

Section I - Introduction to the Summary of Benefits for  
**Rocky Mountain Health Plans**  
**Thrifty with Thrifty Drug Plan – M, Standard with Standard Drug Plan - M, and**  
**Gold with Enhanced Drug Plan - M**

**January 1, 2009 – December 31, 2009**  
**Denver Metro Colorado**

Rocky Mountain Health Plans is a Federally Qualified HMO with a Medicare contract.

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Thank you for your interest in RMHP Thrifty with Thrifty Drug Plan – M, Standard with Standard Drug Plan – M and Gold with Enhanced Drug Plan – M. Our plans are offered by Rocky Mountain Health Plans, a Medicare Cost Managed Care organization. This Summary of Benefits tells you some features of our plans. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call RMHP Thrifty with Thrifty Drug Plan – M, Standard with Standard Drug Plan – M and Gold with Enhanced Drug Plan – M and ask for the "Evidence of Coverage".

**YOU HAVE CHOICES IN YOUR HEALTH CARE**

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like RMHP Thrifty with Thrifty Drug Plan – M, Standard with Standard Drug Plan – M and Gold with Enhanced Drug Plan – M. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may be able to join or leave a plan only at certain times. Please call RMHP Thrifty with Thrifty Drug Plan – M, Standard with Standard Drug Plan – M and Gold with Enhanced Drug Plan – M at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

**HOW CAN I COMPARE MY OPTIONS?**

You can compare RMHP Thrifty with Thrifty Drug Plan – M, Standard with Standard Drug Plan – M and Gold with Enhanced Drug Plan – M and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our Members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

**WHERE ARE RMHP THRIFTY WITH THRIFTY DRUG PLAN – M, STANDARD WITH STANDARD DRUG PLAN – M AND GOLD WITH ENHANCED DRUG PLAN – M AVAILABLE?**

The service area for these plans include: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson Counties. You must live in one of these areas to join the plan.

There is more than one plan listed in this Summary of Benefits. If you are enrolled in one plan and wish to switch to another plan, you may do so only during certain times of the year. Please call Customer Service at the number listed at the end of this introduction for more information.

## **WHO IS ELIGIBLE TO JOIN RMHP THRIFTY WITH THRIFTY DRUG PLAN – M, STANDARD WITH STANDARD DRUG PLAN – M AND GOLD WITH ENHANCED DRUG PLAN – M?**

You can join RMHP Thrifty with Thrifty Drug Plan – M, Standard with Standard Drug Plan – M and Gold with Enhanced Drug Plan – M if you are entitled to Medicare Part A and enrolled in Part B or enrolled in Part B only and live in the service area. However, individuals with End Stage Renal Disease are generally not eligible to enroll in RMHP Thrifty with Thrifty Drug Plan – M, Standard with Standard Drug Plan – M or Gold with Enhanced Drug Plan – M unless they are members of our organization and have been since their dialysis began.

You cannot enroll in RMHP Gold with Enhanced Drug Plan – M if your current or former employer or union (or your spouse's current or former employer or union) helps pay for your drugs.

## **CAN I CHOOSE MY DOCTORS?**

RMHP Thrifty with Thrifty Drug Plan – M, Standard with Standard Drug Plan – M and Gold with Enhanced Drug Plan – M has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory or for an up-to-date list visit us at [www.rmhp.org](http://www.rmhp.org). Our customer service number is listed at the end of this introduction.

## **WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?**

You can always choose to go to a doctor outside our network. We may not pay for the services you receive outside of our network, but Medicare will pay for its share of charges it approves. You will be responsible for Medicare Part B deductible and coinsurance.

## **DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?**

RMHP Thrifty with Thrifty Drug Plan – M, Standard with Standard Drug Plan – M and Gold with Enhanced Drug Plan – M do cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

## **WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN ONE OF THESE PLANS?**

RMHP Thrifty with Thrifty Drug Plan – M, Standard with Standard Drug Plan – M and Gold with Enhanced Drug Plan – M have formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at [www.rmhp.org](http://www.rmhp.org). Our customer service number is listed at the end of this introduction.

## **WHAT IS A PRESCRIPTION DRUG FORMULARY?**

RMHP Thrifty with Thrifty Drug Plan – M, Standard with Standard Drug Plan – M and Gold with Enhanced Drug Plan – M use a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our Members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at [www.rmhp.org](http://www.rmhp.org).

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

## **HOW CAN I GET EXTRA HELP WITH PRESCRIPTION DRUG PLAN COSTS?**

If you qualify for extra help with your Medicare prescription drug plan costs, your premium and costs at the pharmacy will be lower. When you join RMHP Thrifty with Thrifty Drug Plan – M, Standard with Standard Drug Plan – M or Gold with Enhanced Drug Plan – M, Medicare will tell us how much extra help you are getting. Then we will let you know the amount you will pay. If you are not getting this extra help you can see if you qualify by calling 1-800-MEDICARE (1-800-633-4227), TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

## **WHAT ARE MY PROTECTIONS IN THESE PLANS?**

All Medicare Cost Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Cost Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a Member of RMHP Thrifty with Thrifty Drug Plan – M, Standard with Standard Drug Plan – M or Gold with Enhanced Drug Plan – M, you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug.

## **WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?**

A Medication Therapy Management (MTM) Program is a free service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact RMHP Thrifty with Thrifty Drug Plan – M, Standard with Standard Drug Plan – M and Gold with Enhanced Drug Plan – M for more details.

## **WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?**

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact RMHP Thrifty with Thrifty Drug Plan – M, Standard with Standard Drug Plan – M and Gold with Enhanced Drug Plan – M for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin alpha or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.

- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen. Inhalation and infusion drugs provided through DME.

Please call Rocky Mountain Health Plans for more information about these plans.

Visit us at [www.rmhp.org](http://www.rmhp.org) or, call us:

Customer Service Hours:

Monday, Tuesday, Wednesday, Thursday, Friday, 8:00 a.m. – 5:00 p.m., Mountain Time

Current and Prospective Members should call toll-free 800-346-4643 for questions related to the RMHP Medicare Cost Plan. (TTY/TDD 800-704-6370).

Current and Prospective Members should call locally 970-243-7050 for questions related to the RMHP Medicare Cost Plan. (TTY/TDD 970-248-5019).

RMHP Medicare Part D Prescription Drug program

Customer Service Hours:

Monday, Tuesday, Wednesday, Thursday, Friday, 8:00 a.m. – 8:00 p.m., Mountain Time. From November 15 through March 1, we are also available 8:00 a.m. to 8:00 p.m., Mountain Time, on weekends and most holidays.

Current and Prospective Members should call toll-free 800-346-4643 for questions related to the RMHP Medicare Part D Prescription Drug program. (TTY/TDD 800-704-6370).

Current and Prospective Members should call locally 970-243-7050 for questions related to the RMHP Medicare Part D Prescription Drug program. (TTY/TDD 970-248-5019).

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227).

TTY users should call 877-486-2048. You can call 24 hours a day, 7 days a week.

Or, visit [www.medicare.gov](http://www.medicare.gov) on the web.

If you have special needs, this document may be available in other formats.

If you have any questions about these plans' benefits or costs, please contact Rocky Mountain Health Plans for details.

