ROCKY MOUNTAIN HEALTH PLANS®

Good Health HMO 2000/70

Coverage Period: Beginning on or after 01/01/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Member/Family | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.rmhp.org or by calling 1-800-346-4643.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,000** Member/ **$4,000** Family Does not apply to preventive services and most copays.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	**No**	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**Yes. $6,000** Member/ **$12,000** Family	The **out-of-pocket** limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	**No**	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	**Yes.** For a list of **network providers**, see www.rmhp.org or call 1-800-346-4643.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	**No**	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	**Yes**	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-346-4643 or visit us at www.rmhp.org.
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at www.cciio.cms.gov or call 1-800-346-4643 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$45 copay/visit	Not covered	Not subject to deductible
	Specialist visit	$65 copay/visit	Not covered	Not subject to deductible
	Other practitioner office visit	$45 copay/visit for vision screening	Not covered	Not subject to deductible
	Preventive care/ screening/ immunization	No charge	Not covered	Not subject to deductible
If you have a test	Diagnostic test (x-ray, blood work)	Lab $30 copay/visit X-ray $55 copay/visit	Not covered	Not subject to deductible
	Imaging (CT/PET scans, MRIs)	30% copay/visit	Not covered	None

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.rmhp.org.	Generic drugs	Brand Option:$15/fill Generic Option:$15/fill	Not covered	Excludes drugs not listed in the formulary. $0 copay for contraceptive drugs/devices noted as "Women's Preventive Healthcare" in the formulary. Retail and Mail Order Pharmacy limited up to a 90-day supply. Specialty Pharmacy limited up to a 31-day supply. Tier 5 limited to a 31-day supply only. Tier 4 copay limited to $150 up to a 31-day supply to any network pharmacy/$375 for up to a 90 day supply for retail or mail order pharmacy paid by Member. Tier 5 copay limited to $250 paid by Member. Copays shown are for up to a 31-day supply. 90-day supply copay is 2.5 times the 31-day supply.
	Preferred brand drugs	Brand Option: $60/fill Generic Option: $60/fill for self-administerable injectables and oral anticancer drugs only	Not covered	
	Non-preferred brand drugs	Brand Option:$75/fill Generic Option: $75/fill for self-administerable injectables and oral anticancer drugs only	Not covered	
	Specialty drugs	Tier 4 Drugs: Brand Option: 20%/fill Generic Option: 20%/fill for self-administerable injectables and oral anticancer drugs only Tier 5 Drugs: Brand Option: 30%/fill Generic Option: 30%/fill for self-administerable injectables and oral anticancer drugs only	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% copay/visit	Not covered	None

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Physician/surgeon fees	30% copay/visit	Not covered	None
If you need immediate medical attention	Emergency room services	30% copay/visit	30% copay/visit	None
	Emergency medical transportation	30% copay/trip	30% copay/trip	None
	Urgent care	$65 copay/visit	$65 copay/visit	Not subject to deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% copay/visit	Not covered	None
	Physician/surgeon fee	30% copay/visit	Not covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$45 copay/visit	Not covered	Not subject to deductible.
	Mental/Behavioral health inpatient services	30% copay/visit	Not covered	None
	Substance use disorder outpatient services	$45 copay/visit	Not covered	Not subject to deductible
	Substance use disorder inpatient services	30% copay/visit	Not covered	None
If you are pregnant	Prenatal and postnatal care	30% copay/visit	Not covered	Prenatal preventive care is no charge.
	Delivery and all inpatient services	30% copay/visit	Not covered	None

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	30% copay/visit	Not covered	Coverage is limited to 60 visits/Member/year.
	Rehabilitation services	$65 copay/visit	Not covered	Not subject to deductible. Coverage is limited to 20 visits/therapy/Member/year.
	Skilled nursing care	30% copay	Not covered	Coverage is limited to 60 days/Member/year.
	Durable medical equipment	30% copay	Not covered	None
	Hospice service	30% copay	Not covered	Not subject to deductible. Coverage for respite care limited to 5 days or less.
If your child needs dental or eye care	Eye exam	$45 copay/visit	Not covered	Not subject to deductible. Coverage is limited to one/Member/year.
	Glasses	30% copay	Not covered	Coverage is provided only after eye surgery.
	Dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Drugs not included in the formulary
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care
- Hearing aids (for children)
- Routine eye care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-346-4643. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact RMHP at 1-800-346-4643.

For group health coverage subject to ERISA, you can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Colorado Department of Insurance at 303-894-7490 or www.dora.state.co.us/insurance.

