1. SCHEDULE OF BENEFITS (Who Pays What)

ROCKY MOUNTAIN HEALTH PLANS
REGIONAL NETWORK INDIVIDUAL HMO EVIDENCE OF COVERAGE
MONUMENT ONE GOLD $2500/80%/$40 RX COPAY PLAN

Underwritten by Rocky Mountain Health Maintenance Organization, Inc.

COVERAGE SCHEDULE

Benefits are subject to the Cost Sharing, Yearly Out-of-Pocket Maximums, and Maximum Benefit Levels shown in this Coverage Schedule. Please see Your Contract for a description of Your Benefits, Limitations, and Exclusions. Benefits are subject to all terms of the Contract.

See the Monument ONE Provider Directory for a list of Network Providers for this Plan.

The following symbols are used to identify Maximum Benefit Levels, Limitations, and Exclusions:	
M	Maximum Benefit Level
L	Limitation
⊗	Exclusion – Not a Benefit of the Contract

Benefits are subject to the following:	
Deductible a) Member (Individual) b) Subscriber and Dependents (Family) Benefits are provided to You after You meet the Individual Deductible. You do not need to meet the Family Deductible if You meet the Individual Deductible. Amounts paid by You to the Deductible will apply to the Yearly Out-of-Pocket Maximum. Deductible must be met before services will be covered, except as noted. Copays and Coinsurance do not apply to the Deductible.	a) $2,500 per Calendar Year b) $5,000 per Calendar Year
Yearly Out-of-Pocket Maximum a) Member (Individual) b) Subscriber and Dependents (Family) Benefits are provided to You without Cost Sharing after You meet the Individual Yearly Out-of-Pocket Maximum. You do not need to meet the Family Yearly Out-of-Pocket Maximum if You meet the Individual Yearly Out-of-Pocket Maximum. All Copays and Coinsurance apply to the Yearly Out-of-Pocket Maximum. You may meet the Yearly Out-of-Pocket Maximum before the Deductible. If that happens, Care will be covered without Copay or Coinsurance.	a) $5,000 per Calendar Year b) $10,000 per Calendar Year

Benefits
The Benefits listed below are subject to Copays or Coinsurance until the applicable Yearly Out-of-Pocket Maximum is met. Cost Sharing will not apply to Benefits if: • You are an Indian; • You got this Policy through the Exchange; and • You receive Care from an Indian Health Program.

Benefits	Copay/Coinsurance
Care not shown on this Coverage Schedule	After Deductible, 20% Coinsurance
Ambulance Services	After Deductible, 20% Coinsurance
Asthma Education - outpatient a) PCP b) Any other Network Provider Related services are subject to the applicable Cost Sharing for the type of service.	a) & b) See Office Visits section on this Coverage Schedule
Autism Spectrum Disorders (ASD)	Benefit level determined by place and type of service
Bariatric Services a) Inpatient and outpatient surgery b) All other bariatric services	a) After Deductible, 20% Coinsurance b) Subject to the applicable Cost Sharing for type of service provided
Behavioral, Mental Health and Substance Use Disorders a) Inpatient and other facility based Care b) Outpatient Care c) Intensive Outpatient Care (does not include detox) **L** – Detox is limited to removal of toxic substances from the body	a) After Deductible, 20% Coinsurance b) No Copay Not subject to Deductible c) After Deductible, 20% Coinsurance
Blood Services – outpatient Office visit Cost Sharing may apply.	After Deductible, 20% Coinsurance
Children's Dental Services **L** – Children's Dental Services are only covered for Members up to age 19.	No Copay Not subject to Deductible
Chiropractic Care (Chiro Care) **M -** 20 visits per Member per Calendar Year. Related services are subject to the Cost Sharing for the type of service.	$40 Copay per visit Not subject to Deductible

Benefits	Copay/Coinsurance
Colorectal Cancer Screenings – outpatient (Including screening colonoscopies and sigmoidoscopies, removal of polyps during the screening and fecal occult blood tests) Related services (anesthesia, laboratory services, medical supplies and radiology) are included in the colorectal cancer screening benefit. Cost Sharing may apply for non-preventive Care provided at the same visit.	No Copay Not subject to Deductible
Diabetic Education - outpatient a) PCP b) Any other Network Provider Related services are subject to the applicable Cost Sharing for the type of service.	a) & b) See Office Visits section on this Coverage Schedule
Dialysis - outpatient Related services are subject to the applicable Cost Sharing for the type of service.	After Deductible, 20% Coinsurance
Disposable Medical Supplies (including diabetic disposable medical supplies) a) Picked up from a pharmacy and on Tiers 1-4 of the RMHP Formulary **L** - Subject to quantity limits noted in the RMHP Formulary. b) All other Disposable Medical Supplies Office visit Cost Sharing may apply. See the RMHP Formulary at www.rmhp.org.	a) See the Prescription Drug Products section on this Coverage Schedule b) After Deductible, 20% Coinsurance
Durable Medical Equipment (DME) and Repairs (Rehabilitative and Habilitative) a) Picked up from a pharmacy and on Tiers 1-4 of the RMHP Formulary **L** - Subject to quantity limits noted in the RMHP Formulary. b) Breast pumps and supplies **L –** Covered with the birth of a child. **L –** Rental or purchase is covered up to the cost of the RMHP Preferred Model. c) All other Durable Medical Equipment (including insulin pumps) Office visit Cost Sharing may apply. See the RMHP Formulary at www.rmhp.org.	a) See Prescription Drug Products section on this Coverage Schedule b) Rental or purchase: No Copay Not subject to Deductible c) After Deductible, 20% Coinsurance

