Health Insurance Rate Review

for

B and L Roofing

Prepared By: **Chris Adams**

Created Date: **1/3/2015**

Rates illustrated in this proposal are preliminary. Actual rates and plan availability are dependent upon information provided at time of enrollment including: which employees and dependents elect or waive coverage, dependent status, employee and dependent dates of birth, tobacco use, location of employer, employees and covered dependents and effective date of coverage.

Final rates will only be provided through the Connect for Health Colorado Marketplace system after all employees have enrolled or waived coverage.

Employee Options

for

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Plan Name	Carrier	Plan Type	Metal Level	EE Cost	Dependent Cost	Employer Cost	Total Cost	
HealthOP Bear HSA Qualified High Deductible Health Plan EPO	Colorado HealthOp, Inc.	EPO	Bronze	$185.04	$242.71	$265.95	$693.70	☐
HealthOP Bear EPO	Colorado HealthOp, Inc.	EPO	Bronze	$196.33	$257.51	$282.17	$736.01	☐
HealthOP Bison Flex EPO	Colorado HealthOp, Inc.	EPO	Silver	$226.65	$297.28	$325.76	$849.69	☐
KP CO Bronze 4500/50%/HSA	Kaiser Foundation Health Plan of Colorado	HMO	Bronze	$229.38	$300.87	$329.68	$859.93	☐
HealthOP Bison HSA Qualified High Deductible Health Plan EPO	Colorado HealthOp, Inc.	EPO	Silver	$234.08	$307.02	$336.42	$877.52	☐
KP CO Bronze 3500/40/HSA	Kaiser Foundation Health Plan of Colorado	HMO	Bronze	$247.97	$325.24	$356.40	$929.61	☐
HealthOP Bison EPO	Colorado HealthOp, Inc.	EPO	Silver	$248.05	$325.35	$356.50	$929.90	☐
HealthOP Bear HSA Qualified High Deductible Health Plan PPO	Colorado HealthOp, Inc.	PPO	Bronze	$249.98	$327.88	$359.29	$937.15	☐
HealthOp Bear PPO	Colorado HealthOp, Inc.	PPO	Bronze	$261.69	$343.24	$376.10	$981.03	☐
Anthem Bronze Pathway X HMO 5000 30 6600 Plus	HMO Colorado Inc(Anthem BCBS)	HMO	Bronze	$269.04	$352.88	$386.67	$1,008.59	☐
KP CO Bronze 4500/50	Kaiser Foundation Health Plan of Colorado	HMO	Bronze	$270.78	$355.15	$389.15	$1,015.08	☐
HealthOP Bison Flex PPO	Colorado HealthOp, Inc.	PPO	Silver	$294.00	$385.63	$422.55	$1,102.18	☐
KP CO Silver 1500/50	Kaiser Foundation Health Plan of Colorado	HMO	Silver	$297.08	$389.65	$426.97	$1,113.70	☐
KP CO Silver 2000/30/HSA	Kaiser Foundation Health Plan of Colorado	HMO	Silver	$299.18	$392.41	$430.00	$1,121.59	☐
New West Focus HMO Bronze HSA - Deductible $3250/70%/Copay $45	Rocky Mountain Health Plans	HMO	Bronze	$304.05	$398.80	$436.98	$1,139.83	☐
KP CO Silver 1200/35	Kaiser Foundation Health Plan of Colorado	HMO	Silver	$305.85	$401.15	$439.57	$1,146.57	☐
HealthOP Bison HSA Qualified High Deductible Health Plan PPO	Colorado HealthOp, Inc.	PPO	Silver	$308.43	$404.54	$443.28	$1,156.25	☐
Anthem Silver Pathway X HMO 2000 30 5000 Plus	HMO Colorado Inc(Anthem BCBS)	HMO	Silver	$318.32	$417.52	$457.51	$1,193.35	☐
Rocky Mountain Summit HMO Bronze HSA - Deductible $6000/100%	Rocky Mountain Health Plans	HMO	Bronze	$321.73	$421.99	$462.39	$1,206.11	☐
HealthOp Bison PPO	Colorado HealthOp, Inc.	PPO	Silver	$323.06	$423.73	$464.30	$1,211.09	☐
Rocky Mountain Summit HMO Bronze - Deductible $4500/60%/Copay $55	Rocky Mountain Health Plans	HMO	Bronze	$324.58	$425.72	$466.49	$1,216.79	☐
Rocky Mountain Summit HMO Bronze HSA - Deductible $5250/100%	Rocky Mountain Health Plans	HMO	Bronze	$334.28	$438.45	$480.44	$1,253.17	☐
Rocky Mountain Summit HMO Bronze HSA - Deductible $3250/70%/Copay $45	Rocky Mountain Health Plans	HMO	Bronze	$337.70	$442.93	$485.35	$1,265.98	☐
New West Focus HMO Silver - Deductible $2000/70%/Copay $45	Rocky Mountain Health Plans	HMO	Silver	$341.12	$447.42	$490.26	$1,278.80	☐
Rocky Mountain Summit PPO Bronze - Deductible $4500/60%/Copay $55	Rocky Mountain Health Plans	PPO	Bronze	$347.70	$456.05	$499.71	$1,303.46	☐

Employee Options

for

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Plan Name	Carrier	Plan Type	Metal Level	EE Cost	Dependent Cost	Employer Cost	Total Cost	
Rocky Mountain Summit PPO Bronze HSA - Deductible $6000/100%	Rocky Mountain Health Plans	PPO	Bronze	$347.70	$456.05	$499.71	$1,303.46	☐
New West Focus HMO Silver - Deductible $1500/70%/Copay $35	Rocky Mountain Health Plans	HMO	Silver	$349.11	$457.90	$501.74	$1,308.75	☐
Rocky Mountain Summit PPO Bronze HSA - Deductible $5250/100%	Rocky Mountain Health Plans	PPO	Bronze	$358.99	$470.86	$515.94	$1,345.79	☐
Rocky Mountain Summit PPO Bronze HSA - Deductible $3250/70%/Copay $45	Rocky Mountain Health Plans	PPO	Bronze	$360.77	$473.20	$518.51	$1,352.48	☐
Rocky Mountain Summit HMO Silver - Deductible $3000/80%/Copay $40	Rocky Mountain Health Plans	HMO	Silver	$368.51	$483.34	$529.63	$1,381.48	☐
Rocky Mountain Summit HMO Silver - Deductible $2000/70% Copay $45	Rocky Mountain Health Plans	HMO	Silver	$378.77	$496.81	$544.38	$1,419.96	☐
Rocky Mountain Summit HMO Silver - Deductible $2000/70%/Copay $40	Rocky Mountain Health Plans	HMO	Silver	$381.62	$500.54	$548.47	$1,430.63	☐
Rocky Mountain Summit HMO Silver - Deductible $1500/70%/Copay $35	Rocky Mountain Health Plans	HMO	Silver	$387.89	$508.77	$557.49	$1,454.15	☐
Rocky Mountain Summit HMO Silver HSA - Deductible $3000/100%	Rocky Mountain Health Plans	HMO	Silver	$391.89	$514.02	$563.24	$1,469.15	☐
Rocky Mountain Summit PPO Silver - Deductible $3000/80%/Copay $40	Rocky Mountain Health Plans	PPO	Silver	$392.86	$515.29	$564.63	$1,472.78	☐
Rocky Mountain Summit PPO Silver - Deductible $2000/70%/Copay $45	Rocky Mountain Health Plans	PPO	Silver	$403.57	$529.33	$580.03	$1,512.93	☐
Rocky Mountain Summit PPO Silver - Deductible $2000/70%/Copay $40	Rocky Mountain Health Plans	PPO	Silver	$405.94	$532.44	$583.42	$1,521.80	☐
Rocky Mountain Summit PPO Silver - Deductible $1500/70%/Copay $35	Rocky Mountain Health Plans	PPO	Silver	$412.48	$541.02	$592.83	$1,546.33	☐
Rocky Mountain Summit PPO Silver HSA - Deductible $3000/100%	Rocky Mountain Health Plans	PPO	Silver	$417.83	$548.03	$600.51	$1,566.37	☐

Employee Options

for

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Plan Name	Carrier	Plan Type	Metal Level	EE Cost	Dependent Cost	Employer Cost	Total Cost	
HealthOP Bear HSA Qualified High Deductible Health Plan EPO	Colorado HealthOp, Inc.	EPO	Bronze	$81.22	$197.38	$147.01	$425.61	☐
HealthOP Bear EPO	Colorado HealthOp, Inc.	EPO	Bronze	$86.17	$209.42	$155.99	$451.58	☐
HealthOP Bison Flex EPO	Colorado HealthOp, Inc.	EPO	Silver	$99.48	$241.76	$180.08	$521.32	☐
KP CO Bronze 4500/50%/HSA	Kaiser Foundation Health Plan of Colorado	HMO	Bronze	$100.68	$244.67	$182.24	$527.59	☐
HealthOP Bison HSA Qualified High Deductible Health Plan EPO	Colorado HealthOp, Inc.	EPO	Silver	$102.74	$249.67	$185.97	$538.38	☐
KP CO Bronze 3500/40/HSA	Kaiser Foundation Health Plan of Colorado	HMO	Bronze	$108.84	$264.50	$197.01	$570.35	☐
HealthOP Bison EPO	Colorado HealthOp, Inc.	EPO	Silver	$108.87	$264.58	$197.08	$570.53	☐
HealthOP Bear HSA Qualified High Deductible Health Plan PPO	Colorado HealthOp, Inc.	PPO	Bronze	$109.72	$266.65	$198.61	$574.98	☐
HealthOp Bear PPO	Colorado HealthOp, Inc.	PPO	Bronze	$114.86	$279.13	$207.90	$601.89	☐
Anthem Bronze Pathway X HMO 5000 30 6600 Plus	HMO Colorado Inc(Anthem BCBS)	HMO	Bronze	$118.09	$286.98	$213.75	$618.82	☐
KP CO Bronze 4500/50	Kaiser Foundation Health Plan of Colorado	HMO	Bronze	$118.85	$288.82	$215.13	$622.80	☐
HealthOP Bison Flex PPO	Colorado HealthOp, Inc.	PPO	Silver	$129.05	$313.60	$233.58	$676.23	☐
KP CO Silver 1500/50	Kaiser Foundation Health Plan of Colorado	HMO	Silver	$130.39	$316.88	$236.03	$683.30	☐
KP CO Silver 2000/30/HSA	Kaiser Foundation Health Plan of Colorado	HMO	Silver	$131.32	$319.12	$237.70	$688.14	☐
New West Focus HMO Bronze HSA - Deductible $3250/70%/Copay $45	Rocky Mountain Health Plans	HMO	Bronze	$133.45	$324.31	$241.57	$699.33	☐
KP CO Silver 1200/35	Kaiser Foundation Health Plan of Colorado	HMO	Silver	$134.24	$326.23	$243.00	$703.47	☐
HealthOP Bison HSA Qualified High Deductible Health Plan PPO	Colorado HealthOp, Inc.	PPO	Silver	$135.37	$328.99	$245.04	$709.40	☐
Anthem Silver Pathway X HMO 2000 30 5000 Plus	HMO Colorado Inc(Anthem BCBS)	HMO	Silver	$139.72	$339.55	$252.90	$732.17	☐
Rocky Mountain Summit HMO Bronze HSA - Deductible $6000/100%	Rocky Mountain Health Plans	HMO	Bronze	$141.21	$343.18	$255.61	$740.00	☐
HealthOp Bison PPO	Colorado HealthOp, Inc.	PPO	Silver	$141.80	$344.59	$256.65	$743.04	☐
Rocky Mountain Summit HMO Bronze - Deductible $4500/60%/Copay $55	Rocky Mountain Health Plans	HMO	Bronze	$142.46	$346.21	$257.88	$746.55	☐
Rocky Mountain Summit HMO Bronze HSA - Deductible $5250/100%	Rocky Mountain Health Plans	HMO	Bronze	$146.72	$356.57	$265.58	$768.87	☐
Rocky Mountain Summit HMO Bronze HSA - Deductible $3250/70%/Copay $45	Rocky Mountain Health Plans	HMO	Bronze	$148.22	$360.21	$268.30	$776.73	☐
New West Focus HMO Silver - Deductible $2000/70%/Copay $45	Rocky Mountain Health Plans	HMO	Silver	$149.72	$363.86	$271.02	$784.60	☐
Rocky Mountain Summit PPO Bronze - Deductible $4500/60%/Copay $55	Rocky Mountain Health Plans	PPO	Bronze	$152.61	$370.87	$276.23	$799.71	☐

Employee Options

for

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Plan Name	Carrier	Plan Type	Metal Level	EE Cost	Dependent Cost	Employer Cost	Total Cost	
Rocky Mountain Summit PPO Bronze HSA - Deductible $6000/100%	Rocky Mountain Health Plans	PPO	Bronze	$152.61	$370.87	$276.23	$799.71	☐
New West Focus HMO Silver - Deductible $1500/70%/Copay $35	Rocky Mountain Health Plans	HMO	Silver	$153.23	$372.37	$277.36	$802.96	☐
Rocky Mountain Summit PPO Bronze HSA - Deductible $5250/100%	Rocky Mountain Health Plans	PPO	Bronze	$157.57	$382.92	$285.21	$825.70	☐
Rocky Mountain Summit PPO Bronze HSA - Deductible $3250/70%/Copay $45	Rocky Mountain Health Plans	PPO	Bronze	$158.35	$384.82	$286.62	$829.79	☐
Rocky Mountain Summit HMO Silver - Deductible $3000/80%/Copay $40	Rocky Mountain Health Plans	HMO	Silver	$161.74	$393.07	$292.77	$847.58	☐
Rocky Mountain Summit HMO Silver - Deductible $2000/70% Copay $45	Rocky Mountain Health Plans	HMO	Silver	$166.25	$404.02	$300.92	$871.19	☐
Rocky Mountain Summit HMO Silver - Deductible $2000/70%/Copay $40	Rocky Mountain Health Plans	HMO	Silver	$167.50	$407.05	$303.19	$877.74	☐
Rocky Mountain Summit HMO Silver - Deductible $1500/70%/Copay $35	Rocky Mountain Health Plans	HMO	Silver	$170.25	$413.75	$308.18	$892.18	☐
Rocky Mountain Summit HMO Silver HSA - Deductible $3000/100%	Rocky Mountain Health Plans	HMO	Silver	$172.01	$418.01	$311.35	$901.37	☐
Rocky Mountain Summit PPO Silver - Deductible $3000/80%/Copay $40	Rocky Mountain Health Plans	PPO	Silver	$172.43	$419.05	$312.12	$903.60	☐
Rocky Mountain Summit PPO Silver - Deductible $2000/70%/Copay $45	Rocky Mountain Health Plans	PPO	Silver	$177.13	$430.47	$320.63	$928.23	☐
Rocky Mountain Summit PPO Silver - Deductible $2000/70%/Copay $40	Rocky Mountain Health Plans	PPO	Silver	$178.17	$433.00	$322.51	$933.68	☐
Rocky Mountain Summit PPO Silver - Deductible $1500/70%/Copay $35	Rocky Mountain Health Plans	PPO	Silver	$181.05	$439.98	$327.71	$948.74	☐
Rocky Mountain Summit PPO Silver HSA - Deductible $3000/100%	Rocky Mountain Health Plans	PPO	Silver	$183.39	$445.68	$331.96	$961.03	☐

Employee Options

for

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Plan Name	Carrier	Plan Type	Metal Level	EE Cost	Dependent Cost	Employer Cost	Total Cost	
HealthOP Bear HSA Qualified High Deductible Health Plan EPO	Colorado HealthOp, Inc.	EPO	Bronze	$96.29	$220.93	$169.94	$487.16	☐
HealthOP Bear EPO	Colorado HealthOp, Inc.	EPO	Bronze	$102.16	$234.41	$180.31	$516.88	☐
HealthOP Bison Flex EPO	Colorado HealthOp, Inc.	EPO	Silver	$117.94	$270.61	$208.16	$596.71	☐
KP CO Bronze 4500/50%/HSA	Kaiser Foundation Health Plan of Colorado	HMO	Bronze	$119.36	$273.88	$210.66	$603.90	☐
HealthOP Bison HSA Qualified High Deductible Health Plan EPO	Colorado HealthOp, Inc.	EPO	Silver	$121.80	$279.48	$214.97	$616.25	☐
KP CO Bronze 3500/40/HSA	Kaiser Foundation Health Plan of Colorado	HMO	Bronze	$129.03	$296.07	$227.73	$652.83	☐
HealthOP Bison EPO	Colorado HealthOp, Inc.	EPO	Silver	$129.08	$296.16	$227.79	$653.03	☐
HealthOP Bear HSA Qualified High Deductible Health Plan PPO	Colorado HealthOp, Inc.	PPO	Bronze	$130.08	$298.47	$229.58	$658.13	☐
HealthOp Bear PPO	Colorado HealthOp, Inc.	PPO	Bronze	$136.17	$312.44	$240.32	$688.93	☐
Anthem Bronze Pathway X HMO 5000 30 6600 Plus	HMO Colorado Inc(Anthem BCBS)	HMO	Bronze	$140.00	$321.23	$247.07	$708.30	☐
KP CO Bronze 4500/50	Kaiser Foundation Health Plan of Colorado	HMO	Bronze	$140.90	$323.29	$248.67	$712.86	☐
HealthOP Bison Flex PPO	Colorado HealthOp, Inc.	PPO	Silver	$152.99	$351.04	$270.00	$774.03	☐
KP CO Silver 1500/50	Kaiser Foundation Health Plan of Colorado	HMO	Silver	$154.59	$354.70	$272.82	$782.11	☐
KP CO Silver 2000/30/HSA	Kaiser Foundation Health Plan of Colorado	HMO	Silver	$155.68	$357.21	$274.76	$787.65	☐
New West Focus HMO Bronze HSA - Deductible $3250/70%/Copay $45	Rocky Mountain Health Plans	HMO	Bronze	$158.21	$363.01	$279.23	$800.45	☐
KP CO Silver 1200/35	Kaiser Foundation Health Plan of Colorado	HMO	Silver	$159.15	$365.17	$280.87	$805.19	☐
HealthOP Bison HSA Qualified High Deductible Health Plan PPO	Colorado HealthOp, Inc.	PPO	Silver	$160.49	$368.26	$283.25	$812.00	☐
Anthem Silver Pathway X HMO 2000 30 5000 Plus	HMO Colorado Inc(Anthem BCBS)	HMO	Silver	$165.64	$380.07	$292.34	$838.05	☐
Rocky Mountain Summit HMO Bronze HSA - Deductible $6000/100%	Rocky Mountain Health Plans	HMO	Bronze	$167.41	$384.13	$295.47	$847.01	☐
HealthOp Bison PPO	Colorado HealthOp, Inc.	PPO	Silver	$168.10	$385.72	$296.68	$850.50	☐
Rocky Mountain Summit HMO Bronze - Deductible $4500/60%/Copay $55	Rocky Mountain Health Plans	HMO	Bronze	$168.90	$387.53	$298.08	$854.51	☐
Rocky Mountain Summit HMO Bronze HSA - Deductible $5250/100%	Rocky Mountain Health Plans	HMO	Bronze	$173.95	$399.12	$306.99	$880.06	☐
Rocky Mountain Summit HMO Bronze HSA - Deductible $3250/70%/Copay $45	Rocky Mountain Health Plans	HMO	Bronze	$175.72	$403.20	$310.13	$889.05	☐
New West Focus HMO Silver - Deductible $2000/70%/Copay $45	Rocky Mountain Health Plans	HMO	Silver	$177.50	$407.29	$313.27	$898.06	☐
Rocky Mountain Summit PPO Bronze - Deductible $4500/60%/Copay $55	Rocky Mountain Health Plans	PPO	Bronze	$180.93	$415.13	$319.31	$915.37	☐

Employee Options

for

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Plan Name	Carrier	Plan Type	Metal Level	EE Cost	Dependent Cost	Employer Cost	Total Cost	
Rocky Mountain Summit PPO Bronze HSA - Deductible $6000/100%	Rocky Mountain Health Plans	PPO	Bronze	$180.93	$415.13	$319.31	$915.37	☐
New West Focus HMO Silver - Deductible $1500/70%/Copay $35	Rocky Mountain Health Plans	HMO	Silver	$181.66	$416.82	$320.61	$919.09	☐
Rocky Mountain Summit PPO Bronze HSA - Deductible $5250/100%	Rocky Mountain Health Plans	PPO	Bronze	$186.80	$428.62	$329.68	$945.10	☐
Rocky Mountain Summit PPO Bronze HSA - Deductible $3250/70%/Copay $45	Rocky Mountain Health Plans	PPO	Bronze	$187.73	$430.75	$331.32	$949.80	☐
Rocky Mountain Summit HMO Silver - Deductible $3000/80%/Copay $40	Rocky Mountain Health Plans	HMO	Silver	$191.75	$439.98	$338.42	$970.15	☐
Rocky Mountain Summit HMO Silver - Deductible $2000/70% Copay $45	Rocky Mountain Health Plans	HMO	Silver	$197.10	$452.24	$347.85	$997.19	☐
Rocky Mountain Summit HMO Silver - Deductible $2000/70%/Copay $40	Rocky Mountain Health Plans	HMO	Silver	$198.58	$455.64	$350.46	$1,004.68	☐
Rocky Mountain Summit HMO Silver - Deductible $1500/70%/Copay $35	Rocky Mountain Health Plans	HMO	Silver	$201.84	$463.13	$356.23	$1,021.20	☐
Rocky Mountain Summit HMO Silver HSA - Deductible $3000/100%	Rocky Mountain Health Plans	HMO	Silver	$203.93	$467.90	$359.90	$1,031.73	☐
Rocky Mountain Summit PPO Silver - Deductible $3000/80%/Copay $40	Rocky Mountain Health Plans	PPO	Silver	$204.43	$469.06	$360.79	$1,034.28	☐
Rocky Mountain Summit PPO Silver - Deductible $2000/70%/Copay $45	Rocky Mountain Health Plans	PPO	Silver	$210.00	$481.85	$370.63	$1,062.48	☐
Rocky Mountain Summit PPO Silver - Deductible $2000/70%/Copay $40	Rocky Mountain Health Plans	PPO	Silver	$211.23	$484.68	$372.80	$1,068.71	☐
Rocky Mountain Summit PPO Silver - Deductible $1500/70%/Copay $35	Rocky Mountain Health Plans	PPO	Silver	$214.64	$492.49	$378.80	$1,085.93	☐
Rocky Mountain Summit PPO Silver HSA - Deductible $3000/100%	Rocky Mountain Health Plans	PPO	Silver	$217.42	$498.87	$383.71	$1,100.00	☐