SECTION II – SUMMARY OF BENEFITS

<b>Benefit</b>	<b>Original Medicare</b>	<b>RMHP Thrifty with Thrifty Drug Plan – M</b>	<b>RMHP Standard with Standard Drug Plan – M</b>	<b>RMHP Gold with Enhanced Drug Plan – M</b>
<b>IMPORTANT INFORMATION</b>				
<b>1 – Premium and Other Important Information</b>	<p>In 2009 the monthly Part B Premium is \$96.40 and the yearly Part B deductible amount is \$135.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p>	\$52.50 monthly plan premium in addition to your monthly Medicare Part B premium.	\$116.40 monthly plan premium in addition to your monthly Medicare Part B premium.	\$244.80 monthly plan premium in addition to your monthly Medicare Part B premium.

(1) Each year, you pay a total of one \$135 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.

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Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
<p><b>2 – Doctor and Hospital Choice</b> (For more information, see Emergency – #15 and Urgently Needed Care – #16.)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p><b>In-Network</b> No referral required for network doctors, specialists, and hospitals.  You may have to pay a separate copay for certain doctor office visits.</p> <p><b>Out-of-Network</b> Plan covers you when you travel in the U.S.</p> <p><b>In- and Out-of-Network</b> You can use any network doctor. If you go to out-of-network doctors the plan may not cover the services, but Medicare will pay its share for Medicare-covered services. When Medicare pays its share, you pay the Medicare Part B deductible and coinsurance.  See Page 49 for additional information about Doctor and Hospital Choice.</p>	<p><b>In-Network</b> No referral required for network doctors, specialists, and hospitals.  You may have to pay a separate copay for certain doctor office visits.</p> <p><b>Out-of-Network</b> Plan covers you when you travel in the U.S.</p> <p><b>In- and Out-of-Network</b> You can use any network doctor. If you go to out-of-network doctors the plan may not cover the services, but Medicare will pay its share for Medicare-covered services. When Medicare pays its share, you pay the Medicare Part B deductible and coinsurance.  See Page 49 for additional information about Doctor and Hospital Choice.</p>	<p><b>In-Network</b> No referral required for network doctors, specialists, and hospitals.  You may have to pay a separate copay for certain doctor office visits.</p> <p><b>Out-of-Network</b> Plan covers you when you travel in the U.S.</p> <p><b>In- and Out-of-Network</b> You can use any network doctor. If you go to out-of-network doctors the plan may not cover the services, but Medicare will pay its share for Medicare-covered services. When Medicare pays its share, you pay the Medicare Part B deductible and coinsurance.  See Page 49 for additional information about Doctor and Hospital Choice.</p>

(1) Each year, you pay a total of one \$135 deductible.

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SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
<b>SUMMARY OF BENEFITS</b>				
<b>INPATIENT CARE</b>				
<b>3 – Inpatient Hospital Care</b> (includes Substance Abuse and Rehabilitation Services)	In 2009 the amounts for each benefit Period (3) are: Days 1 - 60: \$1,068 deductible Days 61 - 90: \$267 per day Days 91 - 150: \$534 per lifetime reserve day	<b>In-Network</b> For Medicare-covered hospital stays: Days 1 – 90: \$200 copay per day Plan covers 60 lifetime reserve days. Cost per lifetime reserve day:	<b>In-Network</b> \$550 copay for each Medicare-covered hospital stay Plan covers 90 days each benefit period. (3)	<b>In-Network</b> \$450 copay for each Medicare-covered hospital stay Plan covers 90 days each benefit period. (3)
Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. (4) Lifetime reserve days can only be used once.	Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. (4) Lifetime reserve days can only be used once.	Days 1 – 60: \$200 copay per day \$1,000 out of pocket limit every stay Plan covers 90 days each benefit period. (3)		

(1) Each year, you pay a total of one \$135 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.

(3) A “benefit period” begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

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SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
<p><b>3 – Inpatient Hospital Care continued</b></p>	<p>A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>			

- (1) Each year, you pay a total of one \$135 deductible.
- (2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.
- (3) A "benefit period" begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.
- (4) Lifetime reserve days can only be used once.

If you have any questions about these plans' benefits or costs, please contact RMHP.

SECTION II – SUMMARY OF BENEFITS

<b>Benefit</b>	<b>Original Medicare</b>	<b>RMHP Thrifty with Thrifty Drug Plan – M</b>	<b>RMHP Standard with Standard Drug Plan – M</b>	<b>RMHP Gold with Enhanced Drug Plan – M</b>
<b>4 – Inpatient Mental Health Care</b>	Same deductible and copay as inpatient hospital care (see “Inpatient Hospital Care” above)  190 day limit in a Psychiatric Hospital.	<b>In-Network</b> For hospital stays: Days 1 - 90: \$200 copay per day  Plan covers 60 lifetime reserve days. Cost per lifetime reserve day:  Days 1 - 60: \$200 copay per day  \$1,000 out of pocket limit every stay.  You get up to 190 days in a Psychiatric Hospital in a lifetime.	<b>In-Network</b> \$550 copay for each Medicare-covered hospital stay.  You get up to 190 days in a Psychiatric Hospital in a lifetime.	<b>In-Network</b> \$450 copay for each Medicare-covered hospital stay.  You get up to 190 days in a Psychiatric Hospital in a lifetime.

(1) Each year, you pay a total of one \$135 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.

(3) A “benefit period” begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

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SECTION II – SUMMARY OF BENEFITS

<b>Benefit</b>	<b>Original Medicare</b>	<b>RMHP Thrifty with Thrifty Drug Plan – M</b>	<b>RMHP Standard with Standard Drug Plan – M</b>	<b>RMHP Gold with Enhanced Drug Plan – M</b>
<p><b>5 – Skilled Nursing Facility</b> (in a Medicare-certified skilled nursing facility)</p>	<p>In 2009 the amounts for each benefit period after at least a 3-day covered hospital stay are:                      – Days 1 - 20: \$0 per day                      – Days 21 - 100: \$133.50 per day                      100 days for each benefit period. (3)</p>	<p><b>In-Network</b> For Medicare-covered SNF stays:                      – Days 1 – 20: \$0 copay per day                      – Days 21 – 100: \$100 copay per day                      Plan covers up to 100 days each benefit period. (3)                      3-day prior hospital stay is required.</p>	<p><b>In-Network</b> For Medicare-covered SNF stays:                      – Days 1 – 20: \$0 copay per day                      – Days 21 – 100: \$50 copay per day                      Plan covers up to 100 days each benefit period. (3)                      3-day prior hospital stay is required.</p>	<p><b>In-Network</b> For Medicare-covered SNF stays:                      – Days 1 – 20: \$0 copay per day                      – Days 21 – 100: \$50 copay per day                      Plan covers up to 100 days each benefit period. (3)                      3-day prior hospital stay is required.</p>

(1) Each year, you pay a total of one \$135 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.

(3) A “benefit period” begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

If you have any questions about these plans' benefits or costs, please contact RMHP.

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
<p><b>5 – Skilled Nursing Facility continued</b> (in a Medicare-certified skilled nursing facility)</p>	<p>A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>			

(1) Each year, you pay a total of one \$135 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.

