ROCKY MOUNTAIN HEALTH PLANS

Monument Health HMO Silver $3500/70%/$35 RX Copay Plan IDV

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.rmhp.org or call 1-800-346-4643. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/or call 1-800-346-4643 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$3,500/$5,000 individual (Tier 1/Tier 2) $7,000/$10,000 family (Tier 1/Tier 2)	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	**Yes.** Preventive care, primary care and specialist visits, prescription drugs, labs, urgent care, inpatient hospital, outpatient mental health/behavioral/substance abuse services, rehabilitation/habilitation services, child eye exams and child dental check-ups are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**No.**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$8,150 individual (Tier 1 and Tier 2) $16,300 family (Tier 1 and Tier 2) Tier 1 and 2 accumulate together	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing 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.
Will you pay less if you use a network provider?	**Yes.** See www.rmhp.org or call 1-800-346-4643 for a list of network providers.	You pay the least if you use a provider in Tier 1. You pay more if you use a provider in Tier 2. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	**No.**	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Tier 1: First 3 PCP visits $10 copay/visit; deductible does not apply then $35 copay/visit; deductible does not apply Tier 2: $50 copay/visit; deductible does not apply	Not Covered	None
	Specialist visit	Tier 1: $70 copay/visit; deductible does not apply Tier 2: $80 copay/visit	Not Covered	None
	Preventive care/ screening/Immunization	Tier 1 and 2: No charge; deductible does not apply	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Tier 1: $40 copay/visit; deductible does not apply Tier 2: 50% coinsurance/Lab	Not Covered	May require preauthorization. Please go to www.rmhp.org to find out if a service needs preauthorization. If you don't get preauthorization for out-of-network services, benefits will be denied.
		Tier 1: 30% coinsurance Tier 2: 50% coinsurance /X-Ray	Not Covered	
	Imaging (CT/PET scans, MRIs)	Tier 1: 30% coinsurance Tier 2: 50% coinsurance	Not Covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.rmhp.org	Tier 1 (Lower-cost. Mostly generic drugs, including drugs for cancer treatment. Some brand-name drugs may also be included.)	$15 (R)/ $37.50 (MO) copay/prescription; deductible does not apply	Not Covered	$0 copay for contraceptive drugs/devices noted as "H" or "H-PA" on any tier of the formulary. There is also no cost sharing for oral anti-cancer drugs on any tier of the formulary. Retail (R) and Mail Order (MO) Pharmacy limited 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.
	Tier 2 (Mid-range cost. A mix of brand-name and generic drugs, including drugs for cancer treatment.)	$50 (R)/ $125 (MO) copay/prescription; deductible does not apply	Not Covered	
	Tier 3 (Mid-range cost. A mix of brand-name and generic drugs, including drugs for cancer treatment.)	$80 (R)/ $200 (MO) copay/prescription; deductible does not apply	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Tier 4 (Highest-cost. Mostly brand-name drugs, as well as some generics, including drugs for cancer treatment.)	$300 (R) copay/prescription; deductible does not apply $750 (MO) copay/prescription; deductible does not apply (if the prescription is for intervals longer than every 31 days)	Not Covered	You can get up to a 1 year supply after an initial 3 month supply for oral contraceptive drugs and patches. 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). Retail copay shown 31-day supply, Mail order copay shown 90-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Tier 1: 30% coinsurance Tier 2: 50% coinsurance	Not Covered	May require preauthorization. Please go to www.rmhp.org to find out if a service needs preauthorization. If you don't get preauthorization for out-of-network services, benefits will be denied.
	Physician/surgeon fees	Tier 1: 30% coinsurance Tier 2: 50% coinsurance	Not Covered	
If you need immediate medical attention	Emergency room care	Tier 1 and 2: $600 copay/visit before deductible then 30% coinsurance	Tier 1 and 2: $600 copay/visit before deductible then 30% coinsurance	Tier 1 and 2 applies to the Tier 1 deductible.
	Emergency medical transportation	Tier 1 and 2: 30% coinsurance	Tier 1 and 2: 30% coinsurance	Tier 1 and 2 applies to the Tier 1 deductible.
	Urgent care	Tier 1 and 2: $60 copay/visit; deductible does not apply	Tier 1 and 2: $60 copay/ visit; deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Tier 1: $750 copay per day up to (4) days; deductible does not apply Tier 2: 50% coinsurance	Not Covered	May require preauthorization. Please go to www.rmhp.org to find out if a service needs preauthorization. If you don't get preauthorization for out-of-network services, benefits will be denied.
	Physician/surgeon fees	Tier 1: No charge; deductible does not apply Tier 2: 50% coinsurance	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Tier 1: $10 copay/visit; deductible does not apply Tier 2: $50 copay/visit; deductible does not apply	Not Covered	May require preauthorization. Please go to www.rmhp.org to find out if a service needs preauthorization. If you don't get preauthorization for out-of-network services, benefits will be denied.
	Inpatient services	Tier 1: $750 copay per day up to (4) days; deductible does not apply Tier 2: 50% coinsurance	Not Covered	
If you are pregnant	Office visits	Tier 1: No charge; deductible does not apply Tier 2: 50% coinsurance	Not Covered	Cost sharing does not apply for preventive services including routine prenatal care.
	Childbirth/delivery professional services	Tier 1: No charge; deductible does not apply Tier 2: 50% coinsurance	Not Covered	
	Childbirth/delivery facility services	Tier 1: $750 copay per day up to (4) days; deductible does not apply Tier 2: 50% coinsurance	Not Covered	
If you need help recovering or have other special health needs	Home health care	Tier 1: 30% coinsurance Tier 2: 50% coinsurance	Not Covered	None
	Rehabilitation services	Tier 1: $30 copay/visit; deductible does not apply Tier 2: 50% coinsurance	Not Covered	Coverage is limited to 20 visits/ Member/therapy/year for rehabilitative and 20 visits/Member/therapy/year for habilitative services.
	Habilitation services	Tier 1: $30 copay/visit; deductible does not apply Tier 2: 50% coinsurance	Not Covered	
	Skilled nursing care	Tier 1: $750 copay per day up to (4) days; deductible does not apply Tier 2: 50% coinsurance	Not Covered	Coverage is limited to 100 days/ Member /year.
	Durable medical equipment	Tier 1: 30% coinsurance Tier 2: 50% coinsurance	Not Covered	May require preauthorization. Please go to www.rmhp.org to find out if a service needs preauthorization. If you don't get preauthorization for out-of-network services, benefits will be denied.
	Hospice services	Tier 1: 30% coinsurance Tier 2: 50% coinsurance	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Tier 1 and 2: No charge; deductible does not apply	Not Covered	Coverage is limited to children up to age 19, limited to one/Member/year.
	Children's glasses	Tier 1: 30% coinsurance Tier 2: 50% coinsurance	Not Covered	Coverage is limited to children up to age 19, or after covered eye surgery, or with a diagnosis of keratoconus.
	Children's dental check-up	Tier 1 and 2: No charge; deductible does not apply	Not Covered	Coverage is limited to children up to age 19.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Drugs not included in the formulary
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortions (cases of rape, incest, or to save the life of the mother)
- Bariatric surgery
- Chiropractic care
- Hearing Aids (for children)
- Infertility treatment
- Private-duty nursing