Employee Options

for

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Plan Name	Carrier	Plan Type	Metal Level	EE Cost	Dependent Cost	Employer Cost	Total Cost	
HealthOP Bear HSA Qualified High Deductible Health Plan EPO	Colorado HealthOp, Inc.	EPO	Bronze	$91.93	$288.99	$188.26	$569.18	☐
HealthOP Bear EPO	Colorado HealthOp, Inc.	EPO	Bronze	$97.53	$306.62	$199.75	$603.90	☐
HealthOP Bison Flex EPO	Colorado HealthOp, Inc.	EPO	Silver	$112.60	$353.97	$230.59	$697.16	☐
KP CO Bronze 4500/50%/HSA	Kaiser Foundation Health Plan of Colorado	HMO	Bronze	$113.95	$358.24	$233.37	$705.56	☐
HealthOP Bison HSA Qualified High Deductible Health Plan EPO	Colorado HealthOp, Inc.	EPO	Silver	$116.28	$365.56	$238.14	$719.98	☐
KP CO Bronze 3500/40/HSA	Kaiser Foundation Health Plan of Colorado	HMO	Bronze	$123.19	$387.27	$252.28	$762.74	☐
HealthOP Bison EPO	Colorado HealthOp, Inc.	EPO	Silver	$123.23	$387.39	$252.36	$762.98	☐
HealthOP Bear HSA Qualified High Deductible Health Plan PPO	Colorado HealthOp, Inc.	PPO	Bronze	$124.19	$390.40	$254.33	$768.92	☐
HealthOp Bear PPO	Colorado HealthOp, Inc.	PPO	Bronze	$130.00	$408.68	$266.24	$804.92	☐
Anthem Bronze Pathway X HMO 5000 30 6600 Plus	HMO Colorado Inc(Anthem BCBS)	HMO	Bronze	$133.65	$420.17	$273.72	$827.54	☐
KP CO Bronze 4500/50	Kaiser Foundation Health Plan of Colorado	HMO	Bronze	$134.52	$422.87	$275.47	$832.86	☐
HealthOP Bison Flex PPO	Colorado HealthOp, Inc.	PPO	Silver	$146.06	$459.16	$299.12	$904.34	☐
KP CO Silver 1500/50	Kaiser Foundation Health Plan of Colorado	HMO	Silver	$147.58	$463.96	$302.24	$913.78	☐
KP CO Silver 2000/30/HSA	Kaiser Foundation Health Plan of Colorado	HMO	Silver	$148.63	$467.23	$304.38	$920.24	☐
New West Focus HMO Bronze HSA - Deductible $3250/70%/Copay $45	Rocky Mountain Health Plans	HMO	Bronze	$151.05	$474.83	$309.32	$935.20	☐
KP CO Silver 1200/35	Kaiser Foundation Health Plan of Colorado	HMO	Silver	$151.94	$477.64	$311.16	$940.74	☐
HealthOP Bison HSA Qualified High Deductible Health Plan PPO	Colorado HealthOp, Inc.	PPO	Silver	$153.22	$481.69	$313.79	$948.70	☐
Anthem Silver Pathway X HMO 2000 30 5000 Plus	HMO Colorado Inc(Anthem BCBS)	HMO	Silver	$158.14	$497.15	$323.85	$979.14	☐
Rocky Mountain Summit HMO Bronze HSA - Deductible $6000/100%	Rocky Mountain Health Plans	HMO	Bronze	$159.83	$502.45	$327.32	$989.60	☐
HealthOp Bison PPO	Colorado HealthOp, Inc.	PPO	Silver	$160.49	$504.52	$328.67	$993.68	☐
Rocky Mountain Summit HMO Bronze - Deductible $4500/60%/Copay $55	Rocky Mountain Health Plans	HMO	Bronze	$161.24	$506.90	$330.22	$998.36	☐
Rocky Mountain Summit HMO Bronze HSA - Deductible $5250/100%	Rocky Mountain Health Plans	HMO	Bronze	$166.06	$522.05	$340.09	$1,028.20	☐
Rocky Mountain Summit HMO Bronze HSA - Deductible $3250/70%/Copay $45	Rocky Mountain Health Plans	HMO	Bronze	$167.76	$527.39	$343.57	$1,038.72	☐
New West Focus HMO Silver - Deductible $2000/70%/Copay $45	Rocky Mountain Health Plans	HMO	Silver	$169.46	$532.75	$347.05	$1,049.26	☐
Rocky Mountain Summit PPO Bronze - Deductible $4500/60%/Copay $55	Rocky Mountain Health Plans	PPO	Bronze	$172.73	$543.00	$353.73	$1,069.46	☐

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Rocky Mountain Summit PPO Bronze HSA - Deductible $6000/100%	Rocky Mountain Health Plans	PPO	Bronze	$172.73	$543.00	$353.73	$1,069.46	☐
New West Focus HMO Silver - Deductible $1500/70%/Copay $35	Rocky Mountain Health Plans	HMO	Silver	$173.43	$545.21	$355.18	$1,073.82	☐
Rocky Mountain Summit PPO Bronze HSA - Deductible $5250/100%	Rocky Mountain Health Plans	PPO	Bronze	$178.34	$560.64	$365.22	$1,104.20	☐
Rocky Mountain Summit PPO Bronze HSA - Deductible $3250/70%/Copay $45	Rocky Mountain Health Plans	PPO	Bronze	$179.23	$563.43	$367.04	$1,109.70	☐
Rocky Mountain Summit HMO Silver - Deductible $3000/80%/Copay $40	Rocky Mountain Health Plans	HMO	Silver	$183.07	$575.51	$374.90	$1,133.48	☐
Rocky Mountain Summit HMO Silver - Deductible $2000/70% Copay $45	Rocky Mountain Health Plans	HMO	Silver	$188.17	$591.54	$385.35	$1,165.06	☐
Rocky Mountain Summit HMO Silver - Deductible $2000/70%/Copay $40	Rocky Mountain Health Plans	HMO	Silver	$189.58	$595.99	$388.25	$1,173.82	☐
Rocky Mountain Summit HMO Silver - Deductible $1500/70%/Copay $35	Rocky Mountain Health Plans	HMO	Silver	$192.70	$605.79	$394.63	$1,193.12	☐
Rocky Mountain Summit HMO Silver HSA - Deductible $3000/100%	Rocky Mountain Health Plans	HMO	Silver	$194.69	$612.03	$398.70	$1,205.42	☐
Rocky Mountain Summit PPO Silver - Deductible $3000/80%/Copay $40	Rocky Mountain Health Plans	PPO	Silver	$195.17	$613.54	$399.69	$1,208.40	☐
Rocky Mountain Summit PPO Silver - Deductible $2000/70%/Copay $45	Rocky Mountain Health Plans	PPO	Silver	$200.49	$630.27	$410.58	$1,241.34	☐
Rocky Mountain Summit PPO Silver - Deductible $2000/70%/Copay $40	Rocky Mountain Health Plans	PPO	Silver	$201.66	$633.97	$412.99	$1,248.62	☐
Rocky Mountain Summit PPO Silver - Deductible $1500/70%/Copay $35	Rocky Mountain Health Plans	PPO	Silver	$204.91	$644.18	$419.65	$1,268.74	☐
Rocky Mountain Summit PPO Silver HSA - Deductible $3000/100%	Rocky Mountain Health Plans	PPO	Silver	$207.57	$652.53	$425.08	$1,285.18	☐

Employee Options

for

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Plan Name	Carrier	Plan Type	Metal Level	EE Cost	Dependent Cost	Employer Cost	Total Cost	
HealthOP Bear HSA Qualified High Deductible Health Plan EPO	Colorado HealthOp, Inc.	EPO	Bronze	$79.63	$0.00	$79.64	$159.27	☐
HealthOP Bear EPO	Colorado HealthOp, Inc.	EPO	Bronze	$84.49	$0.00	$84.49	$168.98	☐
HealthOP Bison Flex EPO	Colorado HealthOp, Inc.	EPO	Silver	$97.54	$0.00	$97.54	$195.08	☐
KP CO Bronze 4500/50%/HSA	Kaiser Foundation Health Plan of Colorado	HMO	Bronze	$98.71	$0.00	$98.72	$197.43	☐
HealthOP Bison HSA Qualified High Deductible Health Plan EPO	Colorado HealthOp, Inc.	EPO	Silver	$100.73	$0.00	$100.74	$201.47	☐
KP CO Bronze 3500/40/HSA	Kaiser Foundation Health Plan of Colorado	HMO	Bronze	$106.71	$0.00	$106.72	$213.43	☐
HealthOP Bison EPO	Colorado HealthOp, Inc.	EPO	Silver	$106.75	$0.00	$106.75	$213.50	☐
HealthOP Bear HSA Qualified High Deductible Health Plan PPO	Colorado HealthOp, Inc.	PPO	Bronze	$107.58	$0.00	$107.58	$215.16	☐
HealthOp Bear PPO	Colorado HealthOp, Inc.	PPO	Bronze	$112.61	$0.00	$112.62	$225.23	☐
Anthem Bronze Pathway X HMO 5000 30 6600 Plus	HMO Colorado Inc(Anthem BCBS)	HMO	Bronze	$115.78	$0.00	$115.78	$231.56	☐
KP CO Bronze 4500/50	Kaiser Foundation Health Plan of Colorado	HMO	Bronze	$116.52	$0.00	$116.53	$233.05	☐
HealthOP Bison Flex PPO	Colorado HealthOp, Inc.	PPO	Silver	$126.52	$0.00	$126.53	$253.05	☐
KP CO Silver 1500/50	Kaiser Foundation Health Plan of Colorado	HMO	Silver	$127.84	$0.00	$127.85	$255.69	☐
KP CO Silver 2000/30/HSA	Kaiser Foundation Health Plan of Colorado	HMO	Silver	$128.75	$0.00	$128.76	$257.51	☐
New West Focus HMO Bronze HSA - Deductible $3250/70%/Copay $45	Rocky Mountain Health Plans	HMO	Bronze	$130.84	$0.00	$130.85	$261.69	☐
KP CO Silver 1200/35	Kaiser Foundation Health Plan of Colorado	HMO	Silver	$131.62	$0.00	$131.62	$263.24	☐
HealthOP Bison HSA Qualified High Deductible Health Plan PPO	Colorado HealthOp, Inc.	PPO	Silver	$132.73	$0.00	$132.74	$265.47	☐
Anthem Silver Pathway X HMO 2000 30 5000 Plus	HMO Colorado Inc(Anthem BCBS)	HMO	Silver	$136.99	$0.00	$136.99	$273.98	☐
Rocky Mountain Summit HMO Bronze HSA - Deductible $6000/100%	Rocky Mountain Health Plans	HMO	Bronze	$138.45	$0.00	$138.46	$276.91	☐
HealthOp Bison PPO	Colorado HealthOp, Inc.	PPO	Silver	$139.02	$0.00	$139.03	$278.05	☐
Rocky Mountain Summit HMO Bronze - Deductible $4500/60%/Copay $55	Rocky Mountain Health Plans	HMO	Bronze	$139.68	$0.00	$139.68	$279.36	☐
Rocky Mountain Summit HMO Bronze HSA - Deductible $5250/100%	Rocky Mountain Health Plans	HMO	Bronze	$143.86	$0.00	$143.86	$287.72	☐
Rocky Mountain Summit HMO Bronze HSA - Deductible $3250/70%/Copay $45	Rocky Mountain Health Plans	HMO	Bronze	$145.33	$0.00	$145.33	$290.66	☐
New West Focus HMO Silver - Deductible $2000/70%/Copay $45	Rocky Mountain Health Plans	HMO	Silver	$146.80	$0.00	$146.80	$293.60	☐
Rocky Mountain Summit PPO Bronze - Deductible $4500/60%/Copay $55	Rocky Mountain Health Plans	PPO	Bronze	$149.63	$0.00	$149.63	$299.26	☐

Employee Options

for

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Plan Name	Carrier	Plan Type	Metal Level	EE Cost	Dependent Cost	Employer Cost	Total Cost	
Rocky Mountain Summit PPO Bronze HSA - Deductible $6000/100%	Rocky Mountain Health Plans	PPO	Bronze	$149.63	$0.00	$149.63	$299.26	☐
New West Focus HMO Silver - Deductible $1500/70%/Copay $35	Rocky Mountain Health Plans	HMO	Silver	$150.24	$0.00	$150.24	$300.48	☐
Rocky Mountain Summit PPO Bronze HSA - Deductible $5250/100%	Rocky Mountain Health Plans	PPO	Bronze	$154.49	$0.00	$154.49	$308.98	☐
Rocky Mountain Summit PPO Bronze HSA - Deductible $3250/70%/Copay $45	Rocky Mountain Health Plans	PPO	Bronze	$155.26	$0.00	$155.26	$310.52	☐
Rocky Mountain Summit HMO Silver - Deductible $3000/80%/Copay $40	Rocky Mountain Health Plans	HMO	Silver	$158.58	$0.00	$158.59	$317.17	☐
Rocky Mountain Summit HMO Silver - Deductible $2000/70% Copay $45	Rocky Mountain Health Plans	HMO	Silver	$163.00	$0.00	$163.01	$326.01	☐
Rocky Mountain Summit HMO Silver - Deductible $2000/70%/Copay $40	Rocky Mountain Health Plans	HMO	Silver	$164.23	$0.00	$164.23	$328.46	☐
Rocky Mountain Summit HMO Silver - Deductible $1500/70%/Copay $35	Rocky Mountain Health Plans	HMO	Silver	$166.93	$0.00	$166.93	$333.86	☐
Rocky Mountain Summit HMO Silver HSA - Deductible $3000/100%	Rocky Mountain Health Plans	HMO	Silver	$168.65	$0.00	$168.65	$337.30	☐
Rocky Mountain Summit PPO Silver - Deductible $3000/80%/Copay $40	Rocky Mountain Health Plans	PPO	Silver	$169.07	$0.00	$169.07	$338.14	☐
Rocky Mountain Summit PPO Silver - Deductible $2000/70%/Copay $45	Rocky Mountain Health Plans	PPO	Silver	$173.67	$0.00	$173.68	$347.35	☐
Rocky Mountain Summit PPO Silver - Deductible $2000/70%/Copay $40	Rocky Mountain Health Plans	PPO	Silver	$174.69	$0.00	$174.70	$349.39	☐
Rocky Mountain Summit PPO Silver - Deductible $1500/70%/Copay $35	Rocky Mountain Health Plans	PPO	Silver	$177.51	$0.00	$177.51	$355.02	☐
Rocky Mountain Summit PPO Silver HSA - Deductible $3000/100%	Rocky Mountain Health Plans	PPO	Silver	$179.81	$0.00	$179.81	$359.62	☐

Employee Options

for

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Plan Name	Carrier	Plan Type	Metal Level	EE Cost	Dependent Cost	Employer Cost	Total Cost	
HealthOP Bear HSA Qualified High Deductible Health Plan EPO	Colorado HealthOp, Inc.	EPO	Bronze	$95.02	$0.00	$95.02	$190.04	☐
HealthOP Bear EPO	Colorado HealthOp, Inc.	EPO	Bronze	$100.81	$0.00	$100.82	$201.63	☐
HealthOP Bison Flex EPO	Colorado HealthOp, Inc.	EPO	Silver	$116.39	$0.00	$116.39	$232.78	☐
KP CO Bronze 4500/50%/HSA	Kaiser Foundation Health Plan of Colorado	HMO	Bronze	$117.79	$0.00	$117.79	$235.58	☐
HealthOP Bison HSA Qualified High Deductible Health Plan EPO	Colorado HealthOp, Inc.	EPO	Silver	$120.20	$0.00	$120.20	$240.40	☐
KP CO Bronze 3500/40/HSA	Kaiser Foundation Health Plan of Colorado	HMO	Bronze	$127.33	$0.00	$127.34	$254.67	☐
HealthOP Bison EPO	Colorado HealthOp, Inc.	EPO	Silver	$127.37	$0.00	$127.38	$254.75	☐
HealthOP Bear HSA Qualified High Deductible Health Plan PPO	Colorado HealthOp, Inc.	PPO	Bronze	$128.37	$0.00	$128.37	$256.74	☐
HealthOp Bear PPO	Colorado HealthOp, Inc.	PPO	Bronze	$134.37	$0.00	$134.38	$268.75	☐
Anthem Bronze Pathway X HMO 5000 30 6600 Plus	HMO Colorado Inc(Anthem BCBS)	HMO	Bronze	$138.15	$0.00	$138.16	$276.31	☐
KP CO Bronze 4500/50	Kaiser Foundation Health Plan of Colorado	HMO	Bronze	$139.05	$0.00	$139.04	$278.09	☐
HealthOP Bison Flex PPO	Colorado HealthOp, Inc.	PPO	Silver	$150.97	$0.00	$150.98	$301.95	☐
KP CO Silver 1500/50	Kaiser Foundation Health Plan of Colorado	HMO	Silver	$152.55	$0.00	$152.55	$305.10	☐
KP CO Silver 2000/30/HSA	Kaiser Foundation Health Plan of Colorado	HMO	Silver	$153.63	$0.00	$153.63	$307.26	☐
New West Focus HMO Bronze HSA - Deductible $3250/70%/Copay $45	Rocky Mountain Health Plans	HMO	Bronze	$156.13	$0.00	$156.13	$312.26	☐
KP CO Silver 1200/35	Kaiser Foundation Health Plan of Colorado	HMO	Silver	$157.05	$0.00	$157.06	$314.11	☐
HealthOP Bison HSA Qualified High Deductible Health Plan PPO	Colorado HealthOp, Inc.	PPO	Silver	$158.38	$0.00	$158.38	$316.76	☐
Anthem Silver Pathway X HMO 2000 30 5000 Plus	HMO Colorado Inc(Anthem BCBS)	HMO	Silver	$163.46	$0.00	$163.46	$326.92	☐
Rocky Mountain Summit HMO Bronze HSA - Deductible $6000/100%	Rocky Mountain Health Plans	HMO	Bronze	$165.21	$0.00	$165.21	$330.42	☐
HealthOp Bison PPO	Colorado HealthOp, Inc.	PPO	Silver	$165.89	$0.00	$165.89	$331.78	☐
Rocky Mountain Summit HMO Bronze - Deductible $4500/60%/Copay $55	Rocky Mountain Health Plans	HMO	Bronze	$166.67	$0.00	$166.67	$333.34	☐
Rocky Mountain Summit HMO Bronze HSA - Deductible $5250/100%	Rocky Mountain Health Plans	HMO	Bronze	$171.65	$0.00	$171.66	$343.31	☐
Rocky Mountain Summit HMO Bronze HSA - Deductible $3250/70%/Copay $45	Rocky Mountain Health Plans	HMO	Bronze	$173.41	$0.00	$173.41	$346.82	☐
New West Focus HMO Silver - Deductible $2000/70%/Copay $45	Rocky Mountain Health Plans	HMO	Silver	$175.16	$0.00	$175.17	$350.33	☐
Rocky Mountain Summit PPO Bronze - Deductible $4500/60%/Copay $55	Rocky Mountain Health Plans	PPO	Bronze	$178.54	$0.00	$178.55	$357.09	☐

Employee Options

for

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Plan Name	Carrier	Plan Type	Metal Level	EE Cost	Dependent Cost	Employer Cost	Total Cost	
Rocky Mountain Summit PPO Bronze HSA - Deductible $6000/100%	Rocky Mountain Health Plans	PPO	Bronze	$178.54	$0.00	$178.55	$357.09	☐
New West Focus HMO Silver - Deductible $1500/70%/Copay $35	Rocky Mountain Health Plans	HMO	Silver	$179.27	$0.00	$179.27	$358.54	☐
Rocky Mountain Summit PPO Bronze HSA - Deductible $5250/100%	Rocky Mountain Health Plans	PPO	Bronze	$184.34	$0.00	$184.34	$368.68	☐
Rocky Mountain Summit PPO Bronze HSA - Deductible $3250/70%/Copay $45	Rocky Mountain Health Plans	PPO	Bronze	$185.26	$0.00	$185.26	$370.52	☐
Rocky Mountain Summit HMO Silver - Deductible $3000/80%/Copay $40	Rocky Mountain Health Plans	HMO	Silver	$189.23	$0.00	$189.23	$378.46	☐
Rocky Mountain Summit HMO Silver - Deductible $2000/70% Copay $45	Rocky Mountain Health Plans	HMO	Silver	$194.50	$0.00	$194.50	$389.00	☐
Rocky Mountain Summit HMO Silver - Deductible $2000/70%/Copay $40	Rocky Mountain Health Plans	HMO	Silver	$195.96	$0.00	$195.97	$391.93	☐
Rocky Mountain Summit HMO Silver - Deductible $1500/70%/Copay $35	Rocky Mountain Health Plans	HMO	Silver	$199.18	$0.00	$199.19	$398.37	☐
Rocky Mountain Summit HMO Silver HSA - Deductible $3000/100%	Rocky Mountain Health Plans	HMO	Silver	$201.24	$0.00	$201.24	$402.48	☐
Rocky Mountain Summit PPO Silver - Deductible $3000/80%/Copay $40	Rocky Mountain Health Plans	PPO	Silver	$201.73	$0.00	$201.74	$403.47	☐
Rocky Mountain Summit PPO Silver - Deductible $2000/70%/Copay $45	Rocky Mountain Health Plans	PPO	Silver	$207.23	$0.00	$207.24	$414.47	☐
Rocky Mountain Summit PPO Silver - Deductible $2000/70%/Copay $40	Rocky Mountain Health Plans	PPO	Silver	$208.45	$0.00	$208.45	$416.90	☐
Rocky Mountain Summit PPO Silver - Deductible $1500/70%/Copay $35	Rocky Mountain Health Plans	PPO	Silver	$211.81	$0.00	$211.81	$423.62	☐
Rocky Mountain Summit PPO Silver HSA - Deductible $3000/100%	Rocky Mountain Health Plans	PPO	Silver	$214.55	$0.00	$214.56	$429.11	☐

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.COhealthOp.org or by calling 1-866-915-6619.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Network** / **Non-Network** **$6,250** individual / **Not Covered** individual **$12,500** family / **Not Covered** family The **deductible** does not apply to preventive care. All **coinsurance** is subject to the annual **deductible** and accumulates towards meeting the **out-of-pocket limit**, unless stated otherwise. **Copayments** are not subject to the annual **deductible** but do accumulate towards meeting the **out-of-pocket limit**, unless stated otherwise. Non-covered services do not accumulate towards meeting the **out-of-pocket limit**.	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 below 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 below for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **Network** / **Non-Network** **$6,250** individual / **Not Covered** individual **$12,500** family / **Not Covered** 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, Non-Network **coinsurance** or **deductibles**, and excluded or health care services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

Important Questions	Answers	Why this Matters:
Is there an overall annual limit on what the plan pays?	No.	The chart below 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. See www.COhealthOp.org **or call 1-866-915-6619** for a list of participating providers.	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 below for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	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 the Excluded Services table below. See your policy or plan document for additional information about **excluded services**.