(3) A “benefit period” begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

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Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
<p><b>6 – Home Health Care</b> (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	<p>\$0 copay.</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered home health visits.</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered home health visits.</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered home health visits.</p>
<p><b>7 – Hospice</b></p>	<p>You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.</p>	<p><b>General</b> You must get care from a Medicare-certified hospice.</p>	<p><b>General</b> You must get care from a Medicare-certified hospice.</p>	<p><b>General</b> You must get care from a Medicare-certified hospice.</p>

(1) Each year, you pay a total of one \$135 deductible.

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<b>SUMMARY OF BENEFITS</b>				
<b>OUTPATIENT CARE</b>				
<b>8 – Doctor Office Visits</b>	20% coinsurance (1)(2)	<p><b>General</b> See “Physical Exams,” for more information.</p> <p><b>In-Network</b> \$20 copay for each primary care doctor visit for Medicare-covered benefits. \$50 copay for each in-area, network urgent care Medicare-covered visit. \$50 copay for each specialist visit for Medicare-covered benefits.</p>	<p><b>General</b> See “Physical Exams,” for more information.</p> <p><b>In-Network</b> \$20 copay for each primary care doctor visit for Medicare-covered benefits. \$40 copay for each in-area, network urgent care Medicare-covered visit. \$40 copay for each specialist visit for Medicare-covered benefits.</p>	<p><b>General</b> See “Physical Exams,” for more information.</p> <p><b>In-Network</b> \$15 copay for each primary care doctor visit for Medicare-covered benefits. \$35 copay for each in-area, network urgent care Medicare-covered visit. \$35 copay for each specialist visit for Medicare-covered benefits.</p>

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<b>9 – Chiropractic Services</b>	Routine care not covered. 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers. (1)(2)	<b>In-Network</b> \$10 copay for Medicare-covered visits.  Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.	<b>In-Network</b> \$10 copay for Medicare-covered visits.  Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.	<b>In-Network</b> \$10 copay for Medicare-covered visits.  Medicare-covered chiropractic visits are for manual manipulation of the spine to correct displacement or misalignment of a joint or body part.
<b>10 – Podiatry Services</b>	Routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs. (1)(2)	<b>In-Network</b> \$50 copay for each Medicare-covered visit.  Medicare-covered podiatry benefits are for medically necessary foot care.	<b>In-Network</b> \$40 copay for each Medicare-covered visit.  Medicare-covered podiatry benefits are for medically necessary foot care.	<b>In-Network</b> \$35 copay for each Medicare-covered visit.  Medicare-covered podiatry benefits are for medically necessary foot care.

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<b>11 – Outpatient Mental Health Care</b>	50% coinsurance for most outpatient mental health services. (1)(2)	<b>In-Network</b> \$50 copay for each Medicare-covered individual or group therapy visit.	<b>In-Network</b> \$40 copay for each Medicare-covered individual or group therapy visit.	<b>In-Network</b> \$35 copay for each Medicare-covered individual or group therapy visit.
<b>12 – Outpatient Substance Abuse Care</b>	20% coinsurance (1)(2)	<b>In-Network</b> \$50 copay for Medicare-covered individual or group visits.	<b>In-Network</b> \$40 copay for Medicare-covered individual or group visits.	<b>In-Network</b> \$35 copay for Medicare-covered individual or group visits.
<b>13 – Outpatient Services/Surgery</b>	20% coinsurance for the doctor. (1)(2) 20% of outpatient facility charges. (1)(2)	<b>In-Network</b> \$400 copay for each Medicare-covered ambulatory surgical center visit. \$400 copay for each Medicare-covered outpatient hospital facility visit.	<b>In-Network</b> \$300 copay for each Medicare-covered ambulatory surgical center visit. \$300 copay for each Medicare-covered outpatient hospital facility visit.	<b>In-Network</b> \$250 copay for each Medicare-covered ambulatory surgical center visit. \$250 copay for each Medicare-covered outpatient hospital facility visit.
<b>14 – Ambulance Services</b> (medically necessary ambulance services)	20% coinsurance (1)(2)	<b>In-Network</b> \$150 copay for Medicare-covered ambulance benefits.	<b>In-Network</b> \$100 copay for Medicare-covered ambulance benefits.	<b>In-Network</b> \$100 copay for Medicare-covered ambulance benefits.

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SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
<p><b>15 – Emergency Care</b> (You may go to any emergency room if you reasonably believe you need emergency care.)</p>	<p>20% coinsurance for the doctor. (1)(2) 20% of facility charge, or a set copay per emergency room visit. You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. (1)(2) NOT covered outside the U.S. except under limited circumstances.</p>	<p><b>In-Network</b> \$50 copay for Medicare-covered emergency room visits. <b>Out-of-Network</b> Not covered outside the U.S. except under limited circumstances. Contact the plan for more details. <b>In- and Out-of-Network</b> If you are admitted to the hospital within 24-hours for the same condition, you pay \$0 for the emergency room visit.</p>	<p><b>In-Network</b> \$50 copay for Medicare-covered emergency room visits. <b>Out-of-Network</b> Not covered outside the U.S. except under limited circumstances. Contact the plan for more details. <b>In- and Out-of-Network</b> If you are admitted to the hospital within 24-hours for the same condition, you pay \$0 for the emergency room visit.</p>	<p><b>In-Network</b> \$50 copay for Medicare-covered emergency room visits. <b>Out-of-Network</b> Worldwide coverage. <b>In- and Out-of-Network</b> If you are admitted to the hospital within 24-hours for the same condition, you pay \$0 for the emergency room visit.</p>

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SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
<p><b>16 – Urgently Needed Care</b> (This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>20% coinsurance, or a set copay. (1)(2) NOT covered outside the U.S. except under limited circumstances.</p>	<p><b>General</b> \$50 copay for Medicare-covered urgently needed care visits.</p>	<p><b>General</b> \$40 copay for Medicare-covered urgently needed care visits.</p>	<p><b>General</b> \$35 copay for Medicare-covered urgently needed care visits. See Page 49 for additional information about Urgently Needed Care.</p>
<p><b>17 – Outpatient Rehabilitation Services</b> (Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p>	<p>20% coinsurance (1)(2)</p>	<p><b>In-Network</b> \$10 copay for Medicare-covered Occupational Therapy visits. \$10 copay for Medicare-covered Physical and/or Speech/Language Therapy visits. See Page 49 for additional information about Outpatient Rehabilitation Services.</p>	<p><b>In-Network</b> \$10 copay for Medicare-covered Occupational Therapy visits. \$10 copay for Medicare-covered Physical and/or Speech/Language Therapy visits. See Page 49 for additional information about Outpatient Rehabilitation Services.</p>	<p><b>In-Network</b> \$10 copay for each Medicare-covered Occupational Therapy visits. \$10 copay for Medicare-covered Physical and/or Speech/Language Therapy visits. See Page 49 for additional information about Outpatient Rehabilitation Services.</p>

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SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
<b>SUMMARY OF BENEFITS</b>				
<b>OUTPATIENT MEDICAL SERVICES AND SUPPLIES</b>				
<b>18 – Durable Medical Equipment</b> (includes wheelchairs, oxygen, etc.)	20% coinsurance (1)(2)	<b>General</b> Authorization rules may apply.	<b>General</b> Authorization rules may apply.	<b>General</b> Authorization rules may apply.
		<b>In-Network</b> 20% of the cost for Medicare-covered items.	<b>In-Network</b> 20% of the cost for Medicare-covered items.	<b>In-Network</b> 20% of the cost for Medicare-covered items.
<b>19 – Prosthetic Devices</b> (includes braces, artificial limbs and eyes, etc.)	20% coinsurance (1)(2)	<b>General</b> Authorization rules may apply.	<b>General</b> Authorization rules may apply.	<b>General</b> Authorization rules may apply.
		<b>In-Network</b> 20% of the cost for Medicare-covered items.	<b>In-Network</b> 20% of the cost for Medicare-covered items.	<b>In-Network</b> 20% of the cost for Medicare-covered items.