For non-federal governmental group health plans and church plans that are group health plans, consumer assistance may be offered directly by the plan such as applicable member services, employee services, Human Relations or Fiscal and Personnel Department, or consumer support services. You can also contact the Colorado Department of Insurance at 303-894-7490 or www.dora.state.co.us/insurance.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-800-346-4643**.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7540
- **Plan pays** $4140
- **Patient pays** $3400

Sample care costs:

Hospital charges (mother)	$2700
Routine obstetric care	$2100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7540**

Patient pays:

Deductibles	$2000
Copays	$1300
Coinsurance	$0
Limits or exclusions	$100
Total	**$3400**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5400
- **Plan pays** $4220
- **Patient pays** $1180

Sample care costs:

Prescriptions	$2900
Medical Equipment and Supplies	$1300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5400**

Patient pays:

Deductibles	$0
Copays	$1100
Coinsurance	$0
Limits or exclusions	$80
Total	**$1180**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

Colorado Supplement to the Summary of Benefits and Coverage Form

Rocky Mountain Health Maintenance Organization, Inc.

Good Health HMO

Large Employer Group Policy

TYPE OF COVERAGE

1. Type of plan.	Health maintenance organization (HMO)
2. Out-of-network care covered? [1]	Only for emergency and urgent care
3. Areas of Colorado where plan is available.	Plan is available throughout Colorado except in the following areas: Gunnison County and Baca County.

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Note: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

	Description	What this means
4. Deductible Period	Calendar year	Calendar year deductibles restart each January 1.
5. Annual Deductible Type	Individual/Family	"Individual" means the deductible amount you and each individual covered by the plan will have to pay for allowable covered expenses before the carrier will cover those expenses. "Family" is the maximum deductible amount that is required to be met for all family members covered by the plan. It may be an aggregated amount (e.g., "$3,000 per family") or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family").

6. What cancer screenings are covered?	Subject to the parameters set forth below, cancer screening tests for the following items are covered subject to any applicable plan deductibles, copayments/ coinsurance, and maximum benefit levels: • Breast – Mammogram • Cervical – PAP test • Colorectal – Colonoscopy, Sigmoidoscopy, Fecal Occult Blood • Ovarian – CA125 • Prostate – PSA Coverage for these cancer screening tests are subject to the following parameters: a) the test must be ordered by your physician, and b) you must comply with plan procedures

LIMITATIONS AND EXCLUSIONS

7. Period during which pre-existing conditions are not covered for covered persons age 19 and older. [2]	Not applicable; plan does not impose limitation periods for pre-existing conditions.
8. How does the policy define a "pre-existing condition"?	Not applicable. Plan does not exclude coverage for pre-existing conditions.
9. Exclusionary Riders. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No.

USING THE PLAN

	IN-NETWORK
10. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No
11. Does the plan have a binding arbitration clause?	Yes

Questions: Call 1-800-346-4643 or visit us at www.rmhp.org.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al **1-800-346-4643**.

If you are not satisfied with the resolution of your complaint or grievance, contact:

Colorado Division of Insurance
Consumer Affairs Section
1560 Broadway, Suite 850, Denver, CO 80202
Call: 303-894-7490 (in-state, toll-free: 800-930-3745)
Email: insurance@dora.state.co.us

Endnotes

1-"Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that this 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).

2-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.

General Multi-Language Insert

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-282-1420 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-282-1420 (TTY: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-282-1420 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-282-1420 (TTY: 711)。
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-282-1420 (TTY: 711)번으로 전화해 주십시오.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-282-1420 (телетайп: 711).
Amharic	ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-280-1420 (መስማት ለተሳናቸው: 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1--888-282-1420 (رقم هاتف الصم والبكم: 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-282-1420 (TTY: 711).
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-282-1420 (ATS : 711).
Nepali	ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-282-1420 (टिटिवाइ: 711) ।
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-282-1420 (TTY: 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-282-1420（TTY:711）まで、お電話にてご連絡ください。
Cushite/Oromo	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-282-1420 (TTY: 711).
Persian	**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-282-1420 (TTY: 711) تماس بگیرید.
Ibo/Igbo	Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-888-282-1420 (TTY: 711).
Kru-Bassa	Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ [Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀] jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Ðá 1-888-282-1420 (TTY: 711)
Yoruba	AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-888-282-1420 (TTY: 711).

Notice of Nondiscrimination

ROCKY MOUNTAIN HEALTH PLANS®

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

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

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

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

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

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

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