- **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 providing a lower maximum out-of-pocket amount by charging you lower **deductibles**, **copayments**, and/or **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**0%** coinsurance	**Not Covered**	---None---
	Specialist visit	**0%** coinsurance	**Not Covered**	---None---
	Other practitioner office visit	**0%** coinsurance	**Not Covered**	---None---
	Preventive care/screening/immunization	**No Charge**	**Not Covered**	---None---
If you have a test	Diagnostic test (x-ray, blood work)	**0%** coinsurance	**Not Covered**	---None---
	Imaging (CT/PET scans, MRIs)	**0%** coinsurance	**Not Covered**	---None---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.COhealthOp.org	Generic drugs	**0%** coinsurance Same coinsurance for Retail and Mail Order prescriptions.	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	**0%** coinsurance Same coinsurance for Retail and Mail Order prescriptions.	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Non-preferred brand drugs	**0%** coinsurance Same coinsurance for Retail and Mail Order prescriptions.	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.COhealthOp.org	Specialty drugs	**0%** coinsurance Same coinsurance for Retail and Mail Order prescriptions.	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31 day supply (mail order prescription)
	Preventive drugs	**No Charge**	**Same as Network**	Covers preventive drugs used in relation to the following five (5) conditions: asthma/COPD, blood pressure, cholesterol, diabetes, and prenatal care.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**0%** coinsurance	**Not Covered**	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Physician/surgeon fees	**0%** coinsurance	**Not Covered**	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
If you need immediate medical attention	Emergency room services	**0%** coinsurance	**Same as Network**	---None---
	Emergency medical transportation	**0%** coinsurance	**Not Covered**	Transportation by other than a licensed ambulance.
	Urgent care	**0%** coinsurance	**Not Covered**	Limited to services received at Urgent Care Centers. Services received from other provider types will be reimbursed according to the provider and service rendered.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	**0%** coinsurance	**Not Covered**	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.
	Physician/surgeon fee	**0%** coinsurance	**Not Covered**	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**0%** coinsurance	**Not Covered**	Early Intervention Services are limited to 45 visits per year. Autism-Applied Behavioral Analysis is limited to 550 sessions from birth to age 8 and 185 sessions age 9-19 (sessions being 25 minute increments) **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health inpatient services	**0%** coinsurance	**Not Covered**	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.
	Substance use disorder outpatient services	**0%** coinsurance	**Not Covered**	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Substance use disorder inpatient services	**0%** coinsurance	**Not Covered**	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.
If you are pregnant	Prenatal and postnatal care	**0%** coinsurance	**Not Covered**	---None---
	Delivery and all inpatient services	**0%** coinsurance	**Not Covered**	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
If you need help recovering or have other special health needs	Home health care	**0%** coinsurance	**Not Covered**	Limit 28 hours per week. **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Rehabilitation services	**0%** coinsurance	**Not Covered**	Combined Network/Non-Network limit of 20 therapy visits per year for **speech therapy**. Combined Network/Non-Network limit of 20 visits per therapy type for **physical therapy and occupational therapy**. Not limited for children up to age 5 with congenital defects; No therapy limitation for autism.
	Habilitation services	**0%** coinsurance	**Not Covered**	Combined Network/Non-Network limit of 20 therapy visits per year for **speech therapy**. Combined Network/Non-Network limit of 20 visits per therapy type for **physical therapy and occupational therapy**. Not limited for children up to age 5 with congenital defects; No therapy limitation for autism.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Skilled nursing care	**0%** coinsurance	**Not Covered**	Limited to 100 days per year. **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Durable medical equipment	**0%** coinsurance	**Not Covered**	**Pre-authorization required** for items over $500; and the Colorado HealthOP will make a determination on whether the item(s) will be purchased or rented.
	Hospice service	**0%** coinsurance	**Not Covered**	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
If your child needs dental or eye care	Eye exam	**No Charge**	**Not Covered**	Limited to 1 exam per year.
	Glasses	**Not Covered**	**Not Covered**	---None---

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Dental check-up	**No Charge**	**Not Covered**	**Oral Exams**: Limit 2 visits per year. **Bitewings X-Ray**: Limit 1 set per year. **Full Mouth/Panoramic X-Ray**: Limit 1 every 60 months. **Intra-Oral X-Ray**: Limit 2 per year. **Cleaning**: Limit 2 per year. **Fluoride Applications**: Limit 2 per year. **Space Maintainer**: Limit 1 per lifetime. **Sealants**: Limit 1 per tooth per year. **Palliative Treatment**: Limit 1 per year. **Fillings**: (amalgam, resin and composite, or sedative): Limit 2 per year. **Crowns**: Limit 1 per year. **Pin Retention**: Limit 1 per year **Surgical Extractions**: Limit 2 per year. **Periodontal Surgery**: Limit 1 per year. **Root Canal**: Limit 2 per year. **Orthodontia & Prosthodontic Treatment for Cleft Lip/Palate**: Limit 1 each.

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
- Spinal manipulation
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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.)

- Cosmetic surgery – If it is to treat a medical condition or to improve or restore physiologic function.
- Hearing aids (minor) – If it is for eligible children under age 18 who have a hearing loss.
- Routine foot care – If it is related to diabetes and/or performed specifically for the purpose of treating pain related to functional limitations.

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

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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: CO HealthOP Member Services at 1-866-915-6619, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa. You can also contact the State of Colorado Department of Regulatory Agencies Division of Insurance at 303-894-7490 or 1-800-930-3745.

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.**

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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:** $7,540
- **Plan pays** $1,290
- **Patient pays** $6,250

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$6,250
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$6,250**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $400
- **Patient pays** $5,000

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$5,000
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$5,000**

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.

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.COhealthOp.org or by calling 1-866-915-6619.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Network** / **Non-Network** **$6,500** individual / **Not Covered** individual **$13,000** family / **Not Covered** family The **deductible** does not apply to preventive care. All **coinsurance** is subject to the annual **deductible** and accumulates towards meeting the **out-of-pocket limit**, unless stated otherwise. **Copayments** are not subject to the annual **deductible** but do accumulate towards meeting the **out-of-pocket limit**, unless stated otherwise. Non-covered services do not accumulate towards meeting the **out-of-pocket limit**.	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 below 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 below for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **Network** / **Non-Network** **$6,500** individual / **Not Covered** individual **$13,000** family / **Not Covered** 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, Non-Network **coinsurance** or **deductibles**, and excluded or health care services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

Important Questions	Answers	Why this Matters:
Is there an overall annual limit on what the plan pays?	No.	The chart below 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. See **www.COhealthOp.org or call 1-866-915-6619** for a list of participating providers.	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 below for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	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 the Excluded Services table below. See your policy or plan document for additional information about **excluded services**.

- **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 providing a lower maximum out-of-pocket amount by charging you lower **deductibles**, **copayments**, and/or **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	First two visits free; subsequent visits **0%** coinsurance after deductible	**Not Covered**	All subsequent visits subject to the deductible (after first 2 visits).
	Specialist visit	**0%** coinsurance	**Not Covered**	---None---
	Other practitioner office visit	**0%** coinsurance	**Not Covered**	---None---
	Preventive care/screening/immunization	**No Charge**	**Not Covered**	---None---
If you have a test	Diagnostic test (x-ray, blood work)	**0%** coinsurance	**Not Covered**	---None---
	Imaging (CT/PET scans, MRIs)	**0%** coinsurance	**Not Covered**	---None---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.COhealthOp.org	Generic drugs	**Retail** **$20** copayment/ prescription **Mail Order** **$40** copayment/ prescription	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	**0%** coinsurance Same coinsurance for Retail and Mail Order prescriptions.	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Non-preferred brand drugs	**0%** coinsurance Same coinsurance for Retail and Mail Order prescriptions.	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.COhealthOp.org	Specialty drugs	**0%** coinsurance Same coinsurance for Retail and Mail Order prescriptions.	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31 day supply (mail order prescription)
	Preventive drugs	**No Charge**	**Same as Network**	Covers preventive drugs used in relation to the following five (5) conditions: asthma/COPD, blood pressure, cholesterol, diabetes, and prenatal care.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**0%** coinsurance	**Not Covered**	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Physician/surgeon fees	**0%** coinsurance	**Not Covered**	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
If you need immediate medical attention	Emergency room services	**0%** coinsurance	**Same as Network**	---None---
	Emergency medical transportation	**0%** coinsurance	**Not Covered**	Transportation by other than a licensed ambulance.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Urgent care	**0%** coinsurance	**Not Covered**	Limited to services received at Urgent Care Centers. Services received from other provider types will be reimbursed according to the provider and service rendered.
If you have a hospital stay	Facility fee (e.g., hospital room)	**0%** coinsurance	**Not Covered**	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.
	Physician/surgeon fee	**0%** coinsurance	**Not Covered**	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**0%** coinsurance	**Not Covered**	Early Intervention Services are limited to 45 visits per year. Autism-Applied Behavioral Analysis is limited to 550 sessions from birth to age 8 and 185 sessions age 9-19 (sessions being 25 minute increments) **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health inpatient services	**0%** coinsurance	**Not Covered**	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Substance use disorder outpatient services	**0%** coinsurance	**Not Covered**	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Substance use disorder inpatient services	**0%** coinsurance	**Not Covered**	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.
If you are pregnant	Prenatal and postnatal care	**0%** coinsurance	**Not Covered**	---None---
	Delivery and all inpatient services	**0%** coinsurance	**Not Covered**	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
If you need help recovering or have other special health needs	Home health care	**0%** coinsurance	**Not Covered**	Limit 28 hours per week. **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Rehabilitation services	**0%** coinsurance	**Not Covered**	Combined Network/Non-Network limit of 20 therapy visits per year for **speech therapy**. Combined Network/Non-Network limit of 20 visits per therapy type for **physical therapy and occupational therapy**. Not limited for children up to age 5 with congenital defects; No therapy limitation for autism.
	Habilitation services	**0%** coinsurance	**Not Covered**	Combined Network/Non-Network limit of 20 therapy visits per year for **speech therapy**. Combined Network/Non-Network limit of 20 visits per therapy type for **physical therapy and occupational therapy**. Not limited for children up to age 5 with congenital defects; No therapy limitation for autism.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Skilled nursing care	**0%** coinsurance	**Not Covered**	Limited to 100 days per year. **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Durable medical equipment	**0%** coinsurance	**Not Covered**	**Pre-authorization required** for items over $500; and the Colorado HealthOP will make a determination on whether the item(s) will be purchased or rented.
	Hospice service	**0%** coinsurance	**Not Covered**	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
If your child needs dental or eye care	Eye exam	**No Charge**	**Not Covered**	Limited to 1 exam per year.
	Glasses	**Not Covered**	**Not Covered**	---None---

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Dental check-up	**No Charge**	**Not Covered**	**Oral Exams**: Limit 2 visits per year. **Bitewings X-Ray**: Limit 1 set per year. **Full Mouth/Panoramic X-Ray**: Limit 1 every 60 months. **Intra-Oral X-Ray**: Limit 2 per year. **Cleaning**: Limit 2 per year. **Fluoride Applications**: Limit 2 per year. **Space Maintainer**: Limit 1 per lifetime. **Sealants**: Limit 1 per tooth per year. **Palliative Treatment**: Limit 1 per year. **Fillings**: (amalgam, resin and composite, or sedative): Limit 2 per year. **Crowns**: Limit 1 per year. **Pin Retention**: Limit 1 per year **Surgical Extractions**: Limit 2 per year. **Periodontal Surgery**: Limit 1 per year. **Root Canal**: Limit 2 per year. **Orthodontia & Prosthodontic Treatment for Cleft Lip/Palate**: Limit 1 each.

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(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $1,040
- **Patient pays** $6,500

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$6,500
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$6,500**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,000
- **Patient pays** $2,400

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,400
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$2,400**

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?

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Does the Coverage Example predict my future expenses?

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✓ **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.

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.COhealthOp.org or by calling 1-866-915-6619.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Network** / **Enhanced*** / **Non-Network** **$3,900** individual / **$3,900** individual / **Not Covered** **$7,800** family / **$7,800** family / **Not Covered** The **deductible** does not apply to preventive care. All **coinsurance** is subject to the annual **deductible** and accumulates towards meeting the **out-of-pocket limit**, unless stated otherwise. **Copayments** are not subject to the annual **deductible** but do accumulate towards meeting the **out-of-pocket limit**, unless stated otherwise. Non-covered services do not accumulate towards meeting the **out-of-pocket limit**. For covered members who qualify for the Enhanced Network benefit level, the **deductible** only has to be met for either the Enhanced or Standard Network benefit level—not both—and whichever one comes first.	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 below 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 below for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **Network** / **Enhanced*** / **Non-Network** **$6,600** individual / **$6,600** individual / **Not Covered** **$13,200** family / **$13,200** family / **Not Covered** For covered members who qualify for the Enhanced Network benefit level, the **out-of-pocket limit** only has to be met for either the Enhanced or Standard Network benefit level—not both—and whichever one comes first.	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.

Important Questions	Answers	Why this Matters:
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, Non-Network **coinsurance** or **deductibles**, and excluded or health care services 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 below 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. See www.COhealthOp.org **or call 1-866-915-6619** for a list of participating providers.	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 below for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	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 the Excluded Services table below. See your policy or plan document for additional information about **excluded services**.

- **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 providing a lower maximum out-of-pocket amount by charging you lower **deductibles**, **copayments**, and/or **coinsurance** amounts.

* **Enhanced Benefits:** Enhanced benefits are incentives offered by your plan when required personal health actions are completed. Incentives are based on completion of the required personal health actions and not on the outcome of those actions.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	First 2 visits free; subsequent visits **40%** coinsurance	First 2 visits free; subsequent visits **40%** coinsurance	**Not Covered**	The first two primary care visits are free under the Enhanced benefit level only if the member has not already received the free visits under the Standard level.
	Specialist visit	**40%** coinsurance	**40%** coinsurance	**Not Covered**	---None---
	Other practitioner office visit	**40%** coinsurance	**40%** coinsurance	**Not Covered**	---None---
	Preventive care/screening/immunization	**No Charge**	**No Charge**	**Not Covered**	---None---
If you have a test	Diagnostic test (x-ray, blood work)	**40%** coinsurance	**40%** coinsurance	**Not Covered**	---None---
	Imaging (CT/PET scans, MRIs)	**40%** coinsurance	**40%** coinsurance	**Not Covered**	---None---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.COhealthOp.org	Generic drugs	**Retail** **$20** copayment/ prescription **Mail Order** **$40** copayment/ prescription	**Retail** **$20** copayment/ prescription **Mail Order** **$40** copayment/ prescription	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.COhealthOp.org	Preferred brand drugs	**40%** coinsurance not subject to deductible Same coinsurance for Retail and Mail Order prescriptions	**40%** coinsurance not subject to deductible Same coinsurance for Retail and Mail Order prescriptions	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Non-preferred brand drugs	**40%** coinsurance not subject to deductible Same coinsurance for Retail and Mail Order prescriptions	**40%** coinsurance not subject to deductible Same coinsurance for Retail and Mail Order prescriptions	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Specialty drugs	**40%** coinsurance not subject to deductible Same coinsurance for Retail and Mail Order prescriptions	**40%** coinsurance not subject to deductible Same coinsurance for Retail and Mail Order prescriptions	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31 day supply (mail order prescription)
	Preventive drugs	**No Charge**	**No Charge**	**Same as Network**	Covers preventive drugs used in relation to the following five (5) conditions: asthma/COPD, blood pressure, cholesterol, diabetes, and prenatal care.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**40%** coinsurance	**40%** coinsurance	**Not Covered**	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Physician/surgeon fees	**40%** coinsurance	**40%** coinsurance	**Not Covered**	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
If you need immediate medical attention	Emergency room services	**40%** coinsurance	**40%** coinsurance	**Same as Network**	---None---
	Emergency medical transportation	**40%** coinsurance	**40%** coinsurance	**Not Covered**	Transportation by other than a licensed ambulance.
	Urgent care	**$150** copayment	**$150** copayment	**Not Covered**	Limited to services received at Urgent Care Centers. Services received from other provider types will be reimbursed according to the provider and service rendered.
If you have a hospital stay	Facility fee (e.g., hospital room)	**40%** coinsurance	**40%** coinsurance	**Not Covered**	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have a hospital stay	Physician/surgeon fee	**40%** coinsurance	**40%** coinsurance	**Not Covered**	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**40%** coinsurance	**40%** coinsurance	**Not Covered**	Early Intervention Services are limited to 45 visits per year. Autism-Applied Behavioral Analysis is limited to 550 sessions from birth to age 8 and 185 sessions age 9-19 (sessions being 25 minute increments) **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Mental/Behavioral health inpatient services	**40%** coinsurance	**40%** coinsurance	**Not Covered**	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Substance use disorder outpatient services	**40%** coinsurance	**40%** coinsurance	**Not Covered**	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Substance use disorder inpatient services	**40%** coinsurance	**40%** coinsurance	**Not Covered**	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.
If you are pregnant	Prenatal and postnatal care	**40%** coinsurance	**40%** coinsurance	**Not Covered**	---None---
	Delivery and all inpatient services	**40%** coinsurance	**40%** coinsurance	**Not Covered**	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
If you need help recovering or have other special health needs	Home health care	**40%** coinsurance	**40%** coinsurance	**Not Covered**	Limit 28 hours per week. **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Rehabilitation services	**40%** coinsurance	**40%** coinsurance	**Not Covered**	Combined Network/Non-Network limit of 20 therapy visits per year for **speech therapy**. Combined Network/Non-Network limit of 20 visits per therapy type for **physical therapy and occupational therapy**. Not limited for children up to age 5 with congenital defects. No therapy limitation for autism.
	Habilitation services	**40%** coinsurance	**40%** coinsurance	**Not Covered**	Combined Network/Non-Network limit of 20 therapy visits per year for **speech therapy**. Combined Network/Non-Network limit of 20 visits per therapy type for **physical therapy and occupational therapy**. Not limited for children up to age 5 with congenital defects. No therapy limitation for autism.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Skilled nursing care	**40%** coinsurance	**40%** coinsurance	**Not Covered**	Limited to 100 days per year. **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Durable medical equipment	**40%** coinsurance	**40%** coinsurance	**Not Covered**	**Pre-authorization required** for items over $500; and the Colorado HealthOP will make a determination on whether the item(s) will be purchased or rented.
	Hospice service	**40%** coinsurance	**40%** coinsurance	**Not Covered**	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
If your child needs dental or eye care	Eye exam	**No Charge**	**No Charge**	**Not Covered**	Limited to 1 exam per year.
	Glasses	**Not Covered**	**Not Covered**	**Not Covered**	---None---

Common Medical Event	Services You May Need	Your Cost If You Use a			Limitations & Exceptions
		Network Provider (Standard Benefits)	Network Provider (*Enhanced Benefits)	Non-Network Provider	
If your child needs dental or eye care	Dental check-up	**No Charge**	**No Charge**	**Not Covered**	**Oral Exams**: Limit 2 visits per year. **Bitewings X-Ray**: Limit 1 set per year. **Full Mouth/Panoramic X-Ray**: Limit 1 every 60 months. **Intra-Oral X-Ray**: Limit 2 per year. **Cleaning**: Limit 2 per year. **Fluoride Applications**: Limit 2 per year. **Space Maintainer**: Limit 1 per lifetime. **Sealants**: Limit 1 per tooth per year. **Palliative Treatment**: Limit 1 per year. **Fillings**: (amalgam, resin and composite, or sedative): Limit 2 per year. **Crowns**: Limit 1 per year. **Pin Retention**: Limit 1 per year. **Surgical Extractions**: Limit 2 per year. **Periodontal Surgery**: Limit 1 per year. **Root Canal**: Limit 2 per year.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Dental check-up (continued)	**No Charge**	**No Charge**	**Not Covered**	**Orthodontia & Prosthodontic Treatment for Cleft Lip/Palate**: Limit 1 each.