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SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
<p><b>20 – Diabetes Self-Monitoring Training, Nutrition Therapy and Supplies</b> (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)</p>	<p>20% coinsurance (1)(2)                      Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p><b>In-Network</b>                      \$0 copay for Diabetes self-monitoring training.                      \$0 copay for Nutrition Therapy for Diabetes.                      20% of the cost for Diabetes supplies.</p>	<p><b>In-Network</b>                      \$0 copay for Diabetes self-monitoring training.                      \$0 copay for Nutrition Therapy for Diabetes.                      20% of the cost for Diabetes supplies.</p>	<p><b>In-Network</b>                      \$0 copay for Diabetes self-monitoring training.                      \$0 copay for Nutrition Therapy for Diabetes.                      20% of the cost for Diabetes supplies.</p>

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SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
<p><b>21 – Diagnostic Tests, X-Rays, and Lab Services</b></p>	<p>20% coinsurance for diagnostic tests and x-rays. (1)(2)                      \$0 copay for Medicare-covered lab services.                      Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare.                      Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.</p>	<p><b>General</b>                      Authorization rules may apply.</p> <p><b>In-Network</b>                      \$0 copay for Medicare-covered lab services.                      \$0 to \$400 copay for Medicare-covered diagnostic procedures and tests.                      20% of the cost for Medicare-covered X-rays.                      \$0 to \$150 copay for Medicare-covered diagnostic radiology services.                      20% of the cost for Medicare-covered therapeutic radiology services.                      See Page 49 for additional information about Diagnostic Tests, X-Rays, and Lab Services.</p>	<p><b>General</b>                      Authorization rules may apply.</p> <p><b>In-Network</b>                      \$0 copay for Medicare-covered lab services.                      \$0 to \$300 copay for Medicare-covered diagnostic procedures and tests.                      \$0 copay for Medicare-covered X-rays.                      \$0 to \$150 copay for Medicare-covered diagnostic radiology services.                      20% of the cost for Medicare-covered therapeutic radiology services.                      See Page 49 for additional information about Diagnostic Tests, X-Rays, and Lab Services.</p>	<p><b>General</b>                      Authorization rules may apply.</p> <p><b>In-Network</b>                      \$0 copay for Medicare-covered lab services.                      \$0 to \$250 copay for Medicare-covered diagnostic procedures and tests.                      \$0 copay for Medicare-covered X-rays.                      \$0 to \$150 copay for Medicare-covered diagnostic radiology services.                      20% of the cost for Medicare-covered therapeutic radiology services.                      See Page 49 for additional information about Diagnostic Tests, X-Rays, and Lab Services.</p>

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SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
<b>SUMMARY OF BENEFITS</b>				
<b>PREVENTIVE SERVICES</b>				
<b>22 – Bone Mass Measurement</b> (for people with Medicare who are at risk)	20% coinsurance (1)(2) Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	<b>In-Network</b> \$0 copay for Medicare-covered bone mass measurement.	<b>In-Network</b> \$0 copay for Medicare-covered bone mass measurement.	<b>In-Network</b> \$0 copay for Medicare-covered bone mass measurement.
<b>23 – Colorectal Screening Exams</b> (for people with Medicare age 50 and older)	20% coinsurance (1)(2) Covered when you are high risk or when you are age 50 and older.	<b>In-Network</b> \$0 copay for Medicare-covered colorectal screenings, – up to 1 additional screening See Page 50 for additional information about Colorectal Screening Exams	<b>In-Network</b> \$0 copay for Medicare-covered colorectal screenings, – up to 1 additional screening See Page 50 for additional information about Colorectal Screening Exams	<b>In-Network</b> \$0 copay for Medicare-covered colorectal screenings, – up to 1 additional screening See Page 50 for additional information about Colorectal Screening Exams

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SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
<p><b>24 – Immunizations</b> (Flu vaccine, Hepatitis B vaccine – for people with Medicare who are at risk, Pneumonia vaccine)</p>	<p>\$0 copay for Flu and Pneumonia vaccines. 20% coinsurance for Hepatitis B vaccine. (1)(2) You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.</p>	<p><b>In-Network</b> \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines.</p>	<p><b>In-Network</b> \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines.</p>	<p><b>In-Network</b> \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines.</p>
<p><b>25 – Mammograms</b> (Annual Screening) (for women with Medicare age 40 and older)</p>	<p>20% coinsurance (2) No referral needed. Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.</p>	<p><b>In-Network</b> \$0 copay for – Medicare-covered screening mammograms, – up to 1 additional screening mammogram. See Page 50 for additional information about Mammograms</p>	<p><b>In-Network</b> \$0 copay for – Medicare-covered screening mammograms, – up to 1 additional screening mammogram. See Page 50 for additional information about Mammograms</p>	<p><b>In-Network</b> \$0 copay for – Medicare-covered screening mammograms, – up to 1 additional screening mammogram. See Page 50 for additional information about Mammograms</p>

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SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
<p><b>26 – Pap Smears and Pelvic Exams</b> (for women with Medicare)</p>	<p>\$0 copay for a Pap smears Covered once every 2 years. Covered once a year for women with Medicare at high risk. (2) 20% coinsurance for Pelvic Exams. (2)</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered pap smears and pelvic exams, – up to 1 additional pap smear and pelvic exam. See Page 50 for additional information about Pap Smears and Pelvic Exams</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered pap smears and pelvic exams, – up to 1 additional pap smear and pelvic exam. See Page 50 for additional information about Pap Smears and Pelvic Exams</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered pap smears and pelvic exams, – up to 1 additional pap smear and pelvic exam. See Page 50 for additional information about Pap Smears and Pelvic Exams</p>
<p><b>27 – Prostate Cancer Screening Exams</b> (for men with Medicare age 50 and older)</p>	<p>20% coinsurance for the digital rectal exam. (1)(2) \$0 for the PSA test; 20% coinsurance for other related services. Covered once a year for all men with Medicare over age 50.</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered prostate cancer screening. – up to 1 additional screening. See Page 50 for additional information about Prostate Cancer Screening Exams</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered prostate cancer screening. – up to 1 additional screening. See Page 50 for additional information about Prostate Cancer Screening Exams</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered prostate cancer screening. – up to 1 additional screening. See Page 50 for additional information about Prostate Cancer Screening Exams</p>

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SECTION II – SUMMARY OF BENEFITS