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272, https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: you can contact RMHP at 1-800-346-4643.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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 section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3500
Specialist copayment	$70
Hospital (facility) copayment	$750
Other coinsurance	30%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$8150
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$8210**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3500
Specialist copayment	$70
Hospital (facility) copayment	$750
Other coinsurance	30%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1200
Copayments	$2200
Coinsurance	$500
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3960**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3500
Specialist copayment	$70
Hospital (facility) copayment	$750
Other coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$900
Copayments	$400
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1700**

Multi-Language Insert

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-346-4643 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-346-4643 (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 1-800-346-4643 (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 1-800-346-4643 (TTY: 711)。
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-346-4643 (TTY: 711)번으로 전화해 주십시오.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-346-4643 (телетайп: 711).
Amharic	ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-346-4643 (መስማት ለተሳናቸው: 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-643-3464 (رقم هاتف الصم والبكم: 117).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-346-4643 (TTY: 711).
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-346-4643 (ATS : 711).
Nepali	ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-346-4643 (टिटिवाइ: 711) ।
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-346-4643 (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。1-800-346-4643（TTY:711）まで、お電話にてご連絡ください。

Notice of Nondiscrimination

Cushite/Oromo	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-346-4643 (TTY: 711).
Persian	**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 3464-643-008-1 (117:YTT) تماس بگیرید.
Ibo/Igbo	Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-800-346-4643 (TTY: 711).
Kru-Bassa	Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jŭ ké m̀ [B̀àsɔ́ɔ̀-wùɖù-po-nyɔ̀] jŭ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Ɗá 1-800-346-4643 (TTY: 711)
Yoruba	AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-800-346-4643 (TTY: 711).

Notice of Nondiscrimination

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

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, sexual orientation, or gender identity , 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.