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
- Spinal manipulation
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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.)

- Cosmetic surgery – If it is to treat a medical condition or to improve or restore physiologic function
- Hearing aids (minor) – If it is for eligible children under age 18 who have a hearing loss
- . Routine foot care – If it is related to diabetes and/or performed specifically for the purpose of treating pain related to functional limitations.

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact your Plan Administrator. You may also contact your state insurance department at 303-894-7499 or Toll Free 1-800-930-3745 or via FAX 303-894-7455 or e-mail at insurance@dora.state.co.us.

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: CO HealthOP Member Services at 1-866-915-6619, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa. You can also contact the State of Colorado Department of Regulatory Agencies Division of Insurance at 303-894-7490 or 1-800-930-3745.

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 1-866-915-6619.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-915-6619.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-866-915-6619.

Questions: Call 1-866-915-6619 or visit us at www.COhealthOp.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.COhealthOp.org or call 1-866-915-6619 to request a copy.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-915-6619.

Si desea más información en español sobre la cobertura y los precios, puede obtener los formas del plan o términos de la póliza, llamándonos al 1-866-915-6619.

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:** $7,540
- **Plan pays** $2,200
- **Patient pays** $5,340

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$3,900
Copays	$0
Coinsurance	$1,440
Limits or exclusions	$0
Total	**$5,340**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,520
- **Patient pays** $2,880

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,400
Copays	$480
Coinsurance	$0
Limits or exclusions	$0
Total	**$2,880**

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.

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.kp.org or by calling 1-855-249-5005 (TTY 1-800-521-4874).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$4,500** individual (applicable when the coverage is subscriber only) / **$9,000** family Does not apply to preventive care services.	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, **$6,350** individual (applicable when the coverage is subscriber only) / **$12,700** 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 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, see **www.kp.org or call 1-855-249-5005 (TTY 1-800-521-4874)** for a list of plan **providers**.	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 1-855-249-5005 (TTY 1-800-521-4874) or visit us at www.kp.org. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-249-5005 (TTY 1-800-521-4874) 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 plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	50% coinsurance	Not covered	---none---
	Specialist visit	50% coinsurance	Not covered	---none---
	Other practitioner office visit	Spinal Manipulations: Not covered; Acupuncture services: Not covered	Not covered	Limited to spinal manipulations and acupuncture services.
	Preventive care/ screening/immunization	No charge	Not covered	Not subject to the overall deductible.
If you have a test	Diagnostic test (x-ray, blood work)	50% coinsurance	Not covered	---none---
	Imaging (CT/PET scans, MRIs)	50% coinsurance	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org/formulary	Generic drugs	50% coinsurance retail and mail order prescriptions	Not covered	Subject to formulary guidelines. Federally mandated over the counter items are covered with a prescription when filled at a Kaiser Permanente pharmacy. For Southern Colorado members: Prescriptions for second and on-going maintenance medications must be filled at a Pharmacy in a Kaiser Permanente medical office or through Kaiser Permanente mail order.
	Brand drugs	50% coinsurance retail and mail order prescriptions	Not covered	Subject to formulary guidelines
	Non-preferred drugs	50% coinsurance retail and mail order prescriptions	Not covered	Must be authorized through the non-preferred drug process.
	Specialty drugs	50% coinsurance retail and mail order prescriptions	Not covered	Subject to formulary guidelines
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	Not covered	---none---
	Physician/surgeon fees	50% coinsurance	Not covered	---none---
If you need immediate medical attention	Emergency room services	50% coinsurance	50% coinsurance	---none---
	Emergency medical transportation	50% coinsurance	50% coinsurance	---none---
	Urgent care/After hours care	50% coinsurance	50% coinsurance	Non-Plan Providers: only covered if you are out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance	Not covered	---none---
	Physician/surgeon fee	50% coinsurance	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	50% coinsurance	Not covered	---none---
	Mental/Behavioral health inpatient services	50% coinsurance	Not covered	---none---
	Substance use disorder outpatient services	50% coinsurance	Not covered	---none---
	Substance use disorder inpatient services	50% coinsurance	Not covered	---none---
If you are pregnant	Prenatal and postnatal care	50% coinsurance	Not covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits.
	Delivery and all inpatient services	50% coinsurance	Not covered	---none---
If you need help recovering or have other special health needs	Home health care	50% coinsurance	Not covered	Limited to less than 8 hours per day and 28 hours per week
	Rehabilitation services	50% coinsurance for outpatient services; See Facility fee under "If you have a hospital stay" for inpatient services.	Not covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit); Inpatient in a multi-disciplinary facility limited to 60 days per condition per year.
	Habilitation services	50% coinsurance for outpatient services	Not covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit).
	Skilled nursing care	50% coinsurance	Not covered	Limited to 100 days per year
	Durable medical equipment	50% coinsurance	Not covered	Coverage is limited to items on our DME formulary. Prosthetic arms and legs not to exceed 20% coinsurance.
	Hospice service	50% coinsurance	Not covered	---none---
If your child needs dental or eye care	Eye exam	50% coinsurance for routine refractive exam	Not covered	Limited to routine refractive eye exams for members up to the age of 19; for services with an ophthalmologist see "Specialist visit"
	Glasses	Not covered	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Dental check-up	No charge	Not covered	Limited to members up to the age of 19; limited coverage for diagnostic and preventive services, minor restorative (fillings), simple extractions and crowns.

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	• Glasses	• Routine eye care (Adult)
• Bariatric surgery	• Hearing Aids (Adult)	• Routine foot care
• Spinal Manipulations	• Infertility treatment	• Weight loss programs
• Cosmetic surgery	• Long-term care	
• Dental care (Adult)	• Non-emergency care when traveling outside the U.S.	

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.)**

• Hearing aids (Children under the age of 18)	• Private-duty nursing

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 1-855-249-5005 or TTY 1-800-521-4874. 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: The plan at 1-855-249-5005 or TTY 1-800-521-4874; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Colorado Division of Insurance, Consumer Affairs Section, at 1560 Broadway, Ste 850, Denver, CO 80202 or call: 303-894-7490 (in-state, toll-free: 800-930-3745), or email: insurance@dora.state.co.us.

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 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 1-855-249-5005.

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:** $7,540
- **Plan pays** $1,440
- **Patient pays** $6,100

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$4,500
Copays	$0
Coinsurance	$1,400
Limits or exclusions	$200
Total	**$6,100**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $520
- **Patient pays** $4,880

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$4,500
Copays	$0
Coinsurance	$300
Limits or exclusions	$80
Total	**$4,880**

Total amounts above are based on subscriber only coverage.

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.

Colorado HealthOP: Bison HSA Qualified High Deductible Health Plan EPO (Small Group)

Coverage Period: Beginning on or after 01/01/15

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

Coverage for: Family/Child Only | **Plan Type:** EPO

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.COhealthOp.org or by calling 1-866-915-6619.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Network** / **Non-Network** **$2,050** individual / **Not Covered** individual **$4,100** family / **Not Covered** family The **deductible** does not apply to preventive care. All **coinsurance** is subject to the annual **deductible** and accumulates towards meeting the **out-of-pocket limit**, unless stated otherwise. **Copayments** are not subject to the annual **deductible** but do accumulate towards meeting the **out-of-pocket limit**, unless stated otherwise. Non-covered services do not accumulate towards meeting the **out-of-pocket limit**.	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 below 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 below for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **Network** / **Non-Network** **$4,200** individual / **Not Covered** individual **$8,400** family / **Not Covered** 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, Non-Network **coinsurance** or **deductibles**, and excluded or health care services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

Important Questions	Answers	Why this Matters:
Is there an overall annual limit on what the plan pays?	No.	The chart below 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. See www.COhealthOp.org **or call 1-866-915-6619** for a list of participating providers.	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 below for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	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 the Excluded Services table below. See your policy or plan document for additional information about **excluded services**.

- **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 providing a lower maximum out-of-pocket amount by charging you lower **deductibles**, **copayments**, and/or **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**40%** coinsurance	**Not Covered**	---None---
	Specialist visit	**40%** coinsurance	**Not Covered**	---None---
	Other practitioner office visit	**40%** coinsurance	**Not Covered**	---None---
	Preventive care/screening/immunization	**No Charge**	**Not Covered**	---None---
If you have a test	Diagnostic test (x-ray, blood work)	**40%** coinsurance	**Not Covered**	---None---
	Imaging (CT/PET scans, MRIs)	**40%** coinsurance	**Not Covered**	---None---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.COhealthOp.org	Generic drugs	**Retail** **$15** copayment/ prescription after deductible **Mail Order** **$30** copayment/ prescription after deductible	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	**40%** coinsurance Same coinsurance for Retail and Mail Order prescriptions.	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Non-preferred brand drugs	**40%** coinsurance Same coinsurance for Retail and Mail Order prescriptions.	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.COhealthOp.org	Specialty drugs	**40%** coinsurance Same coinsurance for Retail and Mail Order prescriptions.	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31 day supply (mail order prescription)
	Preventive drugs	**No Charge**	**Same as Network**	Covers preventive drugs used in relation to the following five (5) conditions: asthma/COPD, blood pressure, cholesterol, diabetes, and prenatal care.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**40%** coinsurance	**Not Covered**	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Physician/surgeon fees	**40%** coinsurance	**Not Covered**	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
If you need immediate medical attention	Emergency room services	**40%** coinsurance	**Same as Network**	---None---
	Emergency medical transportation	**40%** coinsurance	**Not Covered**	Transportation by other than a licensed ambulance.
	Urgent care	**40%** coinsurance	**Not Covered**	Limited to services received at Urgent Care Centers. Services received from other provider types will be reimbursed according to the provider and service rendered.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	**40%** coinsurance	**Not Covered**	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.
	Physician/surgeon fee	**40%** coinsurance	**Not Covered**	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**40%** coinsurance	**Not Covered**	Early Intervention Services are limited to 45 visits per year. Autism-Applied Behavioral Analysis is limited to 550 sessions from birth to age 8 and 185 sessions age 9-19 (sessions being 25 minute increments) **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health inpatient services	**40%** coinsurance	**Not Covered**	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.
	Substance use disorder outpatient services	**40%** coinsurance	**Not Covered**	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Substance use disorder inpatient services	**40%** coinsurance	**Not Covered**	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.
If you are pregnant	Prenatal and postnatal care	**40%** coinsurance	**Not Covered**	---None---
	Delivery and all inpatient services	**40%** coinsurance	**Not Covered**	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
If you need help recovering or have other special health needs	Home health care	**40%** coinsurance	**Not Covered**	Limit 28 hours per week. **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Rehabilitation services	**40%** coinsurance	**Not Covered**	Combined Network/Non-Network limit of 20 therapy visits per year for **speech therapy**. Combined Network/Non-Network limit of 20 visits per therapy type for **physical therapy and occupational therapy**. Not limited for children up to age 5 with congenital defects; No therapy limitation for autism.
	Habilitation services	**40%** coinsurance	**Not Covered**	Combined Network/Non-Network limit of 20 therapy visits per year for **speech therapy**. Combined Network/Non-Network limit of 20 visits per therapy type for **physical therapy and occupational therapy**. Not limited for children up to age 5 with congenital defects; No therapy limitation for autism.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Skilled nursing care	**40%** coinsurance	**Not Covered**	Limited to 100 days per year. **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Durable medical equipment	**40%** coinsurance	**Not Covered**	**Pre-authorization required** for items over $500; and the Colorado HealthOP will make a determination on whether the item(s) will be purchased or rented.
	Hospice service	**40%** coinsurance	**Not Covered**	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
If your child needs dental or eye care	Eye exam	**No Charge**	**Not Covered**	Limited to 1 exam per year.
	Glasses	**Not Covered**	**Not Covered**	---None---

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Dental check-up	**No Charge**	**Not Covered**	**Oral Exams**: Limit 2 visits per year. **Bitewings X-Ray**: Limit 1 set per year. **Full Mouth/Panoramic X-Ray**: Limit 1 every 60 months. **Intra-Oral X-Ray**: Limit 2 per year. **Cleaning**: Limit 2 per year. **Fluoride Applications**: Limit 2 per year. **Space Maintainer**: Limit 1 per lifetime. **Sealants**: Limit 1 per tooth per year. **Palliative Treatment**: Limit 1 per year. **Fillings**: (amalgam, resin and composite, or sedative): Limit 2 per year. **Crowns**: Limit 1 per year. **Pin Retention**: Limit 1 per year **Surgical Extractions**: Limit 2 per year. **Periodontal Surgery**: Limit 1 per year. **Root Canal**: Limit 2 per year. **Orthodontia & Prosthodontic Treatment for Cleft Lip/Palate**: Limit 1 each.

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
- Spinal manipulation
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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.)

- Cosmetic surgery – If it is to treat a medical condition or to improve or restore physiologic function.
- Hearing aids (minor) – If it is for eligible children under age 18 who have a hearing loss.
- Routine foot care – If it is related to diabetes and/or performed specifically for the purpose of treating pain related to functional limitations.

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact your Plan Administrator. You may also contact your state insurance department at 303-894-7499 or Toll Free 1-800-930-3745 or via FAX 303-894-7455 or e-mail at insurance@dora.state.co.us.

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: CO HealthOP Member Services at 1-866-915-6619, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa. You can also contact the State of Colorado Department of Regulatory Agencies Division of Insurance at 303-894-7490 or 1-800-930-3745.

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 1-866-915-6619.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-915-6619.

Chinese (中文): 如果需要中文的帮助, **请拨打这个号码** 1-866-915-6619.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-915-6619.

Si desea más información en español sobre la cobertura y los precios, puede obtener los formas del plan o términos de la póliza, llamándonos al 1-866-915-6619.

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:** $7,540
- **Plan pays** $3,310
- **Patient pays** $ 4,230

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,050
Copays	$0
Coinsurance	$2,180
Limits or exclusions	$0
Total	**$4,230**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,315
- **Patient pays** $2,085

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,050
Copays	$15
Coinsurance	$20
Limits or exclusions	$0
Total	**$2,085**

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.

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.kp.org or by calling 1-855-249-5005 (TTY 1-800-521-4874).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$3,500** individual (applicable when the coverage is subscriber only) / **$7,000** family Does not apply to preventive care services.	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, **$6,350** individual (applicable when the coverage is subscriber only) / **$12,700** 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 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, see **www.kp.org or call 1-855-249-5005 (TTY 1-800-521-4874)** for a list of plan **providers**.	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 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-855-249-5005 (TTY 1-800-521-4874) or visit us at www.kp.org. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-249-5005 (TTY 1-800-521-4874) 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 plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay per visit (30% coinsurance for covered services received during a visit)	Not covered	---none---
	Specialist visit	$60 copay per visit (30% coinsurance for covered services received during a visit)	Not covered	---none---
	Other practitioner office visit	Spinal Manipulations: Not covered; Acupuncture services: Not covered	Not covered	Limited to spinal manipulations and acupuncture services.
	Preventive care/ screening/immunization	No charge	Not covered	Not subject to the overall deductible.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not covered	---none---
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org/formulary	Generic drugs	$20 / retail prescription; $40 mail order prescription	Not covered	Subject to formulary guidelines. Federally mandated over the counter items are covered with a prescription when filled at a Kaiser Permanente pharmacy. For Southern Colorado members: Prescriptions for second and on-going maintenance medications must be filled at a Pharmacy in a Kaiser Permanente medical office or through Kaiser Permanente mail order.
	Brand drugs	$45 / retail prescription; $90 mail order prescription	Not covered	Subject to formulary guidelines
	Non-preferred drugs	30% coinsurance retail and mail order prescriptions	Not covered	Must be authorized through the non-preferred drug process.
	Specialty drugs	30% coinsurance retail and mail order prescriptions	Not covered	Subject to formulary guidelines
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	---none---
	Physician/surgeon fees	30% coinsurance	Not covered	---none---
If you need immediate medical attention	Emergency room services	30% coinsurance	30% coinsurance	---none---
	Emergency medical transportation	30% coinsurance	30% coinsurance	---none---
	Urgent care/After hours care	30% coinsurance	30% coinsurance	Non-Plan Providers: only covered if you are out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	---none---
	Physician/surgeon fee	30% coinsurance	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 copay per visit; group visits are 50% of the individual visit (30% coinsurance for covered services received during a visit	Not covered	---none---
	Mental/Behavioral health inpatient services	30% coinsurance	Not covered	---none---
	Substance use disorder outpatient services	$40 copay per visit; group visits are 50% of the individual visit (30% coinsurance for covered services received during a visit	Not covered	---none---
	Substance use disorder inpatient services	30% coinsurance	Not covered	---none---
If you are pregnant	Prenatal and postnatal care	30% coinsurance	Not covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits.
	Delivery and all inpatient services	30% coinsurance	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	Limited to less than 8 hours per day and 28 hours per week
	Rehabilitation services	30% coinsurance for outpatient services; See Facility fee under "If you have a hospital stay" for inpatient services.	Not covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit); Inpatient in a multi-disciplinary facility limited to 60 days per condition per year.
	Habilitation services	30% coinsurance for outpatient services	Not covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit).
	Skilled nursing care	30% coinsurance	Not covered	Limited to 100 days per year
	Durable medical equipment	30% coinsurance	Not covered	Coverage is limited to items on our DME formulary. Prosthetic arms and legs not to exceed 20% coinsurance.
	Hospice service	30% coinsurance	Not covered	---none---
If your child needs dental or eye care	Eye exam	$40 copay per visit for routine refractive exam (30% coinsurance for covered services received during a visit)	Not covered	Limited to routine refractive eye exams for members up to the age of 19; for services with an ophthalmologist see "Specialist visit"
	Glasses	Not covered	Not covered	---none---
	Dental check-up	No charge	Not covered	Limited to members up to the age of 19; limited coverage for diagnostic and preventive services, minor restorative (fillings), simple extractions and crowns.

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	• Glasses	• Routine eye care (Adult)
• Bariatric surgery	• Hearing Aids (Adult)	• Routine foot care
• Spinal Manipulations	• Infertility treatment	• Weight loss programs
• Cosmetic surgery	• Long-term care	
• Dental care (Adult)	• Non-emergency care when traveling outside the U.S.	

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.)	
• Hearing aids (Children under the age of 18)	• Private-duty nursing

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 1-855-249-5005 or TTY 1-800-521-4874. 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: The plan at 1-855-249-5005 or TTY 1-800-521-4874; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Colorado Division of Insurance, Consumer Affairs Section, at 1560 Broadway, Ste 850, Denver, CO 80202 or call: 303-894-7490 (in-state, toll-free: 800-930-3745), or email: insurance@dora.state.co.us.

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 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 1-855-249-5005.

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:** $7,540
- **Plan pays** $2,720
- **Patient pays** $4,820

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$3,500
Copays	$20
Coinsurance	$1,100
Limits or exclusions	$200
Total	**$4,820**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $1,320
- **Patient pays** $4,080

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$3,500
Copays	$400
Coinsurance	$100
Limits or exclusions	$80
Total	**$4,080**

Total amounts above are based on subscriber only coverage.

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.

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.COhealthOp.org or by calling 1-866-915-6619.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Network** / **Enhanced*** / **Non-Network** **$2,050** individual / **$2,000** individual / **Not Covered** **$4,100** family / **$4,000** family / **Not Covered** The **deductible** does not apply to preventive care. All **coinsurance** is subject to the annual **deductible** and accumulates towards meeting the **out-of-pocket limit**, unless stated otherwise. **Copayments** are not subject to the annual **deductible** but do accumulate towards meeting the **out-of-pocket limit**, unless stated otherwise. Non-covered services do not accumulate towards meeting the **out-of-pocket limit**. For covered members who qualify for the Enhanced Network benefit level, the **deductible** only has to be met for either the Enhanced or Standard Network benefit level—not both—and whichever one comes first.	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 below 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 below for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **Network** / **Enhanced*** / **Non-Network** **$6,600** individual / **$6,600** individual / **Not Covered** **$13,200** family / **$13,200** family / **Not Covered** For covered members who qualify for the Enhanced Network benefit level, the **out-of-pocket limit** only has to be met for either the Enhanced or Standard Network benefit level—not both—and whichever one comes first.	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.