<b>Benefit</b>	<b>Original Medicare</b>	<b>RMHP Thrifty with Thrifty Drug Plan – M</b>	<b>RMHP Standard with Standard Drug Plan – M</b>	<b>RMHP Gold with Enhanced Drug Plan – M</b>
<p><b>28 – End-Stage Renal Disease</b></p>	<p>20% coinsurance for renal dialysis.                      20% coinsurance for Nutrition Therapy for End-Stage Renal Disease.                      Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p><b>General</b>                      Cost plan Members pay Fee-for-Service cost sharing for out-of-area dialysis.</p> <p><b>In-Network</b>                      \$0 copay for renal dialysis.                      \$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p>	<p><b>General</b>                      Cost plan Members pay Fee-for-Service cost sharing for out-of-area dialysis.</p> <p><b>In-Network</b>                      \$0 copay for renal dialysis.                      \$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p>	<p><b>General</b>                      Cost plan Members pay Fee-for-Service cost sharing for out-of-area dialysis.</p> <p><b>In-Network</b>                      \$0 copay for renal dialysis.                      \$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p>

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SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
<p><b>29 – Prescription Drugs</b></p>	<p>Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p>	<p><b>Drugs covered under Medicare Part B</b> <b>General</b> 20% of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs).  20% of the cost for Part B-covered chemotherapy drugs.</p> <p><b>Drugs covered under Medicare Part D</b> <b>General</b> This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at <a href="http://www.rmhp.org">www.rmhp.org</a> on the web.</p>	<p><b>Drugs covered under Medicare Part B</b> <b>General</b> 20% of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs).  20% of the cost for Part B-covered chemotherapy drugs.</p> <p><b>Drugs covered under Medicare Part D</b> <b>General</b> This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at <a href="http://www.rmhp.org">www.rmhp.org</a> on the web.</p>	<p><b>Drugs covered under Medicare Part B</b> <b>General</b> 20% of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs).  20% of the cost for Part B-covered chemotherapy drugs.</p> <p><b>Drugs covered under Medicare Part D</b> <b>General</b> This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at <a href="http://www.rmhp.org">www.rmhp.org</a> on the web.</p>

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SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
<p><b>29 – Prescription Drugs continued</b></p>		<p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> <li>– have limited incomes,</li> <li>– live in long term care facilities, or</li> <li>– have access to Indian/Tribal/Urban (Indian Health Service).</li> </ul> <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p>	<p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> <li>– have limited incomes,</li> <li>– live in long term care facilities, or</li> <li>– have access to Indian/Tribal/Urban (Indian Health Service).</li> </ul> <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p>	<p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> <li>– have limited incomes,</li> <li>– live in long term care facilities, or</li> <li>– have access to Indian/Tribal/Urban (Indian Health Service).</li> </ul> <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p>

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SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
<p><b>29 – Prescription Drugs continued</b></p>		<p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from RMHP Thrifty with Thrifty Drug Plan – M for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p>	<p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from RMHP Standard with Standard Drug Plan – M for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p>	<p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from RMHP Gold with Enhanced Drug Plan – M for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p>

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SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
29 – Prescription Drugs continued		<p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p><b>In-Network</b>                      \$115 deductible on all drugs except generic drugs.                      You pay \$9.25 copay for generic drugs until you reach the deductible.</p> <p><b>Initial Coverage</b>                      After you pay your yearly deductible, you pay the following until total yearly drug costs reach \$2,700:  <b>Retail Pharmacy</b>                      Generic drugs                      – \$9.25 copay for a one-month (30-day) supply of drugs in this tier</p>	<p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p><b>In-Network</b>                      \$0 deductible.</p> <p><b>Initial Coverage</b>                      You pay the following until total yearly drug costs reach \$2,700:  <b>Retail Pharmacy</b>                      Generic drugs                      – \$9 copay for a one-month (30-day) supply of drugs in this tier</p>	<p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p><b>In-Network</b>                      \$0 deductible.</p> <p><b>Initial Coverage</b>                      You pay the following until total yearly drug costs reach \$2,700:  <b>Retail Pharmacy</b>                      Generic drugs                      – \$8.50 copay for a one-month (30-day) supply of drugs in this tier</p>

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SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
29 – Prescription Drugs continued		<ul style="list-style-type: none"> <li>– \$27.75 copay for a three-month (90-day) supply of drugs in this tier</li> <li>Preferred Brand drugs</li> <li>– \$40.50 copay for a one-month (30-day) supply of drugs in this tier</li> <li>– \$121.50 copay for a three-month (90-day) supply of drugs in this tier</li> <li>Non-preferred Brand drugs</li> <li>– \$60.50 copay for a one-month (30-day) supply of drugs in this tier</li> <li>– \$181.50 copay for a three-month (90-day) supply of drugs in this tier</li> </ul>	<ul style="list-style-type: none"> <li>– \$27 copay for a three-month (90-day) supply of drugs in this tier</li> <li>Preferred Brand drugs</li> <li>– \$40 copay for a one-month (30-day) supply of drugs in this tier</li> <li>– \$120 copay for a three-month (90-day) supply of drugs in this tier</li> <li>Non-preferred Brand drugs</li> <li>– \$60 copay for a one-month (30-day) supply of drugs in this tier</li> <li>– \$180 copay for a three-month (90-day) supply of drugs in this tier</li> </ul>	<ul style="list-style-type: none"> <li>– \$25.50 copay for a three-month (90-day) supply of drugs in this tier</li> <li>Preferred Brand drugs</li> <li>– \$38 copay for a one-month (30-day) supply of drugs in this tier</li> <li>– \$114 copay for a three-month (90-day) supply of drugs in this tier</li> <li>Non-preferred Brand drugs</li> <li>– \$58 copay for a one-month (30-day) supply of drugs in this tier</li> <li>– \$174 copay for a three-month (90-day) supply of drugs in this tier</li> </ul>

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SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
29 – Prescription Drugs continued		<p>Specialty drugs</p> <ul style="list-style-type: none"> <li>– 30% coinsurance for a one-month (30-day) supply of drugs in this tier</li> <li>– 30% coinsurance for a three-month (90-day) supply of drugs in this tier</li> </ul> <p><b>Long Term Care Pharmacy</b></p> <p>Generic drugs</p> <ul style="list-style-type: none"> <li>– \$9.25 copay for a one-month (31-day) supply of drugs in this tier</li> </ul> <p>Preferred Brand drugs</p> <ul style="list-style-type: none"> <li>– \$40.50 copay for a one-month (31-day) supply of drugs in this tier</li> </ul> <p>Non-preferred Brand drugs</p> <ul style="list-style-type: none"> <li>– \$60.50 copay for a one-month (31-day) supply of drugs in this tier</li> </ul>	<p>Specialty drugs</p> <ul style="list-style-type: none"> <li>– 33% coinsurance for a one-month (30-day) supply of drugs in this tier</li> <li>– 33% coinsurance for a three-month (90-day) supply of drugs in this tier</li> </ul> <p><b>Long Term Care Pharmacy</b></p> <p>Generic drugs</p> <ul style="list-style-type: none"> <li>– \$9 copay for a one-month (31-day) supply of drugs in this tier</li> </ul> <p>Preferred Brand drugs</p> <ul style="list-style-type: none"> <li>– \$40 copay for a one-month (31-day) supply of drugs in this tier</li> </ul> <p>Non-preferred Brand drugs</p> <ul style="list-style-type: none"> <li>– \$60 copay for a one-month (31-day) supply of drugs in this tier</li> </ul>	<p>Specialty drugs</p> <ul style="list-style-type: none"> <li>– 33% coinsurance for a one-month (30-day) supply of drugs in this tier</li> <li>– 33% coinsurance for a three-month (90-day) supply of drugs in this tier</li> </ul> <p><b>Long Term Care Pharmacy</b></p> <p>Generic drugs</p> <ul style="list-style-type: none"> <li>– \$8.50 copay for a one-month (31-day) supply of drugs in this tier</li> </ul> <p>Preferred Brand drugs</p> <ul style="list-style-type: none"> <li>– \$38 copay for a one-month (31-day) supply of drugs in this tier</li> </ul> <p>Non-preferred Brand drugs</p> <ul style="list-style-type: none"> <li>– \$58 copay for a one-month (31-day) supply of drugs in this tier</li> </ul>