Benefits	Copay/Coinsurance
Early Intervention Services (EIS) **M** - 45 therapeutic visits per Member per Calendar Year. Any therapy Benefits received as part of EIS are not subject to and will not apply to the Maximum Benefit Levels for other therapy services under this Contract **L** - EIS are only a Benefit for Members who are under age 3.	No Copay Not subject to Deductible
Emergency Room Care Copay waived if You are admitted to a hospital.	**Before Your Deductible is met:** $500 Copay per visit, not subject to Deductible, then balance of Allowed Charges for visit subject to Deductible. If Deductible is met during the visit, 20% Coinsurance applies to remainder of Allowed Charges **After Your Deductible is met:** $500 Copay per visit, then 20% Coinsurance
Enteral Nutrition **L** - Covered for Members up to age 3. a) Picked up from a pharmacy b) Not picked up from a pharmacy Office visit Cost Sharing may apply. See the RMHP Formulary at www.rmhp.org.	a) & b) After Deductible, 20% Coinsurance
Eye Care a) Vision screening **M** - One per Member per Calendar Year. b) Eyeglasses, lenses and contact lenses Related services are subject to the applicable Cost Sharing for the type of service. **L** – Vision screenings are only covered for children up to age 19. **L** – Eyeglasses, lenses and contact lenses are only covered for children up to age 19, or after covered eye surgery, or with a diagnosis of keratoconus. **L** – Replacement eyeglasses, lenses and contact lenses are limited to one pair or set every two (2) years for children up to age 19.	a) No Copay Not subject to Deductible b) After Deductible, 20% Coinsurance

Benefits	Copay/Coinsurance
Family Planning and Sterilization a) Any medically acceptable device or procedure used to prevent pregnancy not listed below b) Counseling and information on birth control **Birth control for women** We cover at least one form of contraceptive in each method identified by the FDA without Cost Sharing. The FDA has currently identified 18 methods of contraception. c) Diaphragms d) IUDs and subdermal implants e) Hormone injections f) Surgical sterilization for women g) Prescription Drug Products picked up from a pharmacy **Birth control for men** h) Surgical sterilization for men ⊗ Over-the-counter contraceptive drugs or devices which do not require a prescription, except those on the RMHP Formulary. See the RMHP Formulary at www.rmhp.org.	a) Subject to the applicable Cost Sharing for type of service provided b) – f) No Copay Not subject to Deductible g) See the Prescription Drug Products section of this Coverage Schedule h) Subject to the applicable Cost Sharing for type of service provided
Hearing Exams and Hearing Aids a) Hearing exams and tests b) Hearing aids **L** - Hearing aids are only covered for Members up to age 18. **L** - Replacement hearing aids are limited to 1 pair every 5 years, unless changes to the current hearing aid cannot meet the needs of the Member.	a) $40 Copay per visit Not subject to Deductible b) After Deductible, 20% Coinsurance
Home Health Services	After Deductible, 20% Coinsurance
Hospice Services – inpatient and outpatient	After Deductible, 20% Coinsurance
Hospital – inpatient and outpatient (Applies to all Hospital Care unless otherwise provided in this Coverage Schedule)	After Deductible, 20% Coinsurance
Infertility Care – outpatient a) PCP b) Any other Network Provider c) Artificial insemination Related services are subject to the Cost Sharing for the type of service.	a) & b) See Office Visits section on this Coverage Schedule c) After Deductible, 20% Coinsurance