Important Questions	Answers	Why this Matters:
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, Non-Network **coinsurance** or **deductibles**, and excluded or health care services 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 below 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. See **www.COhealthOp.org or call 1-866-915-6619** for a list of participating providers.	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 below for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	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 the Excluded Services table below. See your policy or plan document for additional information about **excluded services**.

- **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 providing a lower maximum out-of-pocket amount by charging you lower **deductibles**, **copayments**, and/or **coinsurance** amounts.

* **Enhanced Benefits:** Enhanced benefits are incentives offered by your plan when required personal health actions are completed. Incentives are based on completion of the required personal health actions and not on the outcome of those actions.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	First 2 visits free; subsequent visits **$25** copayment/visit	**No Charge**	**Not Covered**	---None---
	Specialist visit	**$60** copayment/visit	**$60** copayment/visit	**Not Covered**	---None---
	Other practitioner office visit	**40%** coinsurance	**40%** coinsurance	**Not Covered**	---None---
	Preventive care/screening/immunization	**No Charge**	**No Charge**	**Not Covered**	---None---
If you have a test	Diagnostic test (x-ray, blood work)	**40%** coinsurance	**40%** coinsurance	**Not Covered**	---None---
	Imaging (CT/PET scans, MRIs)	**40%** coinsurance	**40%** coinsurance	**Not Covered**	---None---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.COhealthOp.org	Generic drugs	**Retail** **$15** copayment/ prescription **Mail Order** **$30** copayment/ prescription	**No Charge**	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.COhealthOp.org	Preferred brand drugs	**Retail** **$40** copayment/ prescription **Mail Order** **$80** copayment/ prescription	**Retail** **$40** copayment/ prescription **Mail Order** **$80** copayment/ prescription	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Non-preferred brand drugs	**40%** coinsurance not subject to deductible Same coinsurance for Retail and Mail Order prescriptions	**40%** coinsurance not subject to deductible Same coinsurance for Retail and Mail Order prescriptions	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Specialty drugs	**40%** coinsurance not subject to deductible Same coinsurance for Retail and Mail Order prescriptions	**40%** coinsurance not subject to deductible Same coinsurance for Retail and Mail Order prescriptions	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31 day supply (mail order prescription)
	Preventive drugs	**No Charge**	**No Charge**	**Same as Network**	Covers preventive drugs used in relation to the following five (5) conditions: asthma/COPD, blood pressure, cholesterol, diabetes, and prenatal care.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**40%** coinsurance	**40%** coinsurance	**Not Covered**	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Physician/surgeon fees	**40%** coinsurance	**40%** coinsurance	**Not Covered**	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
If you need immediate medical attention	Emergency room services	**$500** copayment	**$500** copayment	**Same as Network**	---None---
	Emergency medical transportation	**40%** coinsurance	**40%** coinsurance	**Not Covered**	Transportation by other than a licensed ambulance.
	Urgent care	**$150** copayment	**$150** copayment	**Not Covered**	Limited to services received at Urgent Care Centers. Services received from other provider types will be reimbursed according to the provider and service rendered.
If you have a hospital stay	Facility fee (e.g., hospital room)	**40%** coinsurance	**40%** coinsurance	**Not Covered**	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have a hospital stay	Physician/surgeon fee	**40%** coinsurance	**40%** coinsurance	**Not Covered**	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**$60** copayment	**No Charge**	**Not Covered**	Early Intervention Services are limited to 45 visits per year. Autism-Applied Behavioral Analysis is limited to 550 sessions from birth to age 8 and 185 sessions age 9-19 (sessions being 25 minute increments) **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Mental/Behavioral health inpatient services	**40%** coinsurance	**40%** coinsurance	**Not Covered**	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Substance use disorder outpatient services	**$60** copayment	**No Charge**	**Not Covered**	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Substance use disorder inpatient services	**40%** coinsurance	**40%** coinsurance	**Not Covered**	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.
If you are pregnant	Prenatal and postnatal care	**40%** coinsurance	**40%** coinsurance	**Not Covered**	---None---
	Delivery and all inpatient services	**40%** coinsurance	**40%** coinsurance	**Not Covered**	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
If you need help recovering or have other special health needs	Home health care	**40%** coinsurance	**40%** coinsurance	**Not Covered**	Limit 28 hours per week. **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Rehabilitation services	**Speech Therapy** **$60** copayment/visit **Occupational and Physical Therapy** **$60** copayment/visit	**Speech Therapy** **$60** copayment/visit **Occupational and Physical Therapy** **$30** copayment/visit	**Not Covered**	Combined Network/Non-Network limit of 20 therapy visits per year for **speech therapy**. Combined Network/Non-Network limit of 20 visits per therapy type for **physical therapy and occupational therapy**. Not limited for children up to age 5 with congenital defects. No therapy limitation for autism.
	Habilitation services	**Speech Therapy** **$60** copayment/visit **Occupational and Physical Therapy** **$60** copayment/visit	**Speech Therapy** **$60** copayment/visit **Occupational and Physical Therapy** **$30** copayment/visit	**Not Covered**	Combined Network/Non-Network limit of 20 therapy visits per year for **speech therapy**. Combined Network/Non-Network limit of 20 visits per therapy type for **physical therapy and occupational therapy**. Not limited for children up to age 5 with congenital defects. No therapy limitation for autism.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Skilled nursing care	**40%** coinsurance	**40%** coinsurance	**Not Covered**	Limited to 100 days per year. **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Durable medical equipment	**40%** coinsurance	**40%** coinsurance	**Not Covered**	**Pre-authorization required** for items over $500; and the Colorado HealthOP will make a determination on whether the item(s) will be purchased or rented.
	Hospice service	**40%** coinsurance	**40%** coinsurance	**Not Covered**	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
If your child needs dental or eye care	Eye exam	**No Charge**	**No Charge**	**Not Covered**	Limited to 1 exam per year.
	Glasses	**Not Covered**	**Not Covered**	**Not Covered**	---None---

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Dental check-up	**No Charge**	**No Charge**	**Not Covered**	**Oral Exams**: Limit 2 visits per year. **Bitewings X-Ray**: Limit 1 set per year. **Full Mouth/Panoramic X-Ray**: Limit 1 every 60 months. **Intra-Oral X-Ray**: Limit 2 per year. **Cleaning**: Limit 2 per year. **Fluoride Applications**: Limit 2 per year. **Space Maintainer**: Limit 1 per lifetime. **Sealants**: Limit 1 per tooth per year. **Palliative Treatment**: Limit 1 per year. **Fillings**: (amalgam, resin and composite, or sedative): Limit 2 per year. **Crowns**: Limit 1 per year. **Pin Retention**: Limit 1 per year. **Surgical Extractions**: Limit 2 per year. **Periodontal Surgery**: Limit 1 per year. **Root Canal**: Limit 2 per year.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Dental check-up (continued)	**No Charge**	**No Charge**	**Not Covered**	**Orthodontia & Prosthodontic Treatment for Cleft Lip/Palate**: Limit 1 each.

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.)

- Bariatric surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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.)

- Acupuncture – If all Covered Persons complete their required health actions for the plan year. Coverage limits are combined with chiropractic and other similar services under the plan's Neuro/Musculo/Skeletal Manipulation and Acupuncture benefit provision.
- Spinal manipulation – If all Covered Persons complete their required health actions for the plan year. Coverage limits are combined with chiropractic and other similar services under the plan's Neuro/Musculo/Skeletal Manipulation and Acupuncture benefit provision.
- Cosmetic surgery – If it is to treat a medical condition or to improve or restore physiologic function.
- Hearing aids (minor) – If it is for eligible children under age 18 who have a hearing loss.
- Routine foot care – If it is related to diabetes and/or performed specifically for the purpose of treating pain related to functional limitations.

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact your Plan Administrator. You may also contact your state insurance department at 303-894-7499 or Toll Free 1-800-930-3745 or via FAX 303-894-7455 or e-mail at insurance@dora.state.co.us.

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: CO HealthOP Member Services at 1-866-915-6619, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa. You can also contact the State of Colorado Department of Regulatory Agencies Division of Insurance at 303-894-7490 or 1-800-930-3745.

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 1-866-915-6619.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-915-6619.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-866-915-6619.

Questions: Call 1-866-915-6619 or visit us at www.COhealthOp.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.COhealthOp.org or call 1-866-915-6619 to request a copy.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-915-6619.

Si desea más información en español sobre la cobertura y los precios, puede obtener los formas del plan o términos de la póliza, llamándonos al 1-866-915-6619.

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:** $7,540
- **Plan pays** $3,310
- **Patient pays** $4,230

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,050
Copays	$0
Coinsurance	$2,180
Limits or exclusions	$0
Total	**$4,230**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,615
- **Patient pays** $1,785

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,400
Copays	$385
Coinsurance	$0
Limits or exclusions	$0
Total	**$1,785**

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.

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.COhealthOp.org or by calling 1-866-915-6619.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Network** / **Non-Network** **$6,250** individual / **$12,500** individual **$12,500** family / **$25,000** family The **deductible** does not apply to preventive care. All **coinsurance** is subject to the annual **deductible** and accumulates towards meeting the **out-of-pocket limit**, unless stated otherwise. **Copayments** are not subject to the annual **deductible** but do accumulate towards meeting the **out-of-pocket limit**, unless stated otherwise. Non-covered services do not accumulate towards meeting the **out-of-pocket limit**.	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 below 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 below for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **Network** / **Non-Network** **$6,250** individual / **No Limit** individual **$12,500** family / **No Limit** 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, Non-Network **coinsurance** or **deductibles**, and excluded or health care services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

Important Questions	Answers	Why this Matters:
Is there an overall annual limit on what the plan pays?	No.	The chart below 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. See www.COhealthOp.org **or call 1-866-915-6619** for a list of participating providers.	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 below for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	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 the Excluded Services table below. See your policy or plan document for additional information about **excluded services**.

- **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 providing a lower maximum out-of-pocket amount by charging you lower **deductibles**, **copayments**, and/or **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**0%** coinsurance	**50%** coinsurance	---None---
	Specialist visit	**0%** coinsurance	**50%** coinsurance	---None---
	Other practitioner office visit	**0%** coinsurance	**50%** coinsurance	---None---
	Preventive care/screening/immunization	**No Charge**	**50%** coinsurance	---None---
If you have a test	Diagnostic test (x-ray, blood work)	**0%** coinsurance	**50%** coinsurance	---None---
	Imaging (CT/PET scans, MRIs)	**0%** coinsurance	**50%** coinsurance	---None---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.COhealthOp.org	Generic drugs	**0%** coinsurance Same coinsurance for Retail and Mail Order prescriptions.	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	**0%** coinsurance Same coinsurance for Retail and Mail Order prescriptions.	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Non-preferred brand drugs	**0%** coinsurance Same coinsurance for Retail and Mail Order prescriptions.	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.COhealthOp.org	Specialty drugs	**0%** coinsurance Same coinsurance for Retail and Mail Order prescriptions.	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31 day supply (mail order prescription)
	Preventive drugs	**No Charge**	**Same as Network**	Covers preventive drugs used in relation to the following five (5) conditions: asthma/COPD, blood pressure, cholesterol, diabetes, and prenatal care.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**0%** coinsurance	**50%** coinsurance	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Physician/surgeon fees	**0%** coinsurance	**50%** coinsurance	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
If you need immediate medical attention	Emergency room services	**0%** coinsurance	**Same as Network**	---None---
	Emergency medical transportation	**0%** coinsurance	**50%** coinsurance	Transportation by other than a licensed ambulance.
	Urgent care	**0%** coinsurance	**50%** coinsurance	Limited to services received at Urgent Care Centers. Services received from other provider types will be reimbursed according to the provider and service rendered.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	**0%** coinsurance	**50%** coinsurance	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.
	Physician/surgeon fee	**0%** coinsurance	**50%** coinsurance	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**0%** coinsurance	**50%** coinsurance	Early Intervention Services are limited to 45 visits per year. Autism-Applied Behavioral Analysis is limited to 550 sessions from birth to age 8 and 185 sessions age 9-19 (sessions being 25 minute increments) **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health inpatient services	**0%** coinsurance	**50%** coinsurance	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.
	Substance use disorder outpatient services	**0%** coinsurance	**50%** coinsurance	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Substance use disorder inpatient services	**0%** coinsurance	**50%** coinsurance	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.
If you are pregnant	Prenatal and postnatal care	**0%** coinsurance	**50%** coinsurance	---None---
	Delivery and all inpatient services	**0%** coinsurance	**50%** coinsurance	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
If you need help recovering or have other special health needs	Home health care	**0%** coinsurance	**50%** coinsurance	Limit 28 hours per week. **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Rehabilitation services	**0%** coinsurance	**50%** coinsurance	Combined Network/Non-Network limit of 20 therapy visits per year for **speech therapy**. Combined Network/Non-Network limit of 20 visits per therapy type for **physical therapy and occupational therapy**. Not limited for children up to age 5 with congenital defects; No therapy limitation for autism.
	Habilitation services	**0%** coinsurance	**50%** coinsurance	Combined Network/Non-Network limit of 20 therapy visits per year for **speech therapy**. Combined Network/Non-Network limit of 20 visits per therapy type for **physical therapy and occupational therapy**. Not limited for children up to age 5 with congenital defects; No therapy limitation for autism.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Skilled nursing care	**0%** coinsurance	**50%** coinsurance	Limited to 100 days per year. **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Durable medical equipment	**0%** coinsurance	**50%** coinsurance	**Pre-authorization required** for items over $500; and the Colorado HealthOP will make a determination on whether the item(s) will be purchased or rented.
	Hospice service	**0%** coinsurance	**50%** coinsurance	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
If your child needs dental or eye care	Eye exam	**No Charge**	**Not Covered**	Limited to 1 exam per year.
	Glasses	**Not Covered**	**Not Covered**	---None---

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Dental check-up	**No Charge**	**Not Covered**	**Oral Exams**: Limit 2 visits per year. **Bitewings X-Ray**: Limit 1 set per year. **Full Mouth/Panoramic X-Ray**: Limit 1 every 60 months. **Intra-Oral X-Ray**: Limit 2 per year. **Cleaning**: Limit 2 per year. **Fluoride Applications**: Limit 2 per year. **Space Maintainer**: Limit 1 per lifetime. **Sealants**: Limit 1 per tooth per year. **Palliative Treatment**: Limit 1 per year. **Fillings**: (amalgam, resin and composite, or sedative): Limit 2 per year. **Crowns**: Limit 1 per year. **Pin Retention**: Limit 1 per year **Surgical Extractions**: Limit 2 per year. **Periodontal Surgery**: Limit 1 per year. **Root Canal**: Limit 2 per year. **Orthodontia & Prosthodontic Treatment for Cleft Lip/Palate**: Limit 1 each.

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
- Spinal manipulation
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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.)

- Cosmetic surgery – If it is to treat a medical condition or to improve or restore physiologic function.
- Hearing aids (minor) – If it is for eligible children under age 18 who have a hearing loss.
- Routine foot care – If it is related to diabetes and/or performed specifically for the purpose of treating pain related to functional limitations.

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact your Plan Administrator. You may also contact your state insurance department at 303-894-7499 or Toll Free 1-800-930-3745 or via FAX 303-894-7455 or e-mail at insurance@dora.state.co.us.

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: CO HealthOP Member Services at 1-866-915-6619, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa. You can also contact the State of Colorado Department of Regulatory Agencies Division of Insurance at 303-894-7490 or 1-800-930-3745.

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 1-866-915-6619.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-915-6619.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-866-915-6619.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-915-6619.

Si desea más información en español sobre la cobertura y los precios, puede obtener los formas del plan o términos de la póliza, llamándonos al 1-866-915-6619.

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:** $7,540
- **Plan pays** $1,290
- **Patient pays** $6,250

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$6,250
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$6,250**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $400
- **Patient pays** $5,000

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$5,000
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$5,000**

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.

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.COhealthOp.org or by calling 1-866-915-6619.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Network** / **Non-Network** **$6,500** individual / **$13,000** individual **$13,000** family / **$26,000** family **Deductibles** are the same for Tier 1 and Tier 2 benefit levels. The **deductible** does not apply to preventive care. All **coinsurance** is subject to the annual **deductible** and accumulates towards meeting the **out-of-pocket limit**, unless stated otherwise. **Copayments** are not subject to the annual **deductible** but do accumulate towards meeting the **out-of-pocket limit**, unless stated otherwise. Non-covered services do not accumulate towards meeting the **out-of-pocket limit**.	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 below 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 below for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **Network** / **Non-Network** **$6,500** individual / **No Limit** individual **$13,000** family / **No Limit** family **Out-of-pocket limits** are the same for Tier 1 and Tier 2 benefit levels.	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.

Important Questions	Answers	Why this Matters:
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, Non-Network **coinsurance** or **deductibles**, and excluded or health care services 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 below 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. See **www.COhealthOp.org or call 1-866-915-6619** for a list of participating providers.	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 below for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	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 the Excluded Services table below. See your policy or plan document for additional information about **excluded services**.

- **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 providing a lower maximum out-of-pocket amount by charging you lower **deductibles**, **copayments**, and/or **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**Tier 1** First 2 visits free; subsequent visits **0%** coinsurance **Tier 2** **0%** coinsurance	**50%** coinsurance	Tier 1 – After the two (2) free visits all subsequent visits are subject to deductible
	Specialist visit	**0%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	---None---
	Other practitioner office visit	**0%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	---None---
	Preventive care/screening/immunization	**No Charge**	**50%** coinsurance	---None---
If you have a test	Diagnostic test (x-ray, blood work)	**0%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	---None---
	Imaging (CT/PET scans, MRIs)	**0%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	---None---

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.COhealthOp.org	Generic drugs	**Retail** **$20** copayment then **No Charge** after deductible or out-of-pocket limit has been met. **Mail Order** **$40** copayment then **No Charge** after deductible or out-of-pocket limit has been met. Same copayments for Tier 1 and Tier 2 benefit levels.	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	**Retail** **0%** coinsurance **Mail Order** **0%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Non-preferred brand drugs	**Retail** **0%** coinsurance **Mail Order** **0%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.COhealthOp.org	Specialty drugs	**Retail** **0%** coinsurance **Mail Order** **0%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31 day supply (mail order prescription)
	Preventive drugs	**No Charge**	**Same as Network**	Covers preventive drugs used in relation to the following five (5) conditions: asthma/COPD, blood pressure, cholesterol, diabetes, and prenatal care.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**0%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Physician/surgeon fees	**0%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	**0%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**Same as Network**	---None---
	Emergency medical transportation	**0%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	Transportation by other than a licensed ambulance.
	Urgent care	**0%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	Limited to services received at Urgent Care Centers. Services received from other provider types will be reimbursed according to the provider and service rendered.
If you have a hospital stay	Facility fee (e.g., hospital room)	**0%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.
	Physician/surgeon fee	**0%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**0%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	Early Intervention Services are limited to 45 visits per year. Autism-Applied Behavioral Analysis is limited to 550 sessions from birth to age 8 and 185 sessions age 9-19 (sessions being 25 minute increments) **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Mental/Behavioral health inpatient services	**0%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.
	Substance use disorder outpatient services	**0%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Substance use disorder inpatient services	**0%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	**0%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	---None---
	Delivery and all inpatient services	**0%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
If you need help recovering or have other special health needs	Home health care	**0%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	Limit 28 hours per week. **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Rehabilitation services	**0%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	Combined Network/Non-Network limit of 20 therapy visits per year for **speech therapy**. Combined Network/Non-Network limit of 20 visits per therapy type for **physical therapy and occupational therapy**. Not limited for children up to age 5 with congenital defects; No therapy limitation for autism.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Habilitation services	**0%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	Combined Network/Non-Network limit of 20 therapy visits per year for **speech therapy**. Combined Network/Non-Network limit of 20 visits per therapy type for **physical therapy and occupational therapy**. Not limited for children up to age 5 with congenital defects; No therapy limitation for autism.
	Skilled nursing care	**0%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	Limited to 100 days per year. **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Durable medical equipment	**0%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	**Pre-authorization required** for items over $500; and the Colorado HealthOP will make a determination on whether the item(s) will be purchased or rented.
	Hospice service	**0%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	**No Charge**	**Not Covered**	Limited to 1 exam per year.
	Glasses	**Not Covered**	**Not Covered**	---None---
If your child needs dental or eye care	Dental check-up	**No Charge**	**Not Covered**	**Oral Exams**: Limit 2 visits per year. **Bitewings X-Ray**: Limit 1 set per year. **Full Mouth/Panoramic X-Ray**: Limit 1 every 60 months. **Intra-Oral X-Ray**: Limit 2 per year. **Cleaning**: Limit 2 per year. **Fluoride Applications**: Limit 2 per year. **Space Maintainer**: Limit 1 per lifetime. **Sealants**: Limit 1 per tooth per year. **Palliative Treatment**: Limit 1 per year. **Fillings**: (amalgam, resin and composite, or sedative): Limit 2 per year. **Crowns**: Limit 1 per year. **Pin Retention**: Limit 1 per year **Surgical Extractions**: Limit 2 per year. **Periodontal Surgery**: Limit 1 per year. **Root Canal**: Limit 2 per year. **Orthodontia & Prosthodontic Treatment for Cleft Lip/Palate**: Limit 1 each.