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SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
29 – Prescription Drugs continued		Specialty drugs – 30% coinsurance for a one-month (31-day) supply of drugs in this tier	Specialty drugs – 33% coinsurance for a one-month (31-day) supply of drugs in this tier	Specialty drugs – 33% coinsurance for a one-month (31-day) supply of drugs in this tier
		<b>Mail Order</b> Generic drugs – \$18.50 copay for a three-month (90-day) supply of drugs in this tier Preferred Brand drugs – \$81 copay for a three-month (90-day) supply of drugs in this tier Non-preferred Brand drugs – \$121 copay for a three-month (90-day) supply of drugs in this tier	<b>Mail Order</b> Generic drugs – \$18 copay for a three-month (90-day) supply of drugs in this tier Preferred Brand drugs – \$80 copay for a three-month (90-day) supply of drugs in this tier Non-preferred Brand drugs – \$120 copay for a three-month (90-day) supply of drugs in this tier	<b>Mail Order</b> Generic drugs – \$17 copay for a three-month (90-day) supply of drugs in this tier Preferred Brand drugs – \$76 copay for a three-month (90-day) supply of drugs in this tier Non-preferred Brand drugs – \$116 copay for a three-month (90-day) supply of drugs in this tier

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SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
<p><b>29 – Prescription Drugs continued</b></p>		<p>Specialty drugs – 30% coinsurance for a three-month (90-day) supply of drugs in this tier</p> <p><b>Coverage Gap</b> After your total yearly drug costs reach \$2,700, you pay 100% until your yearly out-of-pocket drug costs reach \$4,350.</p> <p><b>Catastrophic Coverage</b> After your yearly out-of-pocket drug costs reach \$4,350, you pay the greater of: – A \$2.40 copay for generic (including brand drugs treated as generic) and a \$6.00 copay for all other drugs, or – 5% coinsurance.</p>	<p>Specialty drugs – 33% coinsurance for a three-month (90-day) supply of drugs in this tier</p> <p><b>Coverage Gap</b> After your total yearly drug costs reach \$2,700, you pay 100% until your yearly out-of-pocket drug costs reach \$4,350.</p> <p><b>Catastrophic Coverage</b> After your yearly out-of-pocket drug costs reach \$4,350, you pay the greater of: – A \$2.40 copay for generic (including brand drugs treated as generic) and a \$6.00 copay for all other drugs, or – 5% coinsurance.</p>	<p>Specialty drugs – 33% coinsurance for a three-month (90-day) supply of drugs in this tier</p> <p><b>Coverage Gap</b> The plan covers All Formulary Generics through the coverage gap. You pay the following: <b>Retail Pharmacy</b> Generic drugs – \$8.50 copay for a one-month (30-day) supply of all drugs covered in this tier – \$25.50 copay for a three-month (90-day) supply of all drugs covered in this tier</p>

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SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
<p><b>29 – Prescription Drugs continued</b></p>		<p><b>Out-of-Network</b>            Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy.</p> <p>In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from RMHP Thrifty with Thrifty Drug Plan – M.</p>	<p><b>Out-of-Network</b>            Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy.</p> <p>In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from RMHP Standard with Standard Drug Plan – M.</p>	<p><b>Long Term Care Pharmacy</b>            Generic drugs            – \$8.50 copay for a one-month (31-day) supply of all drugs</p> <p><b>Mail Order</b>            Generic drugs            – \$17 copay for a three-month (90-day) supply of all drugs covered in this tier.</p> <p>For all other covered drugs, after your total yearly drug costs reach \$2,700, you pay 100% until your yearly out-of-pocket drug costs reach \$4,350.</p>

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SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
29 – Prescription Drugs continued		<p><b>Out-of-Network Initial Coverage</b>            After you pay your yearly deductible, you will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,700:</p> <p><b>Out-of-Network Pharmacy</b>            Generic drugs            – \$9.25 copay for a one-month (30-day) supply of drugs in this tier            Preferred Brand drugs            – \$40.50 copay for a one-month (30-day) supply of drugs in this tier</p>	<p><b>Out-of-Network Initial Coverage</b>            You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,700:</p> <p><b>Out-of-Network Pharmacy</b>            Generic drugs            – \$9 copay for a one-month (30-day) supply of drugs in this tier            Preferred Brand drugs            – \$40 copay for a one-month (30-day) supply of drugs in this tier</p>	<p><b>Catastrophic Coverage</b>            After your yearly out-of-pocket drug costs reach \$4,350, you pay the greater of:            – A \$2.40 copay for generic (including brand drugs treated as generic) and a \$6.00 copay for all other drugs, or            – 5% coinsurance.</p> <p><b>Out-of-Network</b>            Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy.</p>

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SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
29 – Prescription Drugs continued		<p>Non-preferred Brand drugs – \$60.50 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Specialty drugs – 30% coinsurance for a one-month (30-day) supply of drugs in this tier</p>	<p>Non-preferred Brand drugs – \$60 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Specialty drugs – 33% coinsurance for a one-month (30-day) supply of drugs in this tier</p>	<p>In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from RMHP Gold with Enhanced Drug Plan – M.</p>
		<p><b>Out-of-Network Coverage Gap</b></p> <p>After your total yearly drug costs reach \$2,700, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,350. You will not be reimbursed by RMHP Thrifty with Thrifty Drug Plan – M for out-of-network purchases when you are in the coverage gap.</p>	<p><b>Out-of-Network Coverage Gap</b></p> <p>After your total yearly drug costs reach \$2,700, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,350. You will not be reimbursed by RMHP Standard with Standard Drug Plan – M for out-of-network purchases when you are in the coverage gap.</p>	<p><b>Out-of-Network Initial Coverage</b></p> <p>You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,700:</p> <p><b>Out-of-Network Pharmacy</b></p> <p>Generic drugs – \$8.50 copay for a one-month (30-day) supply of drugs in this tier</p>

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SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
<p><b>29 – Prescription Drugs continued</b></p>		<p>However, you should still submit documentation to RMHP Thrifty with Thrifty Drug Plan – M so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p><b>Out-of-Network Catastrophic Coverage</b></p> <p>After your yearly out-of-pocket drug costs reach \$4,350, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following:</p> <ul style="list-style-type: none"> <li>– A \$2.40 copay for generic (including brand drugs treated as generic) and a \$6.00 copay for all other drugs, or</li> <li>– 5% coinsurance.</li> </ul>	<p>However, you should still submit documentation to RMHP Standard with Standard Drug Plan – M so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p><b>Out-of-Network Catastrophic Coverage</b></p> <p>After your yearly out-of-pocket drug costs reach \$4,350, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following:</p> <ul style="list-style-type: none"> <li>– A \$2.40 copay for generic (including brand drugs treated as generic) and a \$6.00 copay for all other drugs, or</li> <li>– 5% coinsurance.</li> </ul>	<p>Preferred Brand drugs</p> <ul style="list-style-type: none"> <li>– \$38 copay for a one-month (30-day) supply of drugs in this tier</li> </ul> <p>Non-preferred Brand drugs</p> <ul style="list-style-type: none"> <li>– \$58 copay for a one-month (30-day) supply of drugs in this tier</li> </ul> <p>Specialty drugs</p> <ul style="list-style-type: none"> <li>– 33% coinsurance for a one-month (30-day) supply of drugs in this tier</li> </ul>

