply toward the annual out-of-pocket maximum will remain payable after the out-of-pocket maximum has been reached.
<b>6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE</b>	No lifetime maximum
<b>7A. COVERED PROVIDERS</b>	Rocky Mountain HMO Network, Horizon Behavioral Health. See participating provider directory for a complete list of current providers.
<b>7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?</b>	Yes
<b>8. ROUTINE MEDICAL OFFICE VISITS</b> a) Designated PCP b) Any other participating provider	a) \$25 per visit copay, not subject to deductible b) \$50 per visit copay, not subject to deductible Copayments do not apply toward annual out-of-pocket maximum

<b>IN-NETWORK ONLY (out of network care is not covered except as noted)</b>	
<p><b>9. PREVENTIVE CARE</b></p> <ul style="list-style-type: none"> <li>a) Children's services (well-child services as age appropriate)</li> <li>b) Adults' services (routine physical and gynecological exam – 1 per member per calendar year)</li> <li>c) Routine screening mammograms, pap smears, prostate screenings, and colorectal cancer screenings</li> <li>d) Routine child immunizations and travel immunizations</li> </ul>	<ul style="list-style-type: none"> <li>a) No copay (100% covered), not subject to deductible</li> <li>b) \$25 per visit copay, not subject to deductible – for exam office visit only. Copayment does not apply toward annual out-of-pocket maximum. Associated services will have the applicable copay for the type of service.</li> <li>c) No copay (100% covered), not subject to deductible – office visit copayment may apply</li> <li>d) No copay (100% covered), not subject to deductible – office visit copayment may apply</li> </ul>
<p><b>10. MATERNITY</b></p> <ul style="list-style-type: none"> <li>a) Initial prenatal office visit</li> <li>b) All other services including delivery &amp; inpatient well baby care</li> </ul>	<ul style="list-style-type: none"> <li>a) No copay (100% covered), not subject to deductible</li> <li>b) After deductible, \$750 per day copay up to 4 days, no copayment thereafter</li> </ul>
<p><b>11. PRESCRIPTION DRUGS</b> Level of coverage and restrictions on prescriptions</p> <ul style="list-style-type: none"> <li>a) Inpatient prescription drugs and injectables</li> <li>b) Outpatient prescription drugs and Insulin (not including injectables)</li> <li>c) Outpatient injectable medication (except Insulin) – administered in a physician's office or outpatient facility</li> <li>d) Self-administered injectable medication – dispensed through a retail or mail order pharmacy</li> </ul>	<ul style="list-style-type: none"> <li>a) Included in inpatient hospital copay</li> <li>b) See benefit schedule attached</li> <li>c) RMHMO will cover 80% copayment after deductible. Member pays 20% copayment after deductible. Member copayments apply toward annual out-of-pocket maximum.</li> <li>d) RMHMO will cover 80% copayment, not subject to deductible. Member pays 20% copayment, not subject to deductible, up to \$500 maximum out of pocket per member per claim. Member copayments do not apply toward annual out-of-pocket maximum.</li> </ul> <p>For Drugs on our approved list, contact Rocky Mountain Health Plans at 1-800-346-4643.</p>
<p><b>12. INPATIENT HOSPITAL</b></p>	<p>After deductible, \$750 per day copay up to 4 days, no copayment thereafter</p>
<p><b>13. OUTPATIENT/AMBULATORY SURGERY</b></p>	<p>After deductible, \$350 per visit copay for outpatient surgery and invasive diagnostic tests</p>
<p><b>14. LABORATORY &amp; X-RAY</b></p> <ul style="list-style-type: none"> <li>a) Laboratory</li> <li>b) X-RAY and other imaging</li> <li>c) MRI/CAT/PET</li> </ul>	<ul style="list-style-type: none"> <li>a) No copay (100% covered), after deductible</li> <li>b) \$50 copay after deductible</li> <li>c) \$150 copay after deductible</li> </ul>
<p><b>15. EMERGENCY CARE<sup>3</sup></b></p> <ul style="list-style-type: none"> <li>a) Emergency Room</li> <li>b) Follow-up treatment for out of service area medical emergencies</li> </ul>	<ul style="list-style-type: none"> <li>a) \$100 per visit copay, not subject to deductible, for emergency room for in-and out-of-network emergency care (waived if admitted)</li> <li>b) RMHMO will cover 50% copayment, not subject to deductible. Maximum Benefit Level: \$250 payable by plan per medical emergency.</li> </ul>
<p><b>16. AMBULANCE</b></p>	<p>\$50 per trip copay after deductible</p>
<p><b>17. URGENT, NON-ROUTINE, AFTER HOURS CARE</b></p> <ul style="list-style-type: none"> <li>a) Urgent Care Services</li> <li>b) Follow-up treatment for out of service area urgent care services</li> </ul>	<ul style="list-style-type: none"> <li>a) \$50 per visit copay, not subject to deductible. Out-of-network urgent care covered only if traveling or temporarily absent from service area. Copayments do not apply toward annual out-of-pocket maximum.</li> <li>b) RMHMO will cover 50% copayment after deductible. Maximum Benefit Level: \$250 payable by plan per medical emergency.</li> </ul>
<p><b>18. BIOLOGICALLY-BASED MENTAL ILLNESS<sup>4</sup> CARE</b></p>	<p>Coverage is no less extensive than the coverage provided for any other physical illness.</p>