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
- Spinal manipulation
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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.)

- Cosmetic surgery – If it is to treat a medical condition or to improve or restore physiologic function.
- Hearing aids (minor) – If it is for eligible children under age 18 who have a hearing loss.
- Routine foot care – If it is related to diabetes and/or performed specifically for the purpose of treating pain related to functional limitations.

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact your Plan Administrator. You may also contact your state insurance department at 303-894-7499 or Toll Free 1-800-930-3745 or via FAX 303-894-7455 or e-mail at insurance@dora.state.co.us.

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: CO HealthOP Member Services at 1-866-915-6619, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa. You can also contact the State of Colorado Department of Regulatory Agencies Division of Insurance at 303-894-7490 or 1-800-930-3745.

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 1-866-915-6619.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-915-6619.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-866-915-6619.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-915-6619.

Si desea más información en español sobre la cobertura y los precios, puede obtener los formas del plan o términos de la póliza, llamándonos al 1-866-915-6619.

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:** $7,540
- **Plan pays** $1,040
- **Patient pays** $6,500

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$6,500
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$6,500**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,820
- **Patient pays** $2,580

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,100
Copays	$480
Coinsurance	$0
Limits or exclusions	$0
Total	**$2,580**

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.

Anthem Blue Cross and Blue Shield
Anthem Bronze Pathway X HMO 5000/30%/6600 Plus

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

Coverage Period: 01/01/2015 - 12/31/2015
Coverage for: Individual/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.anthem.com or by calling 1-855-453-7032.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$5,000** person / **$10,000** family for In-Network Provider. Does not apply to Prescription Drugs, Preventive Care, Primary Care visit and Specialist visit.	You must pay all 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?	Yes; **$500** person / **$1000** family for In-Network Provider Tier 2, Tier 3 and Tier 4 Prescription Drugs. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes; **$6,600** person / **$13,200** family for In-Network Provider.	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, 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; This policy has no overall annual limit on the amount it will pay each year.	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, Pathway X (CO); See www.anthem.com or call 1-855-453-7032 for a list of participating providers.	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 do not need a referral to see a specialist.	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 8. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-855-453-7032 or visit us at www.anthem.com.
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 1-855-453-7032 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 In-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	$30 copay for first 3 visits and then 30% coinsurance	Not covered	All office visit copayments count towards the same 3 visit limit.
	Specialist visit	$30 copay for first 3 visits and then 30% coinsurance	Not covered	All office visit copayments count towards the same 3 visit limit.
	Other practitioner office visit	Spinal Manipulations $30 copay for first 3 visits and then 30% coinsurance Acupuncture $30 copay for first 3 visits and then 30% coinsurance	Spinal Manipulations Not covered Acupuncture Not covered	Spinal Manipulations Coverage for In-Network is limited to 20 visits per benefit period. All office visit copayments count towards the same 3 visit limit. Acupuncture Coverage for In-Network is limited to 20 visits per benefit period. All office visit copayments count towards the same 3 visit limit.
	Preventive care/screening/immunization	No charge	Not covered	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office 30% coinsurance X-Ray – Office 30% coinsurance	Lab – Office Not covered X-Ray – Office Not covered	Lab – Office --------none-------- X-Ray – Office --------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
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyinformation/	Tier 1 - Typically Generic	$15 copay per prescription (retail only) and $38 copay per prescription (home delivery only)	Not covered	Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs.
	Tier 2 - Typically Preferred/Formulary Brand	$35 copay per prescription and then 0% coinsurance (retail only) and $88 copay per prescription and then 0% coinsurance (home delivery only)	Not covered	Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs.
	Tier 3 – Typically Non-preferred/Non-formulary Drugs	$70 copay per prescription and then 0% coinsurance (retail only) and $175 copay per prescription and then 0% coinsurance (home delivery only)	Not covered	Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs.
	Tier 4 - Typically Specialty Drugs	30% up to $500 per prescription (retail and home delivery)	Not covered	Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance and then $250 copay	Not covered	--------none--------
	Physician/surgeon fees	30% coinsurance	Not covered	--------none--------
If you need immediate medical attention	Emergency room services	30% coinsurance and then $250 copay	30% coinsurance and then $250 copay	Copay waived if admitted.

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
	Emergency medical transportation	30% coinsurance	30% coinsurance	--------none--------
	Urgent care	30% coinsurance	30% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance and then $500 copay	Not covered	Coverage for Inpatient physical medicine and rehabilitation In-Network is limited to 2 months per benefit period. Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Physician/surgeon fee	30% coinsurance	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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit $30 copay for first 3 visits and then 30% coinsurance Mental/Behavioral Health Facility Visit – Facility Charges 30% coinsurance and then $250 copay	Mental/Behavioral Health Office Visit Not covered Mental/Behavioral Health Facility Visit – Facility Charges Not covered	Mental/Behavioral Health Office Visit All office visit copayments count towards the same 3 visit limit. Mental/Behavioral Health Facility Visit – Facility Charges Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Mental/Behavioral health inpatient services	30% coinsurance and then $500 copay	Not covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Substance use disorder outpatient services	Substance Abuse Office Visit $30 copay for first 3 visits and then 30% coinsurance Substance Abuse Facility Visit – Facility Charges 30% coinsurance and then $250 copay	Substance Abuse Office Visit Not covered Substance Abuse Facility Visit – Facility Charges Not covered	Substance Abuse Office Visit All office visit copayments count towards the same 3 visit limit. Substance Abuse Facility Visit – Facility Charges Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Substance use disorder inpatient services	30% coinsurance and then $500 copay	Not covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
If you are pregnant	Prenatal and postnatal care	30% coinsurance	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
	Delivery and all inpatient services	30% coinsurance and then $500 copay	Not covered	Applies to inpatient facility. Other cost shares may apply depending on services provided. Failure to obtain preauthorization may result in non- coverage or reduced coverage.
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	Coverage is limited to 28 hours per week. Apply to In-Network Providers.
	Rehabilitation services	$30 copay for first 3 visits and then 30% coinsurance	Not covered	Coverage for speech therapy is limited to 20 visits per benefit period, occupational therapy is limited to 20 visits per benefit period, and physical therapy is limited to 20 visits per benefit period. In-Network. All office visit copayments count towards the same 3 visit limit.
	Habilitation services	$30 copay for first 3 visits and then 30% coinsurance	Not covered	Coverage for speech therapy is limited to 20 visits per benefit period, occupational therapy is limited to 20 visits per benefit period, and physical therapy is limited to 20 visits per benefit period. In-Network. All office visit copayments count towards the same 3 visit limit.
	Skilled nursing care	30% coinsurance and then $500 copay	Not covered	Coverage for skilled nursing services including day rehabilitation programs In-Network is limited to 100 days per benefit period. Failure to obtain preauthorization may result in non- coverage or reduced coverage.
	Durable medical equipment	30% coinsurance	Not covered	--------none--------
	Hospice service	0% coinsurance	Not covered	--------none--------
If your child needs dental or eye care	Eye exam	No charge	Not covered	Coverage is limited to 1 exam per benefit period. Apply to In-Network Providers.

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
	Glasses	Not covered	Not covered	--------none--------
	Dental check-up	10% coinsurance	Not covered	Costs may vary by site of service. You should refer to your formal contract of coverage for details. This policy DOES NOT provide any dental benefits to individuals age nineteen (19) or older, except as specifically covered in your evidence of coverage. This policy is being offered so the purchaser will have pediatric dental coverage as required by the Affordable Care Act. If you want adult dental benefits, you will need to buy a different plan. This plan WILL NOT pay for any adult dental care, so you will have to pay the full price of any dental care you receive, unless you have another dental plan.

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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Hearing aids (Ages 18+)
- Infertility treatment
- Long-term care
- Non-Formulary drugs
- Routine eye care (adult)
- 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.)

- Acupuncture
- Spinal Manipulations
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide
- Private-duty nursing Coverage is limited to 28 hours per week.

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 1-855-453-7032. 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:

ATTN: Grievances and Appeals
700 Broadway
Mail Stop CO0104-0430
Denver, CO 80273

Department of Labors Employee
Benefits Security Administration
(866) 444-EBSA (3272)
www.dol.gov/ebsa/healthreform

Division of Insurance
ICARE Section
1560 Broadway
Suite 850
Denver, Colorado 80202
(303) 894-7490

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:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

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:** $7,540
- **Plan pays:** $1,690
- **Patient pays:** $5,850

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$5,000
Copays	$20
Coinsurance	$680
Limits or exclusions	$150
Total	**$5,850**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $230
- **Patient pays:** $5,170

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$5,000
Copays	$50
Coinsurance	$40
Limits or exclusions	$80
Total	**$5,170**

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.

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.kp.org or by calling 1-855-249-5005 (TTY 1-800-521-4874).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$4,500** individual/ **$9,000** family Does not apply to preventive care services and certain services with a copay.	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, **$6,350** individual / **$12,700** 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, balanced-billed charges 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, see **www.kp.org or call 1-855-249-5005 (TTY 1-800-521-4874)** for a list of plan **providers**.	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 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-855-249-5005 (TTY 1-800-521-4874) or visit us at www.kp.org**.** If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-249-5005 (TTY 1-800-521-4874) 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 plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$50 copay per visit (40% coinsurance for covered services received during a visit)	Not covered	Copay not subject to the overall deductible.
	Specialist visit	$70 copay per visit (40% coinsurance for covered services received during a visit)	Not covered	---none---
	Other practitioner office visit	Spinal Manipulations: Not covered; Acupuncture services: Not covered	Not covered	Limited to spinal manipulations and acupuncture services.
	Preventive care/ screening/immunization	No charge	Not covered	Not subject to the overall deductible.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: 40% coinsurance Lab: 40% coinsurance	Not covered	---none---
	Imaging (CT/PET scans, MRIs)	40% coinsurance	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org/formulary	Generic drugs	$20/retail prescription; $40/mail order prescription	Not covered	Subject to formulary guidelines. Federally mandated over the counter items are covered with a prescription when filled at a Kaiser Permanente pharmacy. For Southern Colorado members: Prescriptions for second and on-going maintenance medications must be filled at a Pharmacy in a Kaiser Permanente medical office or through Kaiser Permanente mail order.
	Brand drugs	40% coinsurance retail and mail order prescriptions	Not covered	Subject to formulary guidelines.
	Non-preferred drugs	40% coinsurance retail and mail order prescriptions	Not covered	Must be authorized through the non-preferred drug process.
	Specialty drugs	40% coinsurance up to $250 per drug dispensed retail and mail order prescriptions	Not covered	Subject to formulary guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	Not covered	---none---
	Physician/surgeon fees	40% coinsurance	Not covered	---none---
If you need immediate medical attention	Emergency room services	40% coinsurance	40% coinsurance	---none---
	Emergency medical transportation	40% coinsurance	40% coinsurance	---none---
	Urgent care/After hours care	$100 copay per visit (40% coinsurance for covered services received during a visit)	$100 copay per visit (40% coinsurance for covered services received during a visit)	Non-Plan Providers: only covered if you are out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	Not covered	---none---
	Physician/surgeon fee	40% coinsurance	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$50 per visit; group visits are 50% of the individual visit (40% coinsurance for covered services received during a visit)	Not covered	Copay not subject to the overall deductible.
	Mental/Behavioral health inpatient services	40% coinsurance	Not covered	---none---
	Substance use disorder outpatient services	$50 per visit; group visits are 50% of the individual visit (40% coinsurance for covered services received during a visit)	Not covered	Copay not subject to the overall deductible.
	Substance use disorder inpatient services	40% coinsurance	Not covered	---none---
If you are pregnant	Prenatal and postnatal care	40% coinsurance	Not covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits.
	Delivery and all inpatient services	40% coinsurance	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	40% coinsurance	Not covered	Limited to less than 8 hours per day and 28 hours per week
	Rehabilitation services	40% coinsurance for outpatient services; See Facility fee under "If you have a hospital stay" for inpatient services.	Not covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit); Inpatient in a multi-disciplinary facility limited to 60 days per condition per year.
	Habilitation services	40% coinsurance for outpatient services	Not covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit).
	Skilled nursing care	40% coinsurance	Not covered	Limited to 100 days per year
	Durable medical equipment	40% coinsurance	Not covered	Coverage is limited to items on our DME formulary. Prosthetic arms and legs at 20% coinsurance (not subject to the overall deductible).
	Hospice service	40% coinsurance	Not covered	---none---
If your child needs dental or eye care	Eye exam	$50 copay per visit for routine refractive exam (40% coinsurance for covered services received during a visit)	Not covered	Limited to routine refractive eye exams for members up to the age of 19; for services with an ophthalmologist see "Specialist visit"; Copay not subject to the deductible.
	Glasses	Not covered	Not covered	---none---
	Dental check-up	No charge	Not covered	Limited to members up to the age of 19; limited coverage for diagnostic and preventive services, minor restorative (fillings), simple extractions and crowns.

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	• Glasses	• Routine eye care (Adult)
• Bariatric surgery	• Hearing Aids (Adult)	• Routine foot care
• Spinal Manipulations	• Infertility treatment	• Weight loss programs
• Cosmetic surgery	• Long-term care	
• Dental care (Adult)	• Non-emergency care when traveling outside the U.S.	

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.)	
• Hearing aids (Children under the age of 18)	• Private-duty nursing

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 1-855-249-5005 or TTY 1-800-521-4874. 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: The plan at 1-855-249-5005 or TTY 1-800-521-4874; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Colorado Division of Insurance, Consumer Affairs Section, at 1560 Broadway, Ste 850, Denver, CO 80202 or call: 303-894-7490 (in-state, toll-free: 800-930-3745), or email: insurance@dora.state.co.us.

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 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 1-855-249-5005.

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:** $7,540
- **Plan pays** $1,720
- **Patient pays** $5,820

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$4,500
Copays	$20
Coinsurance	$1,100
Limits or exclusions	$200
Total	**$5,820**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $420
- **Patient pays** $4,980

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$4,500
Copays	$400
Coinsurance	$0
Limits or exclusions	$80
Total	**$4,980**

Total amounts above are based on subscriber only coverage.

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.

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.COhealthOp.org or by calling 1-866-915-6619.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Network** / **Enhanced*** / **Non-Network** **$3,900** individual / **$3,900** individual / **$7,800** individual **$7,800** family / **$7,800** family / **$15,600** family The **deductible** does not apply to preventive care. All **coinsurance** is subject to the annual **deductible** and accumulates towards meeting the **out-of-pocket limit**, unless stated otherwise. **Copayments** are not subject to the annual **deductible** but do accumulate towards meeting the **out-of-pocket limit**, unless stated otherwise. Non-covered services do not accumulate towards meeting the **out-of-pocket limit**. For covered members who qualify for the Enhanced Network benefit level, the **deductible** only has to be met for either the Enhanced or Standard Network benefit level—not both—and whichever one comes first.	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 below 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 below for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **Network** / **Enhanced*** / **Non-Network** **$6,600** individual / **$6,600** individual / **No Limit** individual **$13,200** family / **$13,200** family / **No Limit** family For covered members who qualify for the Enhanced Network benefit level, the **out-of-pocket limit** only has to be met for either the Enhanced or Standard Network benefit level—not both—and whichever one comes first.	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.

Important Questions	Answers	Why this Matters:
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, Non-Network **coinsurance** or **deductibles**, and excluded or health care services 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 below 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. See **www.COhealthOp.org or call 1-866-915-6619** for a list of participating providers.	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 below for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	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 the Excluded Services table below. See your policy or plan document for additional information about **excluded services**.

- **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 providing a lower maximum out-of-pocket amount by charging you lower **deductibles**, **copayments**, and/or **coinsurance** amounts.

* **Enhanced Benefits:** Enhanced benefits are incentives offered by your plan when required personal health actions are completed. Incentives are based on completion of the required personal health actions and not on the outcome of those actions.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	First 2 visits free; subsequent visits **40%** coinsurance	First 2 visits free; subsequent visits **40%** coinsurance	**50%** coinsurance	The first two primary care visits are free under the Enhanced benefit level only if the member has not already received the free visits under the Standard level.
	Specialist visit	**40%** coinsurance	**40%** coinsurance	**50%** coinsurance	---None---
	Other practitioner office visit	**40%** coinsurance	**40%** coinsurance	**50%** coinsurance	---None---
	Preventive care/screening/immunization	**No Charge**	**No Charge**	**50%** coinsurance	---None---
If you have a test	Diagnostic test (x-ray, blood work)	**40%** coinsurance	**40%** coinsurance	**50%** coinsurance	---None---
	Imaging (CT/PET scans, MRIs)	**40%** coinsurance	**40%** coinsurance	**50%** coinsurance	---None---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.COhealthOp.org	Generic drugs	**Retail** **$20** copayment/ prescription **Mail Order** **$40** copayment/ prescription	**Retail** **$20** copayment/ prescription **Mail Order** **$40** copayment/ prescription	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.COhealthOp.org	Preferred brand drugs	**40%** coinsurance not subject to deductible Same coinsurance for Retail and Mail Order prescriptions	**40%** coinsurance not subject to deductible Same coinsurance for Retail and Mail Order prescriptions	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Non-preferred brand drugs	**40%** coinsurance not subject to deductible Same coinsurance for Retail and Mail Order prescriptions	**40%** coinsurance not subject to deductible Same coinsurance for Retail and Mail Order prescriptions	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Specialty drugs	**40%** coinsurance not subject to deductible Same coinsurance for Retail and Mail Order prescriptions	**40%** coinsurance not subject to deductible Same coinsurance for Retail and Mail Order prescriptions	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31 day supply (mail order prescription)
	Preventive drugs	**No Charge**	**No Charge**	**Same as Network**	Covers preventive drugs used in relation to the following five (5) conditions: asthma/COPD, blood pressure, cholesterol, diabetes, and prenatal care.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**40%** coinsurance	**40%** coinsurance	**50%** coinsurance	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Physician/surgeon fees	**40%** coinsurance	**40%** coinsurance	**50%** coinsurance	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
If you need immediate medical attention	Emergency room services	**40%** coinsurance	**40%** coinsurance	**Same as Network**	---None---
	Emergency medical transportation	**40%** coinsurance	**40%** coinsurance	**50%** coinsurance	Transportation by other than a licensed ambulance.
	Urgent care	**$150** copayment	**$150** copayment	**50%** coinsurance	Limited to services received at Urgent Care Centers. Services received from other provider types will be reimbursed according to the provider and service rendered.
If you have a hospital stay	Facility fee (e.g., hospital room)	**40%** coinsurance	**40%** coinsurance	**50%** coinsurance	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have a hospital stay	Physician/surgeon fee	**40%** coinsurance	**40%** coinsurance	**50%** coinsurance	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**40%** coinsurance	**40%** coinsurance	**50%** coinsurance	Early Intervention Services are limited to 45 visits per year. Autism-Applied Behavioral Analysis is limited to 550 sessions from birth to age 8 and 185 sessions age 9-19 (sessions being 25 minute increments) **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Mental/Behavioral health inpatient services	**40%** coinsurance	**40%** coinsurance	**50%** coinsurance	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Substance use disorder outpatient services	**40%** coinsurance	**40%** coinsurance	**50%** coinsurance	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Substance use disorder inpatient services	**40%** coinsurance	**40%** coinsurance	**50%** coinsurance	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.
If you are pregnant	Prenatal and postnatal care	**40%** coinsurance	**40%** coinsurance	**50%** coinsurance	---None---
	Delivery and all inpatient services	**40%** coinsurance	**40%** coinsurance	**50%** coinsurance	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
If you need help recovering or have other special health needs	Home health care	**40%** coinsurance	**40%** coinsurance	**50%** coinsurance	Limit 28 hours per week. **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Rehabilitation services	**40%** coinsurance	**40%** coinsurance	**50%** coinsurance	Combined Network/Non-Network limit of 20 therapy visits per year for **speech therapy**. Combined Network/Non-Network limit of 20 visits per therapy type for **physical therapy and occupational therapy**. Not limited for children up to age 5 with congenital defects. No therapy limitation for autism.
	Habilitation services	**40%** coinsurance	**40%** coinsurance	**50%** coinsurance	Combined Network/Non-Network limit of 20 therapy visits per year for **speech therapy**. Combined Network/Non-Network limit of 20 visits per therapy type for **physical therapy and occupational therapy**. Not limited for children up to age 5 with congenital defects. No therapy limitation for autism.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Skilled nursing care	**40%** coinsurance	**40%** coinsurance	**50%** coinsurance	Limited to 100 days per year. **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Durable medical equipment	**40%** coinsurance	**40%** coinsurance	**50%** coinsurance	**Pre-authorization required** for items over $500; and the Colorado HealthOP will make a determination on whether the item(s) will be purchased or rented.
	Hospice service	**40%** coinsurance	**40%** coinsurance	**50%** coinsurance	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
If your child needs dental or eye care	Eye exam	**No Charge**	**No Charge**	**Not Covered**	Limited to 1 exam per year.
	Glasses	**Not Covered**	**Not Covered**	**Not Covered**	---None---

Common Medical Event	Services You May Need	Your Cost If You Use a			Limitations & Exceptions
		Network Provider (Standard Benefits)	Network Provider (*Enhanced Benefits)	Non-Network Provider	
If your child needs dental or eye care	Dental check-up	**No Charge**	**No Charge**	**Not Covered**	**Oral Exams**: Limit 2 visits per year. **Bitewings X-Ray**: Limit 1 set per year. **Full Mouth/Panoramic X-Ray**: Limit 1 every 60 months. **Intra-Oral X-Ray**: Limit 2 per year. **Cleaning**: Limit 2 per year. **Fluoride Applications**: Limit 2 per year. **Space Maintainer**: Limit 1 per lifetime. **Sealants**: Limit 1 per tooth per year. **Palliative Treatment**: Limit 1 per year. **Fillings**: (amalgam, resin and composite, or sedative): Limit 2 per year. **Crowns**: Limit 1 per year. **Pin Retention**: Limit 1 per year. **Surgical Extractions**: Limit 2 per year. **Periodontal Surgery**: Limit 1 per year. **Root Canal**: Limit 2 per year.