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SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
29 – Prescription Drugs continued				<p><b>Out-of-Network Coverage Gap</b>                      The plan covers All Formulary Generics through the gap.                      You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following:                      Generic drugs                      – \$8.50 copay for a one-month (30-day) supply of all drugs covered in this tier</p>

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SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
29 – Prescription Drugs continued				<p>Preferred Brand drugs</p> <ul style="list-style-type: none"> <li>– After your total yearly drug costs reach \$2,700, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,350. You will not be reimbursed by RMHP Gold with Enhanced Drug Plan – M for out-of-network purchases when you are in the coverage gap.</li> </ul> <p>However, you should still submit documentation to RMHP Gold with Enhanced Drug Plan – M so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p>

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SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
29 – Prescription Drugs continued				Non-preferred Brand drugs – After your total yearly drug costs reach \$2,700, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,350. You will not be reimbursed by RMHP Gold with Enhanced Drug Plan – M for out-of-network purchases when you are in the coverage gap.

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SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
29 – Prescription Drugs continued				<p>However, you should still submit documentation to RMHP Gold with Enhanced Drug Plan – M so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p>Specialty drugs</p> <ul style="list-style-type: none"> <li>– After your total yearly drug costs reach \$2,700, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,350. You will not be reimbursed by RMHP Gold with Enhanced Drug Plan – M for out-of-network purchases when you are in the coverage gap.</li> </ul>

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SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
29 – Prescription Drugs continued				<p>However, you should still submit documentation to RMHP Gold with Enhanced Drug Plan – M so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p><b>Out-of-Network Catastrophic Coverage</b>            After your yearly out-of-pocket drug costs reach \$4,350, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following:            – A \$2.40 copay for generic (including brand drugs treated as generic) and a \$6.00 copay for all other drugs, or            – 5% coinsurance.</p>

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SECTION II – SUMMARY OF BENEFITS

<b>Benefit</b>	<b>Original Medicare</b>	<b>RMHP Thrifty with Thrifty Drug Plan – M</b>	<b>RMHP Standard with Standard Drug Plan – M</b>	<b>RMHP Gold with Enhanced Drug Plan – M</b>
<b>30 – Dental Services</b>	Preventive dental services (such as cleaning) not covered.	<p><b>In-Network</b>                      In general, preventive dental benefits (such as cleaning) not covered.                      \$0 to \$1,000 copay [or 0% to 20% of the cost] for Medicare-covered dental benefits.                      See Page 50 for additional information about Dental Services.</p>	<p><b>In-Network</b>                      In general, preventive dental benefits (such as cleaning) not covered. However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits.")                      \$0 to \$550 copay [or 0% to 20% of the cost] for Medicare-covered dental benefits.                      See Page 50 for additional information about Dental Services.</p>	<p><b>In-Network</b>                      In general, preventive dental benefits (such as cleaning) not covered. However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits.")                      \$0 to \$450 copay [or 0% to 20% of the cost] for Medicare-covered dental benefits.                      See Page 50 for additional information about Dental Services.</p>

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SECTION II – SUMMARY OF BENEFITS

<b>Benefit</b>	<b>Original Medicare</b>	<b>RMHP Thrifty with Thrifty Drug Plan – M</b>	<b>RMHP Standard with Standard Drug Plan – M</b>	<b>RMHP Gold with Enhanced Drug Plan – M</b>
<b>31 – Hearing Services</b>	Routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams. (1)(2)	<b>In-Network</b> In general, routine hearing exams and hearing aids not covered. – \$20 to \$50 copay for Medicare-covered diagnostic hearing exams.	<b>In-Network</b> In general, routine hearing exams and hearing aids not covered. – \$20 to \$40 copay for Medicare-covered diagnostic hearing exams.	<b>In-Network</b> In general, routine hearing exams and hearing aids not covered. – \$15 to \$35 copay for Medicare-covered diagnostic hearing exams.
<b>32 – Vision Services</b>	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after each cataract surgery. (1)(2) Annual glaucoma screenings covered for people at risk. (1)(2)	<b>In-Network</b> Non-Medicare-covered eye exams and glasses not covered. \$0 copay for – one pair of eyeglasses or contact lenses after each cataract surgery – \$20 to \$50 copay for exams to diagnose and treat diseases and conditions of the eye.	<b>In-Network</b> Non-Medicare-covered eye exams and glasses not covered. \$0 copay for – one pair of eyeglasses or contact lenses after each cataract surgery – \$20 to \$40 copay for exams to diagnose and treat diseases and conditions of the eye.	<b>In-Network</b> \$0 copay for – one pair of eyeglasses or contact lenses after each cataract surgery – \$15 to \$35 copay for exams to diagnose and treat diseases and conditions of the eye. – \$15 copay for up to 1 routine eye exam every year.

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SECTION II – SUMMARY OF BENEFITS

<b>Benefit</b>	<b>Original Medicare</b>	<b>RMHP Thrifty with Thrifty Drug Plan – M</b>	<b>RMHP Standard with Standard Drug Plan – M</b>	<b>RMHP Gold with Enhanced Drug Plan – M</b>
<b>33 – Physical Exams</b>	<p>20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage. (1)(2)</p> <p>When you get Medicare Part B, you can get a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.</p>	<p><b>In-Network</b>                      \$0 copay for routine exams.                      Limited to 1 exam every year.                      See Page 50 for additional information about Physical Exams.</p>	<p><b>In-Network</b>                      \$0 copay for routine exams.                      Limited to 1 exam every year.                      See Page 50 for additional information about Physical Exams.</p>	<p><b>In-Network</b>                      \$0 copay for routine exams.                      Limited to 1 exam every year.                      See Page 50 for additional information about Physical Exams.</p>

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SECTION II – SUMMARY OF BENEFITS

<b>Benefit</b>	<b>Original Medicare</b>	<b>RMHP Thrifty with Thrifty Drug Plan – M</b>	<b>RMHP Standard with Standard Drug Plan – M</b>	<b>RMHP Gold with Enhanced Drug Plan – M</b>
<b>Health/Wellness Education</b>	Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.	<b>In-Network</b> This plan covers health/wellness education benefits: – Written health education materials, including Newsletters – Other Wellness Benefits	<b>In-Network</b> This plan covers health/wellness education benefits: – Written health education materials, including Newsletters – Other Wellness Benefits	<b>In-Network</b> This plan covers health/wellness education benefits: – Written health education materials, including Newsletters – Other Wellness Benefits

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SECTION II – SUMMARY OF BENEFITS

<b>Benefit</b>	<b>Original Medicare</b>	<b>RMHP Thrifty with Thrifty Drug Plan – M</b>	<b>RMHP Standard with Standard Drug Plan – M</b>	<b>RMHP Gold with Enhanced Drug Plan – M</b>
<b>Transportation (Routine)</b>	Not covered.	<b>In-Network</b> This plan does not cover routine transportation.	<b>In-Network</b> This plan does not cover routine transportation.	<b>In-Network</b> This plan does not cover routine transportation.
<b>Acupuncture</b>	Not covered.	<b>In-Network</b> This plan does not cover Acupuncture.	<b>In-Network</b> This plan does not cover Acupuncture.	<b>In-Network</b> This plan does not cover Acupuncture.