<b>IN-NETWORK ONLY (out of network care is not covered except as noted)</b>	
<p><b>19. OTHER MENTAL HEALTH CARE</b>                      a) Inpatient care                      b) Outpatient care</p>	<p>a) After deductible, \$750 per day copay up to 8 days, no copayment thereafter. Maximum Benefit Level: 45 days or 90 partial days per member per calendar year</p> <p>b) \$50 per visit copay, not subject to deductible – Maximum Benefit Level: 20 visits or \$1,000 payable by plan per member per calendar year, whichever is greater, except that for groups over 50 employees are limited to 20 visits and the \$1,000 limit does not apply.</p> <p>Copayments do not apply toward annual out-of-pocket maximum</p>
<p><b>20. ALCOHOL &amp; SUBSTANCE ABUSE</b>                      a) Inpatient care – Rehabilitation                      b) Outpatient care – Rehabilitation                      c) Inpatient care – Detoxification                      d) Outpatient care – Detoxification</p>	<p>a) RMHMO will cover 50% per admission copay after deductible. Maximum Benefit Level: 45 days or 90 partial days per member per calendar year. Member's copayment does not apply toward annual out-of-pocket maximum.</p> <p>b) RMHMO will cover 50% per visit copay after deductible. Maximum Benefit Level: \$500 payable by plan per member per calendar year. Member's copayment does not apply toward annual out-of-pocket maximum.</p> <p>c) After deductible, \$750 per day copay up to 4 days, no copayment thereafter – limited to removal of the toxic substances from the body</p> <p>d) \$50 per visit copay, not subject to deductible – limited to removal of the toxic substances from the body. Copayments do not apply toward annual out-of-pocket maximum.</p> <p>No coverage unless entire treatment program is completed as prescribed.</p>
<p><b>21. PHYSICAL, OCCUPATIONAL, &amp; SPEECH THERAPY</b>                      a) Inpatient care                      b) Outpatient care</p>	<p>a) Included in inpatient hospital copay - Maximum Benefit Level: 60 days per episode per medical condition</p> <p>b) \$50 per visit copay, not subject to deductible – Maximum Benefit Level: 20 visits per episode per condition per calendar year</p> <p>Copayments for outpatient services do not apply toward annual out-of-pocket maximum.</p>
<p><b>22. DURABLE MEDICAL EQUIPMENT</b>                      Durable Medical Equipment, Repairs, Disposable Medical Supplies, and Orthotics/Prosthetics</p>	<p>RMHMO will cover 80% copayment after deductible. Maximum Benefit Level: \$1,200 per calendar year paid by plan for DME, Repairs, DMS, oxygen, and prosthetics/orthotics combined, except for arm and leg, which have no limit</p> <ul style="list-style-type: none"> <li>- Member copayments do not apply toward annual out-of-pocket maximum</li> <li>- Disposable Medical Supplies obtained from a pharmacy are not subject to deductible and are limited to a 90 day supply.</li> <li>- Diabetic supplies are not subject to deductible and do not apply toward the annual limit.</li> </ul>
<p><b>23. OXYGEN</b></p>	<p>RMHMO will cover 80% copayment after deductible. Maximum Benefit Level: \$1,200 per calendar year paid by plan for DME, Repairs, DMS, oxygen, and prosthetics/orthotics combined</p> <p>Member copayments do not apply toward annual out-of-pocket maximum</p>
<p><b>24. ORGAN TRANSPLANTS</b>                      a) Inpatient care                      b) Outpatient care</p>	<p>a) After deductible, \$750 copay per day up to 4 days, no copayment thereafter</p> <p>b) After deductible, \$350 outpatient surgical facility copay</p>
<p><b>25. HOME HEALTH CARE</b></p>	<p>No copay (100% covered), not subject to deductible</p>
<p><b>26. HOSPICE CARE</b></p>	<p>No copay (100% covered), not subject to deductible – Maximum Benefit Level: Respite care is limited to periods of 5 days or less</p>
<p><b>27. SKILLED NURSING FACILITY CARE</b></p>	<p>\$50 per day copay after deductible – Maximum Benefit Level: 100 days per member per calendar year</p>
<p><b>28. DENTAL CARE</b></p>	<p><b>Routine:</b> Not covered.  <b>Non-Routine:</b> \$25 per visit copay/PCP                      \$50 per visit copay/Any other participating provider</p> <p>For treatment due to injury to sound and natural teeth.</p> <p>Copayments are not subject to deductible and do not apply toward annual out-of-pocket maximum.                      Additional coverage may be obtained as an optional benefit</p>

