




**Monument ONE HMO Gold \$2500/80%/\$40 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](http://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:
<b>What is the overall <u>deductible</u>?</b>	\$2,500 individual/\$5,000 family (In- <u>Network</u> )	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	<b>Yes.</b> <u>Preventive care</u> , primary care, <u>prescription drugs</u> , labs, x-rays, CT/PET scans and MRIs, <u>urgent care</u> , <u>rehabilitation/habilitation services</u> , outpatient mental health/behavioral health/substance abuse services, child eye exams and child dental check-ups are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	<b>No.</b>	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	\$5,000 individual/\$10,000 family (In- <u>Network</u> )	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance-billing</u> charges (unless balanced billing is prohibited), and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	<b>Yes.</b> See <a href="http://www.rmhp.org">www.rmhp.org</a> or call 1-800-346-4643 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	<b>No.</b>	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	No <u>copay</u> for the first 3 visits; <u>deductible</u> does not apply, then \$40 <u>copay</u> /visit; <u>deductible</u> does not apply	Not Covered	None
	<u>Specialist</u> visit	\$80 <u>copay</u> for the first 3 visits; <u>deductible</u> does not apply, then \$80 <u>copay</u> /visit	Not Covered	None
	<u>Preventive care/screening</u> /Immunization	No charge; <u>deductible</u> does not apply	Not Covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply/Lab	Not Covered	May require <u>preauthorization</u> . Please go to <a href="http://www.rmhp.org">www.rmhp.org</a> to find out if a service needs <u>preauthorization</u> . If you don't get <u>preauthorization</u> for out-of- <u>network</u> services, benefits will be denied.
		\$70 <u>copay</u> /visit; <u>deductible</u> does not apply/X-Ray	Not Covered	
	Imaging (CT/PET scans, MRIs)	\$400 <u>copay</u> /visit; <u>deductible</u> does not apply	Not Covered	
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.rmhp.org">www.rmhp.org</a>	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) <u>copay</u> /prescription; <u>deductible</u> does not apply	Not Covered	\$0 <u>copay</u> for contraceptive drugs/devices noted as "H" or "H-PA" on any tier of the <u>formulary</u> . There is also no cost sharing for oral anti-cancer drugs on any tier of the <u>formulary</u> .  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.)	\$40 (R)/ \$100 (MO) <u>copay</u> /prescription; <u>deductible</u> 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) <u>copay</u> /prescription; <u>deductible</u> 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.)	\$350 (R) <u>copay</u> /prescription; <u>deductible</u> does not apply  \$875 (MO) <u>copay</u> / prescription; <u>deductible</u> 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 <u>copay</u> shown 31-day supply, Mail order <u>copay</u> shown 90-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not Covered	May require <u>preauthorization</u> . Please go to <a href="http://www.rmhp.org">www.rmhp.org</a> to find out if a service needs <u>preauthorization</u> . If you don't get <u>preauthorization</u> for out-of- <u>network</u> services, benefits will be denied.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not Covered	
If you need immediate medical attention	<u>Emergency room care</u>	\$500 <u>copay</u> /visit before <u>deductible</u> then 20% <u>coinsurance</u>	\$500 <u>copay</u> /visit before <u>deductible</u> then 20% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$65 <u>copay</u> /visit; <u>deductible</u> does not apply	\$65 <u>copay</u> / visit; <u>deductible</u> does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not Covered	May require <u>preauthorization</u> . Please go to <a href="http://www.rmhp.org">www.rmhp.org</a> to find out if a service needs <u>preauthorization</u> . If you don't get <u>preauthorization</u> for out-of- <u>network</u> services, benefits will be denied.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge; <u>deductible</u> does not apply	Not Covered	May require <u>preauthorization</u> . Please go to <a href="http://www.rmhp.org">www.rmhp.org</a> to find out if a service needs <u>preauthorization</u> . If you don't get <u>preauthorization</u> for out-of- <u>network</u> services, benefits will be denied.
	Inpatient services	20% <u>coinsurance</u>	Not Covered	
If you are pregnant	Office visits	20% <u>coinsurance</u>	Not Covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> including <u>routine prenatal</u> care.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not Covered	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	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)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	20% <u>coinsurance</u>	Not Covered	None
	<u>Rehabilitation services</u>	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	Not Covered	Coverage is limited to 20 visits/Member/therapy/year for rehabilitative and 20 visits/Member/therapy/year for habilitative services.
	<u>Habilitation services</u>	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	Not Covered	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not Covered	Coverage is limited to 100 days/Member /year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not Covered	May require <u>preauthorization</u> . Please go to <a href="http://www.rmhp.org">www.rmhp.org</a> to find out if a service needs <u>preauthorization</u> . If you don't get <u>preauthorization</u> for out-of- <u>network</u> services, benefits will be denied.
	<u>Hospice services</u>	20% <u>coinsurance</u>	Not Covered	None
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge; <u>deductible</u> does not apply	Not Covered	Coverage is limited to children up to age 19, limited to one/Member/year.
	Children's glasses	20% <u>coinsurance</u>	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	No charge; <u>deductible</u> 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.)**

- |   |   |   |
|---|---|---|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Drugs not included in the <u>formulary</u></li> </ul> | <ul style="list-style-type: none"> <li>• Dental care (Adult)</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |
|---|---|---|

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

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|---|---|--|
| <ul style="list-style-type: none"> <li>• Abortions (cases of rape, incest, or to save the life of the mother)</li> <li>• Bariatric surgery</li> </ul> | <ul style="list-style-type: none"> <li>• Chiropractic care</li> <li>• Hearing Aids (for children)</li> <li>• Infertility treatment</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing</li> </ul> |
|---|---|--|

### 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](http://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](http://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.