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SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
<b>OPTIONAL SUPPLEMENTAL PACKAGE #1</b>				
<b>Premium and Other Important Information</b>			<p><b>General</b>            Package: 1 – Dental Services:            \$15.50 monthly premium, in addition to your \$116.40 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits:            – Dental Services            \$1,500 limit every year for these benefits.</p>	<p><b>General</b>            Package: 1 – Dental Services:            \$15.50 monthly premium, in addition to your \$244.80 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits:            – Dental Services            \$1,500 limit every year for these benefits.</p>
<b>Prescription Drugs</b>			<p>This plan offers Medicare Prescription Drug coverage (Part D) as an optional benefit. Refer to "Prescription Drugs" for more information on this coverage.</p>	<p>This plan offers Medicare Prescription Drug coverage (Part D) as an optional benefit. Refer to "Prescription Drugs" for more information on this coverage.</p>

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SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
<b>Dental Services</b>			<p><b>General</b> Plan offers additional comprehensive dental benefits.</p> <p><b>In-Network</b>                      – 30% of the cost for up to 2 cleaning(s) every year.                      – 30% of the cost for fluoride treatments.                      – 30% of the cost for up to 2 oral exam(s) every year.                      – 50% of the cost for dental x-rays.                      \$1,500 limit for dental benefits every year.                      See Page 51 for additional information about Dental Services.</p>	<p><b>General</b> Plan offers additional comprehensive dental benefits.</p> <p><b>In-Network</b>                      – 30% of the cost for up to 2 cleaning(s) every year.                      – 30% of the cost for fluoride treatments.                      – 30% of the cost for up to 2 oral exam(s) every year.                      – 50% of the cost for dental x-rays.                      \$1,500 limit for dental benefits every year.                      See Page 51 for additional information about Dental Services.</p>

(1) Each year, you pay a total of one \$135 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.

## Additional Information Regarding RMHP Medicare Plans

**Percentage copayments are based on the allowed amount of the primary payor (either RMHP or Medicare) and can vary depending on service and provider.**

### 2 – Doctor and Hospital Choice

Visitor/Travel Program:

You can be out of the RMHP service area for up to six months per calendar year and remain eligible for benefits. Services when you are in a continuous course of treatment are covered when pre-approved by RMHP. We may not pay for other services you receive outside of our network, but Medicare will pay for its share of charges it approves. You will be responsible for Medicare Part B deductible and coinsurance. Call RMHP for details about out of service area care.

### 16 – Urgently Needed Care

FOR RMHP GOLD WITH ENHANCED DRUG PLAN – M ONLY:

You are covered worldwide for Medicare-covered urgently needed care. You pay the applicable in-network copayment.

### 17 – Outpatient Rehabilitation Services

Original Medicare limits how much it covers for medically-necessary outpatient physical therapy, speech-language therapy, and occupational therapy. The limit is about \$1810 for physical therapy and speech language therapy combined, and for occupational therapy. RMHP will limit therapy coverage in the same manner.

There is no copayment for Medicare-covered Occupational, Physical, and/or Speech/Language Therapy visits received at a network Comprehensive Outpatient Rehabilitation Facility.

There is no copayment for Medicare-covered Cardiac Rehabilitation visits.

### 21 – Diagnostic Tests, X-Rays and Lab Services

Lab Services:

Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, including those received at a health fair, like checking your cholesterol.

Medicare-covered service	RMHP Thrifty with Thrifty Drug Plan – M	RMHP Standard with Standard Drug Plan – M	RMHP Gold with Enhanced Drug Plan – M
Clinical and Diagnostic Lab Services	You pay nothing.	You pay nothing.	You pay nothing.
MRI/PET scans	You pay \$150 per visit.	You pay \$150 per visit.	You pay \$150 per visit.
Medicare-covered	RMHP Thrifty with	RMHP Standard with	RMHP Gold with

service	Thrifty Drug Plan – M	Standard Drug Plan – M	Enhanced Drug Plan – M
CT scans	You pay \$75 per visit.	You pay \$75 per visit.	You pay \$75 per visit.
Diagnostic procedures and tests	You pay \$400 for diagnostic procedures and tests in an outpatient facility.  You pay the applicable office visit copayment for diagnostic procedures and tests in a doctor’s office.	You pay \$300 for diagnostic procedures and tests in an outpatient facility.  You pay the applicable office visit copayment for diagnostic procedures and tests in a doctor’s office.	You pay \$250 for diagnostic procedures and tests in an outpatient facility.  You pay the applicable office visit copayment for diagnostic procedures and tests in a doctor’s office.

**23 – Colorectal Screening Exams**

You are covered for one annual Colorectal Screening Exam every year, including any exam covered by Medicare.

**25 – Mammograms**

You are covered for one annual screening Mammogram every year, including any exam covered by Medicare.

**26 – Pap Smears and Pelvic Exams**

You are covered for one annual screening pap smear and pelvic every year, including any exam covered by Medicare.

**27 – Prostate Cancer Screening Exams**

You are covered for one annual Prostate Screening Exam every year, including any exam covered by Medicare.

**30 – Dental Services**

For Medicare-covered dental services, you pay the applicable copayment or coinsurance for the type of service.

**33 – Physical Exams**

You are covered for one Physical Exam every calendar year. This exam includes the following services:

- Bone Mass Measurement tests for Members at risk;
- Cardiovascular Screening;
- Colorectal Screening Exams\*;
- Diabetes screening for Members at risk;
- For women: Mammogram\*, Pap Smears\*, Pelvic Exam\*;
- For men: Prostate Cancer Screening Exam\*

\*Limited to one type of service per Member/per calendar year, Medicare-covered annual screening included.

## Optional Supplemental Benefits

FOR RMHP STANDARD WITH STANDARD DRUG PLAN – M AND GOLD WITH ENHANCED DRUG PLAN – M ONLY:

Enrollment in an optional dental services package is voluntary. Members may enroll in any of the medical plans without taking a dental services package.

### Optional Supplement Package #1 - Dental Services through Delta Dental

The annual deductible for dental services is \$50 per Member per calendar year. Preventive services are not subject to the deductible.

The maximum amount paid by the plan per Member per calendar year is \$1,500.

Service	Copayment
Type I – Preventive Services Oral exams, prophylaxis (2 cleanings + 2 periodontal cleanings per year), fluoride treatments (approved for adults with specific conditions)	30%
Type II – Basic Services X-rays, simple extractions, palliative treatment, fillings	50%
Type III – Endodontal and periodontal services	70%

The level of coverage for dental care varies depending on the dentist you see. You will pay the copayments shown above when you receive care from a provider in the preferred network. Benefits are also available from other network providers and out-of-network providers. For services from those providers, you will pay higher copayments, and may be responsible for the difference between the allowed charge and the dentists' actual charge. See the plan summary for Delta Dental benefits in your Member materials for details on enrollment, benefits, and network providers.