<b>IN-NETWORK ONLY (out of network care is not covered except as noted)</b>	
<b>29. VISION CARE</b>	<p><b>Annual Routine Vision Screening:</b> \$25 copay</p> <p><b>Non-Routine:</b> \$25 per visit copay/PCP \$50 per visit copay/Any other participating provider For treatment due to injury or disease of the eye.</p> <p>Copayments are not subject to deductible and do not apply toward annual out-of-pocket maximum. Additional coverage may be obtained as an optional benefit</p>
<b>30. CHIROPRACTIC CARE</b>	Coverage may be obtained as an optional benefit
<b>31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)</b>	<b>Medically Necessary Eyeglasses and Contacts:</b> RMHMO will cover 80% copayment after deductible (when required as a result of eye surgery or with a diagnosis of keratoconus)

**PART C: LIMITATIONS AND EXCLUSIONS**

<b>32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.<sup>5</sup></b>	<p><b>For Business Groups of One:</b> Twelve months for all pre-existing conditions (18 months for late enrollees) unless the covered person is a HIPAA-eligible individual as defined under federal and state law, in which case there are no pre-existing condition exclusions.</p> <p><b>For small groups (with less than 51 employees):</b> Six months for all pre-existing conditions (18 months for late enrollees) unless the covered person is a HIPAA-eligible individual as defined under federal and state law, in which case there are no pre-existing condition exclusions.</p> <p><b>For large groups (with 51 or more employees):</b> Not applicable; plan does not impose limitation periods for pre-existing conditions.</p>
<b>33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?</b>	No.
<b>34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?</b>	<p><b>For small groups:</b> A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last six months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.</p> <p><b>For large groups:</b> Not applicable. Plan does not exclude coverage for pre-existing conditions.</p>
<b>35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?</b>	Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review them to see if a service or treatment you may need is excluded from the policy.