Common Medical Event	Services You May Need	Your Cost If You Use a			Limitations & Exceptions
		Network Provider (Standard Benefits)	Network Provider (*Enhanced Benefits)	Non-Network Provider	
If your child needs dental or eye care	Dental check-up (continued)	**No Charge**	**No Charge**	**Not Covered**	**Orthodontia & Prosthodontic Treatment for Cleft Lip/Palate**: Limit 1 each.

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
- Spinal manipulation
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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.)**

- Cosmetic surgery – If it is to treat a medical condition or to improve or restore physiologic function.
- Hearing aids (minor) – If it is for eligible children under age 18 who have a hearing loss.
- Routine foot care – If it is related to diabetes and/or performed specifically for the purpose of treating pain related to functional limitations.

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact your Plan Administrator. You may also contact your state insurance department at 303-894-7499 or Toll Free 1-800-930-3745 or via FAX 303-894-7455 or e-mail at insurance@dora.state.co.us.

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: CO HealthOP Member Services at 1-866-915-6619, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa. You can also contact the State of Colorado Department of Regulatory Agencies Division of Insurance at 303-894-7490 or 1-800-930-3745.

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 1-866-915-6619.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-915-6619.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-866-915-6619.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-915-6619.

Si desea más información en español sobre la cobertura y los precios, puede obtener los formas del plan o términos de la póliza, llamándonos al 1-866-915-6619.

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:** $7,540
- **Plan pays** $2,200
- **Patient pays** $ 5,340

Sample care costs:

Hospital charges (mother)	$2,900
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$3,900
Copays	$0
Coinsurance	$1,440
Limits or exclusions	$0
Total	**$5,340**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,520
- **Patient pays** $2,880

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,400
Copays	$480
Coinsurance	$0
Limits or exclusions	$0
Total	**$2,880**

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.

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.kp.org or by calling 1-855-249-5005 (TTY 1-800-521-4874).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,500** individual/ **$3,000** family Does not apply to preventive care services, certain services with a copay and prescription drugs.	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?	Yes, **$500** per person for prescription drug expenses. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes, **$6,350** individual / **$12,700** 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, balanced-billed charges 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, see **www.kp.org or call 1-855-249-5005 (TTY 1-800-521-4874)** for a list of plan **providers**.	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 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-855-249-5005 (TTY 1-800-521-4874) or visit us at www.kp.org**.** If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-249-5005 (TTY 1-800-521-4874) 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 plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$50 copay per visit (35% coinsurance for covered services received during a visit)	Not covered	Copay not subject to the overall deductible.
	Specialist visit	$70 copay per visit (35% coinsurance for covered services received during a visit)	Not covered	Copay not subject to the overall deductible.
	Other practitioner office visit	Spinal Manipulations: Not covered; Acupuncture services: Not covered	Not covered	Limited to spinal manipulations and acupuncture services.
	Preventive care/ screening/immunization	No charge	Not covered	Not subject to the overall deductible.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: 35% coinsurance Lab: 35% coinsurance	Not covered	---none---
	Imaging (CT/PET scans, MRIs)	$300 per test	Not covered	Multiple cost shares may apply per encounter.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org/formulary	Generic drugs	$15/retail prescription; $30/mail order prescription	Not covered	Not subject to the pharmacy deductible. Not subject to the overall deductible. Subject to formulary guidelines. Federally mandated over the counter items are covered with a prescription when filled at a Kaiser Permanente pharmacy. For Southern Colorado members: Prescriptions for second and on-going maintenance medications must be filled at a Pharmacy in a Kaiser Permanente medical office or through Kaiser Permanente mail order.
	Brand drugs	$45/retail prescription; $90/mail order prescription	Not covered	Not subject to the overall deductible. Subject to formulary guidelines.
	Non-preferred drugs	50% coinsurance retail and mail order prescriptions	Not covered	Not subject to the overall deductible. Must be authorized through the non-preferred drug process.
	Specialty drugs	35% coinsurance up to $250 per drug dispensed retail and mail order prescriptions	Not covered	Not subject to the overall deductible. Subject to formulary guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	35% coinsurance	Not covered	---none---
	Physician/surgeon fees	35% coinsurance	Not covered	---none---
If you need immediate medical attention	Emergency room services	35% coinsurance	35% coinsurance	---none---
	Emergency medical transportation	35% coinsurance	35% coinsurance	---none---
	Urgent care/After hours care	$100 copay per visit (35% coinsurance for covered services received during a visit)	$100 copay per visit (35% coinsurance for covered services received during a visit)	Non-Plan Providers: only covered if you are out of the service area. Copay not subject to the overall deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	35% coinsurance	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Physician/surgeon fee	35% coinsurance	Not covered	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$50 per visit; group visits are 50% of the individual visit (35% coinsurance for covered services received during a visit)	Not covered	Copay not subject to the overall deductible.
	Mental/Behavioral health inpatient services	35% coinsurance	Not covered	---none---
	Substance use disorder outpatient services	$50 per visit; group visits are 50% of the individual visit (35% coinsurance for covered services received during a visit)	Not covered	Copay not subject to the overall deductible.
	Substance use disorder inpatient services	35% coinsurance	Not covered	---none---
If you are pregnant	Prenatal and postnatal care	35% coinsurance	Not covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits.
	Delivery and all inpatient services	35% coinsurance	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	35% coinsurance	Not covered	Limited to less than 8 hours per day and 28 hours per week
	Rehabilitation services	35% coinsurance for outpatient services; See Facility fee under "If you have a hospital stay" for inpatient services.	Not covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit); Inpatient in a multi-disciplinary facility limited to 60 days per condition per year.
	Habilitation services	35% coinsurance for outpatient services	Not covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit).
	Skilled nursing care	35% coinsurance	Not covered	Limited to 100 days per year
	Durable medical equipment	35% coinsurance	Not covered	Coverage is limited to items on our DME formulary. Prosthetic arms and legs at 20% coinsurance (not subject to the overall deductible).
	Hospice service	35% coinsurance	Not covered	---none---
If your child needs dental or eye care	Eye exam	$50 copay per visit for routine refractive exam (35% coinsurance for covered services received during a visit)	Not covered	Limited to routine refractive eye exams for members up to the age of 19; for services with an ophthalmologist see "Specialist visit"; Copay not subject to the deductible.
	Glasses	Not covered	Not covered	---none---
	Dental check-up	No charge	Not covered	Limited to members up to the age of 19; limited coverage for diagnostic and preventive services, minor restorative (fillings), simple extractions and crowns.

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	• Glasses	• Routine eye care (Adult)
• Bariatric surgery	• Hearing Aids (Adult)	• Routine foot care
• Spinal Manipulations	• Infertility treatment	• Weight loss programs
• Cosmetic surgery	• Long-term care	
• Dental care (Adult)	• Non-emergency care when traveling outside the U.S.	

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.)	
• Hearing aids (Children under the age of 18)	• Private-duty nursing

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 1-855-249-5005 or TTY 1-800-521-4874. 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: The plan at 1-855-249-5005 or TTY 1-800-521-4874; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Colorado Division of Insurance, Consumer Affairs Section, at 1560 Broadway, Ste 850, Denver, CO 80202 or call: 303-894-7490 (in-state, toll-free: 800-930-3745), or email: insurance@dora.state.co.us.

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 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 1-855-249-5005.

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:** $7,540
- **Plan pays** $3,820
- **Patient pays** $3,720

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Copays	$20
Coinsurance	$2,000
Limits or exclusions	$200
Total	**$3,720**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,820
- **Patient pays** $1,580

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$1,100
Coinsurance	$300
Limits or exclusions	$80
Total	**$1,580**

Total amounts above are based on subscriber only coverage.

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.

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.kp.org or by calling 1-855-249-5005 (TTY 1-800-521-4874).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,000** individual (applicable when the coverage is subscriber only) / **$4,000** family Does not apply to preventive care services.	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, **$6,350** individual (applicable when the coverage is subscriber only) / **$12,700** 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 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, see **www.kp.org or call 1-855-249-5005 (TTY 1-800-521-4874)** for a list of plan **providers**.	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 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-855-249-5005 (TTY 1-800-521-4874) or visit us at www.kp.org. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-249-5005 (TTY 1-800-521-4874) 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 plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay per visit (15% coinsurance for covered services received during a visit)	Not covered	---none---
	Specialist visit	$50 copay per visit (15% coinsurance for covered services received during a visit)	Not covered	---none---
	Other practitioner office visit	Spinal Manipulations: Not covered; Acupuncture services: Not covered	Not covered	Limited to spinal manipulations and acupuncture services.
	Preventive care/ screening/immunization	No charge	Not covered	Not subject to the overall deductible.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	Not covered	---none---
	Imaging (CT/PET scans, MRIs)	15% coinsurance	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org/formulary	Generic drugs	$10 / retail prescription; $20 mail order prescription	Not covered	Subject to formulary guidelines. Federally mandated over the counter items are covered with a prescription when filled at a Kaiser Permanente pharmacy. For Southern Colorado members: Prescriptions for second and on-going maintenance medications must be filled at a Pharmacy in a Kaiser Permanente medical office or through Kaiser Permanente mail order.
	Brand drugs	$30 / retail prescription; $60 mail order prescription	Not covered	Subject to formulary guidelines
	Non-preferred drugs	15% coinsurance retail and mail order prescriptions	Not covered	Must be authorized through the non-preferred drug process.
	Specialty drugs	15% coinsurance retail and mail order prescriptions	Not covered	Subject to formulary guidelines
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	Not covered	---none---
	Physician/surgeon fees	15% coinsurance	Not covered	---none---
If you need immediate medical attention	Emergency room services	15% coinsurance	15% coinsurance	---none---
	Emergency medical transportation	15% coinsurance	15% coinsurance	---none---
	Urgent care/After hours care	15% coinsurance	15% coinsurance	Non-Plan Providers: only covered if you are out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	Not covered	---none---
	Physician/surgeon fee	15% coinsurance	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay per visit; group visits are 50% of the individual visit (15% coinsurance for covered services received during a visit	Not covered	---none---
	Mental/Behavioral health inpatient services	15% coinsurance	Not covered	---none---
	Substance use disorder outpatient services	$30 copay per visit; group visits are 50% of the individual visit (15% coinsurance for covered services received during a visit	Not covered	---none---
	Substance use disorder inpatient services	15% coinsurance	Not covered	---none---
If you are pregnant	Prenatal and postnatal care	15% coinsurance	Not covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits.
	Delivery and all inpatient services	15% coinsurance	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	15% coinsurance	Not covered	Limited to less than 8 hours per day and 28 hours per week
	Rehabilitation services	15% coinsurance for outpatient services; See Facility fee under "If you have a hospital stay" for inpatient services.	Not covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit); Inpatient in a multi-disciplinary facility limited to 60 days per condition per year.
	Habilitation services	15% coinsurance for outpatient services	Not covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit).
	Skilled nursing care	15% coinsurance	Not covered	Limited to 100 days per year
	Durable medical equipment	15% coinsurance	Not covered	Coverage is limited to items on our DME formulary.
	Hospice service	15% coinsurance	Not covered	---none---
If your child needs dental or eye care	Eye exam	$30 copay per visit for routine refractive exam (15% coinsurance for covered services received during a visit)	Not covered	Limited to routine refractive eye exams for members up to the age of 19; for services with an ophthalmologist see "Specialist visit"
	Glasses	Not covered	Not covered	---none---
	Dental check-up	No charge	Not covered	Limited to members up to the age of 19; limited coverage for diagnostic and preventive services, minor restorative (fillings), simple extractions and crowns.

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	• Glasses	• Routine eye care (Adult)
• Bariatric surgery	• Hearing Aids (Adult)	• Routine foot care
• Spinal Manipulatons	• Infertility treatment	• Weight loss programs
• Cosmetic surgery	• Long-term care	
• Dental care (Adult)	• Non-emergency care when traveling outside the U.S.	

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.)	
• Hearing aids (Children under the age of 18)	• Private-duty nursing

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 1-855-249-5005 or TTY 1-800-521-4874. 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: The plan at 1-855-249-5005 or TTY 1-800-521-4874; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Colorado Division of Insurance, Consumer Affairs Section, at 1560 Broadway, Ste 850, Denver, CO 80202 or call: 303-894-7490 (in-state, toll-free: 800-930-3745), or email: insurance@dora.state.co.us.

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 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 1-855-249-5005.

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:** $7,540
- **Plan pays** $4,520
- **Patient pays** $3,020

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,000
Copays	$20
Coinsurance	$800
Limits or exclusions	$200
Total	**$3,020**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,720
- **Patient pays** $2,680

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,000
Copays	$400
Coinsurance	$200
Limits or exclusions	$80
Total	**$2,680**

Total amounts above are based on subscriber only coverage.

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.

NWF HMO HSA Bronze 3250/70 $45 Copay

Coverage Period Begins on or After: January 1, 2015

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?	$3,250 person /$6,500 family (In-Network) Doesn't apply to preventive care.	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**. $6,350 person /$12,700 family (In-Network)	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**, visit 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**.

NWF HMO HSA Bronze 3250/70 $45 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type:** HMO

- **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 participating **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 after Deductible	Not Covered	None
	Specialist visit	$65 Copay after Deductible	Not Covered	None
	Other practitioner office visit	$45 Copay after Deductible	Not Covered	None
	Preventive care screening/immunization/ Smoking Cessation	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	30% Coinsurance after Deductible/Lab	Not Covered	None
		30% Coinsurance after Deductible/X-Ray	Not Covered	None
	Imaging (CT/PET scans, MRIs)	30% Coinsurance after Deductible	Not Covered	None

NWF HMO HSA Bronze 3250/70 $45 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type:** HMO

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	Tier 1 - $15 Copay after Deductible	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, Mail Order, and Preferred Network Pharmacy limited up to a 90-day supply. Specialty Pharmacy limited up to a 31-day supply. Tier 5 limited to 31-day supply only. Copays shown are for retail, up to a 31-day supply. Mail order is 2.5 times the retail copay or coinsurance amount.
	Preferred brand drugs	Tier 2 - $40 Copay after Deductible	Not Covered	
	Non-preferred brand drugs	Tier 3 -$55 Copay after Deductible	Not Covered	
	Specialty drugs	Tier 4 - 30% Coinsurance after Deductible	Not Covered	
		Tier 5 - 40% Coinsurance after Deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance after Deductible	Not Covered	None
	Physician/surgeon fees/Anesthesia	30% Coinsurance after Deductible	Not Covered	None
If you need immediate medical attention	Emergency room services	30% Coinsurance after Deductible	30% Coinsurance after Deductible	None
	Emergency medical transportation	30% Coinsurance after Deductible	30% Coinsurance after Deductible	None
	Urgent care	$65 Copay after Deductible	$65 Copay after Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance after Deductible	Not Covered	None
	Physician/surgeon fee/Anesthesia	30% Coinsurance after Deductible	Not Covered	None

NWF HMO HSA Bronze 3250/70 $45 Copay

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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$45 Copay after Deductible	Not Covered	None
	Mental/Behavioral health inpatient services	30% Coinsurance after Deductible	Not Covered	None
	Substance use disorder outpatient services	$45 Copay after Deductible	Not Covered	None
	Substance use disorder inpatient services	30% Coinsurance after Deductible	Not Covered	None
If you are pregnant	Prenatal and postnatal care	30% Coinsurance after Deductible	Not Covered	None
	Delivery and all inpatient services	30% Coinsurance after Deductible	Not Covered	None
If you need help recovering or have other special health needs	Home health care	30% Coinsurance after Deductible	Not Covered	None
	Rehabilitation services (Including Cardiac and Pulmonary Rehabilitation)	30% Coinsurance after Deductible	Not Covered	Coverage is limited to 20 visits/ Member/therapy/year for rehabilitative and 20 visits/Member/therapy/year for habilitative services. (Cardiac and Pulmonary are not limited)
	Habilitation services (Including Cardiac and Pulmonary Habilitation)	30% Coinsurance after Deductible	Not Covered	
	Skilled nursing care	30% Coinsurance after Deductible	Not Covered	Coverage is limited to 100 days/Member/year.
	Durable medical equipment	30% Coinsurance after Deductible	Not Covered	None
	Hospice service	30% Coinsurance after Deductible	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 your child needs dental or eye care	Eye exam	No Charge	Not Covered	Coverage is limited to children up to age 19, limited to one/Member/year.
	Glasses	Not Covered	Not Covered	None
	Dental check-up	No Charge	Not Covered	Coverage is limited to children up to age 19.

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
- Breast reconstruction (unless medically necessary or as part of a mastectomy)
- Cosmetic Surgery
- Drugs not included in the formulary
- Infertility treatment
- Long-term care
- Neuromusculoskeletal Services (unless purchased)
- Non-emergency care when traveling outside the U.S.
- 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.)

- Hearing Aids (for children)

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** $2920
- **Patient pays** $4620

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	$3250
Copays	$20
Coinsurance	$1200
Limits or exclusions	$150
Total	**$4620**

Managing Type 2 Diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5400
- **Plan pays** $670
- **Patient pays** $4730

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	$3250
Copays	$230
Coinsurance	$0
Limits or exclusions	$1250
Total	**$4730**

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.

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.kp.org or by calling 1-855-249-5005 (TTY 1-800-521-4874).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,200** individual/ **$2,400** family Does not apply to preventive care services, certain services with a copay and prescription drugs.	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?	Yes, **$500** per person for prescription drug expenses. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes, **$6,350** individual / **$12,700** 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, balanced-billed charges 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, see **www.kp.org or call 1-855-249-5005 (TTY 1-800-521-4874)** for a list of plan **providers**.	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 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-855-249-5005 (TTY 1-800-521-4874) or visit us at www.kp.org**.** If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-249-5005 (TTY 1-800-521-4874) 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 plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay per visit (35% coinsurance for covered services received during a visit)	Not covered	Copay not subject to the overall deductible.
	Specialist visit	$65 copay per visit (35% coinsurance for covered services received during a visit)	Not covered	Copay not subject to the overall deductible.
	Other practitioner office visit	Spinal Manipulations: Not covered; Acupuncture services: Not covered	Not covered	Limited to spinal manipulations and acupuncture services.
	Preventive care/ screening/immunization	No charge	Not covered	Not subject to the overall deductible.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: 35% coinsurance Lab: 35% coinsurance	Not covered	---none---
	Imaging (CT/PET scans, MRIs)	$300 per test	Not covered	Multiple cost shares may apply per encounter.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org/formulary	Generic drugs	$15/retail prescription; $30/mail order prescription	Not covered	Not subject to the pharmacy deductible. Not subject to the overall deductible. Subject to formulary guidelines. Federally mandated over the counter items are covered with a prescription when filled at a Kaiser Permanente pharmacy. For Southern Colorado members: Prescriptions for second and on-going maintenance medications must be filled at a Pharmacy in a Kaiser Permanente medical office or through Kaiser Permanente mail order.
	Brand drugs	$45/retail prescription; $90/mail order prescription	Not covered	Not subject to the overall deductible. Subject to formulary guidelines.
	Non-preferred drugs	50% coinsurance retail and mail order prescriptions	Not covered	Not subject to the overall deductible. Must be authorized through the non-preferred drug process.
	Specialty drugs	35% coinsurance up to $250 per drug dispensed retail and mail order prescriptions	Not covered	Not subject to the overall deductible. Subject to formulary guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	35% coinsurance	Not covered	---none---
	Physician/surgeon fees	35% coinsurance	Not covered	---none---
If you need immediate medical attention	Emergency room services	35% coinsurance	35% coinsurance	---none---
	Emergency medical transportation	35% coinsurance	35% coinsurance	---none---
	Urgent care/After hours care	$100 copay per visit (35% coinsurance for covered services received during a visit)	$100 copay per visit (35% coinsurance for covered services received during a visit)	Non-Plan Providers: only covered if you are out of the service area. Copay not subject to the overall deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	35% coinsurance	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Physician/surgeon fee	35% coinsurance	Not covered	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 per visit; group visits are 50% of the individual visit (35% coinsurance for covered services received during a visit)	Not covered	Copay not subject to the overall deductible.
	Mental/Behavioral health inpatient services	35% coinsurance	Not covered	---none---
	Substance use disorder outpatient services	$35 per visit; group visits are 50% of the individual visit (35% coinsurance for covered services received during a visit)	Not covered	Copay not subject to the overall deductible.
	Substance use disorder inpatient services	35% coinsurance	Not covered	---none---
If you are pregnant	Prenatal and postnatal care	35% coinsurance	Not covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits.
	Delivery and all inpatient services	35% coinsurance	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	35% coinsurance	Not covered	Limited to less than 8 hours per day and 28 hours per week
	Rehabilitation services	35% coinsurance for outpatient services; See Facility fee under "If you have a hospital stay" for inpatient services.	Not covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit); Inpatient in a multi-disciplinary facility limited to 60 days per condition per year.
	Habilitation services	35% coinsurance for outpatient services	Not covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit).
	Skilled nursing care	35% coinsurance	Not covered	Limited to 100 days per year
	Durable medical equipment	35% coinsurance	Not covered	Coverage is limited to items on our DME formulary. Prosthetic arms and legs at 20% coinsurance (not subject to the overall deductible).
	Hospice service	35% coinsurance	Not covered	---none---
If your child needs dental or eye care	Eye exam	$35 copay per visit for routine refractive exam (35% coinsurance for covered services received during a visit)	Not covered	Limited to routine refractive eye exams for members up to the age of 19; for services with an ophthalmologist see "Specialist visit"; Copay not subject to the deductible.
	Glasses	Not covered	Not covered	---none---
	Dental check-up	No charge	Not covered	Limited to members up to the age of 19; limited coverage for diagnostic and preventive services, minor restorative (fillings), simple extractions and crowns.