Benefits	Copay/Coinsurance
Injectable Drugs (Self-Administered) a) Picked up from a pharmacy and on Tiers 1-4 of the RMHP Formulary b) Received in a Physician's office or outpatient facility See the RMHP Formulary at www.rmhp.org.	a) See the Prescription Drug Products section of this Coverage Schedule b) ⊗ Not covered
Injectable Drugs, including allergy injections (Non Self-Administered) and Infusion Drugs a) Picked up from a pharmacy and on Tier 6 or higher of the RMHP Formulary b) Not picked up from a pharmacy Office visit Cost Sharing may apply. See the RMHP Formulary at www.rmhp.org.	a) & b) After Deductible, 20% Coinsurance
Laboratory Services – outpatient Office visits and related services are subject to the applicable Cost Sharing for the type of service.	$40 Copay per visit Not subject to Deductible
Maternity Care a) Routine prenatal office visits b) Other routine prenatal Care c) Delivery and inpatient well-baby Care Non-routine maternity services are subject to the applicable Cost Sharing for the type of service.	a) & b) No Copay Not subject to Deductible c) After Deductible, 20% Coinsurance
Medical Foods and Therapeutic Formulas a) Picked up from a pharmacy b) Not picked up from a pharmacy Office visit Cost Sharing may apply. See the RMHP Formulary at www.rmhp.org.	a) & b) After Deductible, 20% Coinsurance
Nutritional Counseling - outpatient a) At an office visit or an outpatient facility Office visit Cost Sharing may apply. b) For Members per the "A" or "B" recommendations of the USPSTF Cost Sharing may apply for non-preventive Care provided at the same visit.	a) After Deductible, 20% Coinsurance b) No Copay Not subject to Deductible

Benefits	Copay/Coinsurance
Office Visits (Applies to all office visit Care unless otherwise provided in this Coverage Schedule) a) First 3 PCP office visits per Member per Calendar Year b) Any PCP office visits after the first 3 per Member per Calendar Year c) First 3 office visits to any other Network Provider per Member per Calendar Year d) Office visits to any other Nework Provider after the first 3 per Member per Calendar Year Related services are subject to the Cost Sharing for the type of service. Visits at an outpatient facility will be subject to the applicable Cost Sharing in addition to any applicable office visit Cost Sharing.	a) No Copay Not subject to Deductible b) $40 Copay per visit Not subject to Deductible c) $80 Copay per visit Not subject to Deductible d) After Deductible, $80 Copay per visit
Orthotic Devices (OD) (Including repairs) Office visit Cost Sharing may apply.	After Deductible, 20% Coinsurance
Oxygen Service – outpatient	After Deductible, 20% Coinsurance
Physician Services Physician's office and outpatient facility Care. Office visit Cost Sharing may apply.	After Deductible, 20% Coinsurance

Benefits	Copay/Coinsurance
Prescription Drug Products **L** - Retail Pharmacy and Mail Order Pharmacy – up to a 90-day supply. Specialty Prescription Drug Products on any tier and Prescription Drug Products on Tier 4 are limited to a 31-day supply. However, certain products may only be available in forms that are given in intervals longer than every 31 days. In this case, Your Cost Sharing will depend upon the days' supply You receive. This Limitation doesn't apply to oral contraceptive drugs, patches and rings. You can get up to a 1 year supply after an initial 3 month supply for oral contraceptive drugs and patches. Benefits are subject to the Limitations and Exclusions in the RMHP Formulary and Your Contract. **There is no Cost Sharing for contraceptive drugs and devices noted as "H" or "H-PA" on any tier of the RMHP Formulary. "H" means Health Care Reform Preventive. "PA" means requires Prior Authorization. There is also no Cost Sharing for oral anti-cancer drugs on any tier of the RMHP Formulary.** **Your Cost Sharing will not exceed $100 per 30 day supply of insulin, regardless of the amount or type of insulin needed to fill Your Prescription Order(s).** You will be charged an Ancillary Charge when a Prescription Drug Product is dispensed at Your or Your provider's request and a Chemically Equivalent Prescription Drug Product is available. For example, if You choose to fill a Prescription Order for a Brand-name Prescription Drug Product when a Generic is available, Your Ancillary Charge will be the difference in cost between the Brand-name and the Generic Prescription Drug Product. The Ancillary Charge does not apply to Your Yearly Out-of-Pocket Maximum. You will continue to pay the Ancillary Charge once Your Yearly Out-of-Pocket Maximum is met. See the RMHP Formulary at www.rmhp.org.	See chart below