**PART D: USING THE PLAN**

	<b>IN-NETWORK</b>
<b>36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?</b>	No
<b>37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?</b>	Yes
<b>38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?</b>	No
<b>39. What is the main customer service number?</b>	1-800-346-4643

	<b>IN-NETWORK</b>
40. Who do I write/call if I have a complaint or want to file a grievance? <sup>6</sup>	Rocky Mountain Health Plans Member Concerns Coordinator P.O. Box 10600 Grand Junction, CO 81502
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance, ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy Form #: <u>HMOF1200</u> - Group - all sizes
43. Does the plan have a binding arbitration clause?	Yes, to the extent permitted by law.

**PART E: COST**

44. What is the cost of this plan?	Contact your agent, this insurance company, or your employer, as appropriate, to find out the premium for this plan. In some cases, plan costs are included with this form.
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**PART F: PHYSICIAN PAYMENT METHODS, AND PLAN EXPENDITURES FOR HEALTH EXPENSES, ADMINISTRATION AND PROFIT**

Any person interested in applying for coverage, or who is covered by, or who purchased coverage under this plan may request answers to the questions listed below. The request may be made orally or in writing to the agent marketing the plan or directly to the insurance company and shall be answered within five (5) working days of the receipt of the request.

- What are the three most frequently used methods of payment for primary care physicians?
- What are the three most frequently used methods of payment for physician specialists?
- What other financial incentives determine physician payment?
- What percentage of total Colorado premiums are spent on health care expenses as distinct from administration and profit?

**Endnotes**

- <sup>1</sup> "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).
- <sup>2</sup> "Out-of-pocket maximum." The maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan.
- <sup>3</sup> "Emergency care" means services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.
- <sup>4</sup> "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.
- <sup>5</sup> Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.
- <sup>6</sup> Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

**Selected Benefit Descriptions**  
**Colorado Health Plan Description Form Addendum**

**Rocky Mountain HMO/Rocky Mountain Health Care Options**

**\$10 Generic Copay Only Prescription Plan**

Coinsurance and percentage copayments reflect the amount the carrier will pay.

<b>IN-NETWORK ONLY (out of network care is not covered except as noted)</b>	
<p><b>11. PRESCRIPTION DRUGS</b>                      Level of coverage and restrictions on prescriptions</p> <p>a) <b>Outpatient prescription drugs and Insulin (not including injectables)</b></p> <p>b) <b>Outpatient injectable medication (except Insulin) – administered in a physician’s office or outpatient facility</b></p> <p>c) <b>Self-administered injectable medication – dispensed through a retail or mail order pharmacy</b></p>	<p>a) <b>Copayments</b></p> <p><u>Retail pharmacy</u></p> <ul style="list-style-type: none"> <li>• Generic drugs - \$10 copayment per prescription for a 31-day supply*</li> <li>• Preferred brand name and Non-preferred brand name drugs - Rocky Mountain Health Plan members may purchase outpatient prescription drugs* included in the Rocky Mountain Health Plan formulary from participating retail pharmacies at 100% of the Rocky Mountain Health plan rate.</li> </ul> <p><u>Mail order pharmacy</u></p> <ul style="list-style-type: none"> <li>• Generic drugs - \$20 copayment per prescription for a 90-day supply*</li> <li>• Preferred brand name and Non-preferred brand name drugs - Rocky Mountain Health Plan members may purchase outpatient prescription drugs* included in the Rocky Mountain Health Plan formulary from participating mail order pharmacies at 100% of the Rocky Mountain Health plan rate.</li> </ul> <p>- Copayments for prescription drugs are made directly to the pharmacy at the time the prescription is purchased. Prescription drugs are covered only through participating retail and mail order pharmacies. See the Participating Provider Directory for a list of participating pharmacies.</p> <p>- Some medications and devices are not covered, including but not limited to:</p> <ul style="list-style-type: none"> <li>• Medications for which a prescription is not required.</li> <li>• Medications for which there is a therapeutic equivalent available over the counter.</li> <li>• Medications used for non-medical reasons, such as to treat wrinkles.</li> <li>• Prescription drugs dispensed in solid or liquid form are limited to a 31-day supply through a participating retail pharmacy or a 90-day supply through a participating mail order pharmacy. Prescription drugs dispensed in inhaler formulation are limited to a maximum of two inhalers per month. Prescription drugs dispensed in patch formulation are limited to a 31-day supply through a participating retail pharmacy or a 90-day supply through a participating mail order pharmacy.</li> </ul> <p>- Access to participating pharmacies is available nationwide. Members can obtain prescription medication at pharmacies throughout the U.S. and pay the applicable copayment. To locate participating pharmacies or for more information about drugs on our approved list, contact Rocky Mountain Health Plans, Customer Service at 1-800-346-4643.</p> <p>b) Covered under Medical Plan</p> <p>c) RMHMO/RMHCO will cover <b>80% coinsurance (70% coinsurance on the PPO Group 1500 plan)</b>, not subject to medical plan deductible (if applicable). Member pays 20% coinsurance (30% coinsurance on the PPO Group 1500 plan), not subject to medical plan deductible (if applicable), up to \$500 maximum out of pocket per member per claim. Member’s coinsurance does not apply toward annual out-of-pocket maximum on the medical plan.</p>