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

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**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** \$2500
- **Specialist copayment** \$80
- **Hospital (facility) copayment** 20%
- **Other coinsurance** 20%

**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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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**In this example, Peg would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2000
<u>Copayments</u>	\$750
<u>Coinsurance</u>	\$2250
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5060</b>

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

- **The plan's overall deductible** \$2500
- **Specialist copayment** \$80
- **Hospital (facility) copayment** 20%
- **Other coinsurance** 20%

**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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1500
<u>Copayments</u>	\$2100
<u>Coinsurance</u>	\$350
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$4010</b>

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

- **The plan's overall deductible** \$2500
- **Specialist copayment** \$80
- **Hospital (facility) copayment** 20%
- **Other coinsurance** 20%

**This EXAMPLE event includes services like:**

- Emergency room care (*including medical supplies*)
- Diagnostic tests (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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**In this example, Mia would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1150
<u>Copayments</u>	\$450
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1900</b>

## Multi-Language Insert

<b>English</b>	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-346-4643 (TTY: 711).
<b>Spanish</b>	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-346-4643 (TTY: 711).
<b>Vietnamese</b>	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).
<b>Chinese</b>	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)。
<b>Korean</b>	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-346-4643 (TTY: 711)번으로 전화해 주십시오.
<b>Russian</b>	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-346-4643 (телетайп: 711).
<b>Amharic</b>	ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚክተሎ ቁጥር ይደውሉ 1-800-346-4643 (መስማት ለተሳናቸው: 711)።
<b>Arabic</b>	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-346-4643 (رقم هاتف الصم والبكم: 117).
<b>German</b>	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-346-4643 (TTY: 711).
<b>French</b>	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-346-4643 (ATS : 711).
<b>Nepali</b>	ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-346-4643 (टिटिवाइ: 711) ।
<b>Tagalog</b>	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).
<b>Japanese</b>	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

<b>Cushite/Oromo</b>	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-346-4643 (TTY: 711).
<b>Persian</b>	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.
<b>Ibo/Igbo</b>	Ige nti: O buru na asu lbo asusu, enyemaka diri gi site na call 1-800-346-4643 (TTY: 711).
<b>Kru-Bassa</b>	Dè dε nìà ke dyédé gbo: ɔ jũ ké ò [Bàsóò-wùdù-po-nyò] jũ ní, níf, à wuɖu kà kò dò po-poò bɛ́in ò gbo kpáa. Đá 1-800-346-4643 (TTY: 711)
<b>Yoruba</b>	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](mailto: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.



**Colorado Supplement to the Summary of Benefits and Coverage Form**

<b>INSURANCE COMPANY NAME</b>	Rocky Mountain Health Maintenance Organization, Inc.
<b>NAME OF PLAN</b>	Monument ONE
<b>1. Type of policy</b>	Individual Policy
<b>2. Type of plan</b>	Health Maintenance Organization (HMO)
<b>3. Areas of Colorado where plan is available.</b>	Plan is only available in Mesa 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.

	<b>Description</b>
<b>4. Annual Deductible Type</b>	<p>INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid. Claims will not be paid for any other individual until their individual deductible or the family deductible has been met.</p> <p>FAMILY – The maximum amount that the family will pay for the year. The family deductible can be met by [2] or more individuals.</p>
<b>5. Out-of-Pocket Maximum</b>	<p>INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid at 100%. Claims will not be paid at 100% for any other individual until their individual out-of-pocket or the family out-of-pocket has been met.</p> <p>FAMILY – the maximum amount that the family will pay for the year. The family out-of-pocket can be met by [2] or more individuals.</p>
<b>6. What is included in the In-Network Out-of-Pocket Maximum?</b>	All deductibles, copayments, and coinsurance, including those for prescription drugs.

<b>7. Is pediatric dental covered by this plan?</b>	Yes, pediatric dental is covered at 100% of allowable charges.
<b>8. What cancer screenings are covered by this plan?</b>	<p>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:</p> <ul style="list-style-type: none"> <li>• Breast – Mammogram</li> <li>• Cervical – PAP test</li> <li>• Colorectal – Colonoscopy, Sigmoidoscopy, Fecal Occult Blood</li> <li>• Ovarian – CA125</li> <li>• Prostate – PSA</li> </ul> <p>Coverage for these cancer screening tests are subject to the following parameters:</p> <ol style="list-style-type: none"> <li>a) the test must be ordered by your physician, and</li> <li>b) you must comply with plan procedures</li> </ol>

**USING THE PLAN**

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>9. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?</b>	No	Yes
<b>10. Does the plan have a binding arbitration clause?</b>	Yes	

**Questions:** Call 1-800-346-4643 or visit us at [www.rmhp.com](http://www.rmhp.com)

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

Colorado Division of Insurance  
Consumer Services, Life and Health Section  
1560 Broadway, Suite 850, Denver, CO 80202  
Call: 303-894-7490 (in-state, toll-free: 800-930-3745)  
Email: [dora\\_insurance@state.co.us](mailto:dora_insurance@state.co.us)