Benefits	Copay/Coinsurance			
In Network Prescription Drug Products Benefit	**Tier 1: Not subject to Deductible**	**Tier 2: Not subject to Deductible**	**Tier 3: Not subject to Deductible**	**Tier 4: Not subject to Deductible**
Up to 31 day supply at all Network Pharmacies	$15.00 Copay	$40.00 Copay	$80.00 Copay	$350.00 Copay
32 to 60 day supply at a Retail Pharmacy & Mail Order Pharmacy* *Specialty Prescription Drug Products on all tiers are limited to a 31-day supply. If given in intervals longer than every 31 days, see applicable tier for Cost Sharing.	$30.00 Copay	$80.00 Copay	$160.00 Copay	Limited to 31 day supply* *If the Prescription Drug Product is given in intervals longer than every 31 days, $700.00 Copay
61 to 90 day supply at a Retail Pharmacy & Mail Order Pharmacy* *Specialty Prescription Drug Products on all tiers are limited to a 31-day supply. If given in intervals longer than every 31 days, see applicable tier for Cost Sharing.	$37.50 Copay	$100.00 Copay	$200.00 Copay	Limited to 31 day supply* *If the Prescription Drug Product is given in intervals longer than every 31 days, $875.00 Copay

Preventive Cancer Screenings – outpatient **M** - One per type of service per Member per Calendar Year. Cost Sharing may apply for non-preventive Care provided at the same visit. a) Mammograms (preventive or diagnostic) b) Prostate screenings c) Routine pap smears (cervical cancer screenings)	a - c) No Copay Not subject to Deductible

Benefits	Copay/Coinsurance
Preventive Services – outpatient Cost Sharing may apply for non-preventive Care provided at the same visit. a) Adult physical exams and routine gynecological exams b) Behavioral health screening **M** - For a) and b) above, one per type of service per Member per Calendar Year, except for additional preventive services recommended by a Physician. c) Well baby Care, well child Care and child health supervision services, not including immunizations **L** - Well child services as age appropriate. d) Immunizations - Adult and child immunizations, vaccination for cervical cancer, and influenza and pneumococcal immunizations as recommended by ACIP ⊗ - Travel immunizations e) Alcohol misuse screening and behavioral counseling interventions for adults, depression screening for adolescents and adults, and perinatal depression counseling, per the "A" or "B" recommendations of the USPSTF f) Tobacco use screening for adults by any primary care provider, unlimited tobacco cessation interventions for adults per the "A" or "B" recommendations of the USPSTF, access to the Colorado Quitline, and all FDA approved tobacco cessation medications (both prescription and over-the-counter) g) Cholesterol screening for lipid disorders h) Chlamydia screening, for female Members within the ages of the USPSTF recommendation i) Type 2 diabetes screening j) Any preventive service not listed above included: • as an "A" or "B" recommendation by the USPSTF; • in the women's preventive care and screening guidelines supported by HRSA; or • in the infants, children, and adolescents preventive care and screenings guidelines supported by HRSA.	a - j) No Copay Not subject to Deductible

Benefits	Copay/Coinsurance
Prosthetic Devices (PD) a) Arm and leg prosthetic devices b) All other prosthetic devices c) Repairs Office visit Cost Sharing may apply.	a) 20% Coinsurance Not subject to Deductible b) & c) After Deductible, 20% Coinsurance
Radiation Therapy	After Deductible, 20% Coinsurance
Skilled Nursing Facility Services **M** - 100 days per Member per Calendar Year.	After Deductible, 20% Coinsurance
Surgery (Applies to all surgery Care and services unless otherwise provided in this Coverage Schedule) a) Inpatient surgery b) Outpatient surgery and invasive diagnostic testing	a) & b) After Deductible, 20% Coinsurance
Therapy Services – inpatient physical, speech, occupational therapy, pulmonary and cardiac rehabilitation **M** - Rehabilitative and Habilitative physical, occupational and speech therapies (combined) are limited to 2 months per Episode per medical condition.	After Deductible, 20% Coinsurance
Therapy Services – outpatient physical, speech, occupational therapy, pulmonary and cardiac rehabilitation **M** - Physical, occupational and speech therapies for rehabilitative purposes are limited to 20 visits per Member per therapy per Calendar Year. **M** - Physical, occupational and speech therapies for rehabilitative purposes for congenital defects and birth abnormalities (for Members up to 6 years of age) are limited to 20 visits per Member per therapy per Calendar Year. **M** - Physical, occupational and speech therapies for Habilitative purposes are limited to 20 visits per Member per therapy per Calendar Year.	$40 Copay per visit Not subject to Deductible
Total Parenteral Nutrition (TPN) – outpatient Office visit Cost Sharing may apply.	After Deductible, 20% Coinsurance
Transplants – inpatient and outpatient	After Deductible, 20% Coinsurance
Urgent Care Services – outpatient Related services are subject to the applicable Cost Sharing for the type of service.	$65 Copay per visit Not subject to Deductible

Benefits	Copay/Coinsurance
X-ray and Other Imaging Services – outpatient	a) $70 Copay per visit
a) X-rays and other imaging	Not subject to Deductible
b) MRI, PET and CT scans	b) $400 Copay per visit
Office visits and related services are subject to the applicable Cost Sharing for the type of service.	Not subject to Deductible