**Selected Benefit Descriptions**  
**Colorado Health Plan Description Form Addendum**  
**Rocky Mountain HMO/Rocky Mountain HealthCare Options**

**Summary of Plan Exclusions – RM Direct**

The following is a partial summary of exclusions in the Rocky Mountain HMO/Rocky Mountain HCO Health Benefits Contract and Plan Attachments. The summary is not all-inclusive. For complete details on benefits, limitations and exclusions please see the applicable contract and plan attachments

- Any services or supplies not listed in the Schedule of Benefits, not Medically Necessary as defined by the Contract, or not required in accordance with the accepted standards of medical, surgical or psychiatric practice of the Service Area
- Personal comfort or convenience items
- Housekeeping, homemaker and meal services
- Surrounding services and supplies used in connection with any service or supply that is not provided as a Benefit of the Contract
- Any service, supply or other item not listed as a Benefit in the Schedule of Benefits
- Services determined by RMHMO/HCO to be experimental in nature
- Custodial, nursing home and domiciliary care
- Blood and blood derivatives
- Eyeglasses and contact lenses, except as provided in the Schedule of Benefits
- Hearing aids, cochlear implants and devices and equipment related to hearing aids or cochlear implants
- Cosmetic surgery, services or supplies, except as provided in the Schedule of Benefits
- Third-party physical and/or psychological examinations for employment, licensing, insurance, adoption or other non-medical purposes
- Expenses for medical reports, including presentations and preparation; and examination or treatment ordered by a court
- Behavior modification programs, including but not limited to, weight loss and stop smoking programs
- Educational testing, learning disability assessments, developmental testing, and any services or supplies related to this testing
- Nonprescription drugs or medicines, vitamins, nutrients and food supplements even if prescribed or administered by a physician
- Treatment for sexual dysfunction, including, but not limited to, testing, therapy, physician services, medical services, surgical treatment, injectables and prescription drugs, and any treatment for impotency, except as provided in the Schedule of Benefits
- Refractive keratoplasty, including, but not limited to, radial and laser keratotomy, and any procedure to correct a visual refractive defect
- School-based therapy of any kind
- Special education, counseling, therapy, or other services for learning deficiencies or behavioral problems
- Infertility services and artificial insemination.
- Extracorporeal shock wave treatment of plantar fasciitis
- Treatment for injury or illness incurred in connection with a felony committed by the member
- Fees and costs that are not for health care services, such as copying charges, file setup charges, financing charges and interest and other billing charges imposed by providers.