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	• Glasses	• Routine eye care (Adult)
• Bariatric surgery	• Hearing Aids (Adult)	• Routine foot care
• Spinal Manipulations	• Infertility treatment	• Weight loss programs
• Cosmetic surgery	• Long-term care	
• Dental care (Adult)	• Non-emergency care when traveling outside the U.S.	

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.)	
• Hearing aids (Children under the age of 18)	• Private-duty nursing

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 1-855-249-5005 or TTY 1-800-521-4874. 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: The plan at 1-855-249-5005 or TTY 1-800-521-4874; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Colorado Division of Insurance, Consumer Affairs Section, at 1560 Broadway, Ste 850, Denver, CO 80202 or call: 303-894-7490 (in-state, toll-free: 800-930-3745), or email: insurance@dora.state.co.us.

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 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 1-855-249-5005.

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:** $7,540
- **Plan pays** $4,020
- **Patient pays** $3,520

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,200
Copays	$20
Coinsurance	$2,100
Limits or exclusions	$200
Total	**$3,520**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,920
- **Patient pays** $1,480

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$1,000
Coinsurance	$300
Limits or exclusions	$80
Total	**$1,480**

Total amounts above are based on subscriber only coverage.

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.

Colorado HealthOP: Bison HSA Qualified High Deductible Health Plan PPO (Small Group)

Coverage Period: Beginning on or after 01/01/15

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

Coverage for: Family/Child Only | **Plan Type:** PPO

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.COhealthOp.org or by calling 1-866-915-6619.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Network** / **Non-Network** **$2,050** individual / **$4,100** individual **$4,100** family / **$8,200** family The **deductible** does not apply to preventive care. All **coinsurance** is subject to the annual **deductible** and accumulates towards meeting the **out-of-pocket limit**, unless stated otherwise. **Copayments** are not subject to the annual **deductible** but do accumulate towards meeting the **out-of-pocket limit**, unless stated otherwise. Non-covered services do not accumulate towards meeting the **out-of-pocket limit**.	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 below 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 below for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **Network** / **Non-Network** **$4,200** individual / **No Limit** individual **$8,400** family / **No Limit** 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, Non-Network **coinsurance** or **deductibles**, and excluded or health care services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

Important Questions	Answers	Why this Matters:
Is there an overall annual limit on what the plan pays?	No.	The chart below 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. See www.COhealthOp.org **or call 1-866-915-6619** for a list of participating providers.	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 below for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	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 the Excluded Services table below. See your policy or plan document for additional information about **excluded services**.

- **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 providing a lower maximum out-of-pocket amount by charging you lower **deductibles**, **copayments**, and/or **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**40%** coinsurance	**50%** coinsurance	---None---
	Specialist visit	**40%** coinsurance	**50%** coinsurance	---None---
	Other practitioner office visit	**40%** coinsurance	**50%** coinsurance	---None---
	Preventive care/screening/immunization	**No Charge**	**50%** coinsurance	---None---
If you have a test	Diagnostic test (x-ray, blood work)	**40%** coinsurance	**50%** coinsurance	---None---
	Imaging (CT/PET scans, MRIs)	**40%** coinsurance	**50%** coinsurance	---None---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.COhealthOp.org	Generic drugs	**Retail** **$15** copayment/ prescription after deductible **Mail Order** **$30** copayment/ prescription after deductible	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	**40%** coinsurance Same coinsurance for Retail and Mail Order prescriptions.	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Non-preferred brand drugs	**40%** coinsurance Same coinsurance for Retail and Mail Order prescriptions.	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.COhealthOp.org	Specialty drugs	**40%** coinsurance Same coinsurance for Retail and Mail Order prescriptions.	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31 day supply (mail order prescription)
	Preventive drugs	**No Charge**	**Same as Network**	Covers preventive drugs used in relation to the following five (5) conditions: asthma/COPD, blood pressure, cholesterol, diabetes, and prenatal care.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**40%** coinsurance	**50%** coinsurance	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Physician/surgeon fees	**40%** coinsurance	**50%** coinsurance	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
If you need immediate medical attention	Emergency room services	**40%** coinsurance	**Same as Network**	---None---
	Emergency medical transportation	**40%** coinsurance	**50%** coinsurance	Transportation by other than a licensed ambulance.
	Urgent care	**40%** coinsurance	**50%** coinsurance	Limited to services received at Urgent Care Centers. Services received from other provider types will be reimbursed according to the provider and service rendered.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	**40%** coinsurance	**50%** coinsurance	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.
	Physician/surgeon fee	**40%** coinsurance	**50%** coinsurance	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**40%** coinsurance	**50%** coinsurance	Early Intervention Services are limited to 45 visits per year. Autism-Applied Behavioral Analysis is limited to 550 sessions from birth to age 8 and 185 sessions age 9-19 (sessions being 25 minute increments) **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health inpatient services	**40%** coinsurance	**50%** coinsurance	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.
	Substance use disorder outpatient services	**40%** coinsurance	**50%** coinsurance	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Substance use disorder inpatient services	**40%** coinsurance	**50%** coinsurance	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.
If you are pregnant	Prenatal and postnatal care	**40%** coinsurance	**50%** coinsurance	---None---
	Delivery and all inpatient services	**40%** coinsurance	**50%** coinsurance	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
If you need help recovering or have other special health needs	Home health care	**40%** coinsurance	**50%** coinsurance	Limit 28 hours per week. **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Rehabilitation services	**40%** coinsurance	**50%** coinsurance	Combined Network/Non-Network limit of 20 therapy visits per year for **speech therapy**. Combined Network/Non-Network limit of 20 visits per therapy type for **physical therapy and occupational therapy**. Not limited for children up to age 5 with congenital defects; No therapy limitation for autism.
	Habilitation services	**40%** coinsurance	**50%** coinsurance	Combined Network/Non-Network limit of 20 therapy visits per year for **speech therapy**. Combined Network/Non-Network limit of 20 visits per therapy type for **physical therapy and occupational therapy**. Not limited for children up to age 5 with congenital defects; No therapy limitation for autism.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Skilled nursing care	**40%** coinsurance	**50%** coinsurance	Limited to 100 days per year. **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Durable medical equipment	**40%** coinsurance	**50%** coinsurance	**Pre-authorization required** for items over $500; and the Colorado HealthOP will make a determination on whether the item(s) will be purchased or rented.
	Hospice service	**40%** coinsurance	**50%** coinsurance	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
If your child needs dental or eye care	Eye exam	**No Charge**	**Not Covered**	Limited to 1 exam per year.
	Glasses	**Not Covered**	**Not Covered**	---None---

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Dental check-up	**No Charge**	**Not Covered**	**Oral Exams**: Limit 2 visits per year. **Bitewings X-Ray**: Limit 1 set per year. **Full Mouth/Panoramic X-Ray**: Limit 1 every 60 months. **Intra-Oral X-Ray**: Limit 2 per year. **Cleaning**: Limit 2 per year. **Fluoride Applications**: Limit 2 per year. **Space Maintainer**: Limit 1 per lifetime. **Sealants**: Limit 1 per tooth per year. **Palliative Treatment**: Limit 1 per year. **Fillings**: (amalgam, resin and composite, or sedative): Limit 2 per year. **Crowns**: Limit 1 per year. **Pin Retention**: Limit 1 per year **Surgical Extractions**: Limit 2 per year. **Periodontal Surgery**: Limit 1 per year. **Root Canal**: Limit 2 per year. **Orthodontia & Prosthodontic Treatment for Cleft Lip/Palate**: Limit 1 each.

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
- Spinal manipulation
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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.)

- Cosmetic surgery – If it is to treat a medical condition or to improve or restore physiologic function.
- Hearing aids (minor) – If it is for eligible children under age 18 who have a hearing loss.
- Routine foot care – If it is related to diabetes and/or performed specifically for the purpose of treating pain related to functional limitations.

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact your Plan Administrator. You may also contact your state insurance department at 303-894-7499 or Toll Free 1-800-930-3745 or via FAX 303-894-7455 or e-mail at insurance@dora.state.co.us.

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: CO HealthOP Member Services at 1-866-915-6619, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa. You can also contact the State of Colorado Department of Regulatory Agencies Division of Insurance at 303-894-7490 or 1-800-930-3745.

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 1-866-915-6619.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-915-6619.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-866-915-6619.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-915-6619.

Si desea más información en español sobre la cobertura y los precios, puede obtener los formas del plan o términos de la póliza, llamándonos al 1-866-915-6619.

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:** $7,540
- **Plan pays** $3,310
- **Patient pays** $4,230

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,050
Copays	$0
Coinsurance	$2,180
Limits or exclusions	$0
Total	**$4,230**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,170
- **Patient pays** $3,230

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,050
Copays	$0
Coinsurance	$1,180
Limits or exclusions	$0
Total	**$3,230**

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.

Anthem Blue Cross and Blue Shield
Anthem Silver Pathway X HMO 2000/30%/5000

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

Coverage Period: 01/01/2015 - 12/31/2015
Coverage for: Individual/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.anthem.com or by calling 1-855-453-7032.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,000** person / **$4,000** family for In-Network Provider. Does not apply to Prescription Drugs, Preventive Care, Primary Care visit and Specialist visit.	You must pay all 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?	Yes; **$250** person / **$500** family for In-Network Provider Tier 2, Tier 3 and Tier 4 Prescription Drugs. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes; **$5,000** person / **$10,000** family for In-Network Provider.	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, 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; This policy has no overall annual limit on the amount it will pay each year.	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, Pathway X (CO); See www.anthem.com or call 1-855-453-7032 for a list of participating providers.	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 do not need a referral to see a specialist.	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 9. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-855-453-7032 or visit us at www.anthem.com.
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 1-855-453-7032 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 In-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	$30 copay for first 3 visits and then 30% coinsurance	Not covered	All office visit copayments count towards the same 3 visit limit.
	Specialist visit	$30 copay for first 3 visits and then 30% coinsurance	Not covered	All office visit copayments count towards the same 3 visit limit.
	Other practitioner office visit	Spinal Manipulations $30 copay for first 3 visits and then 30% coinsurance Acupuncture $30 copay for first 3 visits and then 30% coinsurance	Spinal Manipulations Not covered Acupuncture Not covered	Spinal Manipulations Coverage for In-Network is limited to 20 visits per benefit period. All office visit copayments count towards the same 3 visit limit. Acupuncture Coverage for In-Network is limited to 20 visits per benefit period. All office visit copayments count towards the same 3 visit limit.
	Preventive care/screening/immunization	No charge	Not covered	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office 30% coinsurance X-Ray – Office 30% coinsurance	Lab – Office Not covered X-Ray – Office Not covered	Lab – Office --------none-------- X-Ray – Office --------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
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyinformation/	Tier 1 - Typically Generic	$15 copay per prescription (retail only) and $38 copay per prescription (home delivery only)	Not covered	Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs.
	Tier 2 - Typically Preferred/Formulary Brand	$35 copay per prescription and then 0% coinsurance (retail only) and $88 copay per prescription and then 0% coinsurance (home delivery only)	Not covered	Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs.
	Tier 3 – Typically Non-preferred/Non-formulary Drugs	$70 copay per prescription and then 0% coinsurance (retail only) and $175 copay per prescription and then 0% coinsurance (home delivery only)	Not covered	Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs.
	Tier 4 - Typically Specialty Drugs	30% up to $500 per prescription (retail and home delivery)	Not covered	Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance and then $250 copay	Not covered	--------none--------
	Physician/surgeon fees	30% coinsurance	Not covered	--------none--------
If you need immediate medical attention	Emergency room services	30% coinsurance and then $250 copay	30% coinsurance and then $250 copay	Copay waived if admitted.

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
	Emergency medical transportation	30% coinsurance	30% coinsurance	--------none--------
	Urgent care	30% coinsurance	30% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance and then $1,250 copay	Not covered	Coverage for Inpatient physical medicine and rehabilitation In-Network is limited to 2 months per benefit period. Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Physician/surgeon fee	30% coinsurance	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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit $30 copay for first 3 visits and then 30% coinsurance Mental/Behavioral Health Facility Visit – Facility Charges 30% coinsurance and then $250 copay	Mental/Behavioral Health Office Visit Not covered Mental/Behavioral Health Facility Visit – Facility Charges Not covered	Mental/Behavioral Health Office Visit All office visit copayments count towards the same 3 visit limit. Mental/Behavioral Health Facility Visit – Facility Charges Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Mental/Behavioral health inpatient services	30% coinsurance and then $1,250 copay	Not covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Substance use disorder outpatient services	Substance Abuse Office Visit $30 copay for first 3 visits and then 30% coinsurance Substance Abuse Facility Visit – Facility Charges 30% coinsurance and then $250 copay	Substance Abuse Office Visit Not covered Substance Abuse Facility Visit – Facility Charges Not covered	Substance Abuse Office Visit All office visit copayments count towards the same 3 visit limit. Substance Abuse Facility Visit – Facility Charges Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Substance use disorder inpatient services	30% coinsurance and then $1,250 copay	Not covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
If you are pregnant	Prenatal and postnatal care	30% coinsurance	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
	Delivery and all inpatient services	30% coinsurance and then $1,250 copay	Not covered	Applies to inpatient facility. Other cost shares may apply depending on services provided. Failure to obtain preauthorization may result in non- coverage or reduced coverage.

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% coinsurance	Not covered	Coverage is limited to 28 hours per week. Apply to In-Network Providers.
	Rehabilitation services	$30 copay for first 3 visits and then 30% coinsurance	Not covered	Coverage for speech therapy is limited to 20 visits per benefit period, occupational therapy is limited to 20 visits per benefit period, and physical therapy is limited to 20 visits per benefit period. In-Network. All office visit copayments count towards the same 3 visit limit.
	Habilitation services	$30 copay for first 3 visits and then 30% coinsurance	Not covered	Coverage for speech therapy is limited to 20 visits per benefit period, occupational therapy is limited to 20 visits per benefit period, and physical therapy is limited to 20 visits per benefit period. In-Network. All office visit copayments count towards the same 3 visit limit.
	Skilled nursing care	30% coinsurance and then $1,250 copay	Not covered	Coverage for skilled nursing services including day rehabilitation programs In-Network is limited to 100 days per benefit period. Failure to obtain preauthorization may result in non- coverage or reduced coverage.
	Durable medical equipment	30% coinsurance	Not covered	--------none--------
	Hospice service	0% coinsurance	Not covered	--------none--------
If your child needs dental or eye care	Eye exam	No charge	Not covered	Coverage is limited to 1 exam per benefit period. Apply to In-Network Providers.
	Glasses	Not covered	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
	Dental check-up	10% coinsurance	Not covered	Costs may vary by site of service. You should refer to your formal contract of coverage for details. This policy DOES NOT provide any dental benefits to individuals age nineteen (19) or older, except as specifically covered in your evidence of coverage. This policy is being offered so the purchaser will have pediatric dental coverage as required by the Affordable Care Act. If you want adult dental benefits, you will need to buy a different plan. This plan WILL NOT pay for any adult dental care, so you will have to pay the full price of any dental care you receive, unless you have another dental plan.

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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Hearing aids (Ages 18+)
- Infertility treatment
- Long-term care
- Non-Formulary drugs
- Routine eye care (adult)
- 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.)

- Acupuncture
- Spinal Manipulations
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide
- Private-duty nursing Coverage is limited to 28 hours per week.

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 1-855-453-7032. 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:

ATTN: Grievances and Appeals
700 Broadway
Mail Stop CO0104-0430
Denver, CO 80273

Department of Labors Employee
Benefits Security Administration
(866) 444-EBSA (3272)
www.dol.gov/ebsa/healthreform

Division of Insurance
ICARE Section
1560 Broadway
Suite 850
Denver, Colorado 80202
(303) 894-7490

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:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

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:** $7,540
- **Plan pays:** $3,790
- **Patient pays:** $3,750

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,000
Copays	$20
Coinsurance	$1,580
Limits or exclusions	$150
Total	**$3,750**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,450
- **Patient pays:** $2,950

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,000
Copays	$590
Coinsurance	$280
Limits or exclusions	$80
Total	**$2,950**

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.

RM Summit HMO HSA Bronze 6000/100

Coverage Period Begins on or After: January 1, 2015

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?	$6,000 person /$12,000 family (In-Network) Doesn't apply to preventive care.	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 person /$12,000 family (In-Network)	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**, visit 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**.

- **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 participating **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	No charge after Deductible	Not Covered	None
	Specialist visit	No charge after Deductible	Not Covered	None
	Other practitioner office visit	No charge after Deductible	Not Covered	None
	Preventive care screening/immunization/ Smoking Cessation	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	No charge after Deductible/Lab	Not Covered	None
		No charge after Deductible/X-Ray	Not Covered	None
	Imaging (CT/PET scans, MRIs)	No charge after Deductible	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	Tier 1 - No charge after Deductible	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, Mail Order, and Preferred Network Pharmacy limited up to a 90-day supply. Specialty Pharmacy limited up to a 31-day supply. Tier 5 limited to 31-day supply only. Copays shown are for retail, up to a 31-day supply. Mail order is 2.5 times the retail copay or coinsurance amount.
	Preferred brand drugs	Tier 2 - No charge after Deductible	Not Covered	
	Non-preferred brand drugs	Tier 3 - No charge after Deductible	Not Covered	
	Specialty drugs	Tier 4 - No charge after Deductible	Not Covered	
		Tier 5 - No charge after Deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after Deductible	Not Covered	None
	Physician/surgeon fees/Anesthesia	No charge after Deductible	Not Covered	None
If you need immediate medical attention	Emergency room services	No charge after Deductible	No charge after Deductible	None
	Emergency medical transportation	No charge after Deductible	No charge after Deductible	None
	Urgent care	No charge after Deductible	No charge after Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after Deductible	Not Covered	None
	Physician/surgeon fee/Anesthesia	No charge after Deductible	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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge after Deductible	Not Covered	None
	Mental/Behavioral health inpatient services	No charge after Deductible	Not Covered	None
	Substance use disorder outpatient services	No charge after Deductible	Not Covered	None
	Substance use disorder inpatient services	No charge after Deductible	Not Covered	None
If you are pregnant	Prenatal and postnatal care	No charge after Deductible	Not Covered	None
	Delivery and all inpatient services	No charge after Deductible	Not Covered	None
If you need help recovering or have other special health needs	Home health care	No charge after Deductible	Not Covered	None
	Rehabilitation services (Including Cardiac and Pulmonary Rehabilitation)	No charge after Deductible	Not Covered	Coverage is limited to 20 visits/ Member/therapy/year for rehabilitative and 20 visits/Member/therapy/year for habilitative services. (Cardiac and Pulmonary are not limited)
	Habilitation services (Including Cardiac and Pulmonary Habilitation)	No charge after Deductible	Not Covered	
	Skilled nursing care	No charge after Deductible	Not Covered	Coverage is limited to 100 days/Member/year.
	Durable medical equipment	No charge after Deductible	Not Covered	None
	Hospice service	No charge after Deductible	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 your child needs dental or eye care	Eye exam	No Charge	Not Covered	Coverage is limited to children up to age 19, limited to one/Member/year.
	Glasses	Not Covered	Not Covered	None
	Dental check-up	No Charge	Not Covered	Coverage is limited to children up to age 19.

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
- Breast reconstruction (unless medically necessary or as part of a mastectomy)
- Cosmetic Surgery
- Drugs not included in the formulary
- Infertility treatment
- Long-term care
- Neuromusculoskeletal Services (unless purchased)
- Non-emergency care when traveling outside the U.S.
- 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.)

- Hearing Aids (for children)

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** $1390
- **Patient pays** $6150

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	$6000
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$6150**

Managing Type 2 Diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5400
- **Plan pays** $50
- **Patient pays** $5350

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	$5270
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$5350**

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.

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.COhealthOp.org or by calling 1-866-915-6619.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Network** / **Enhanced*** / **Non-Network** **$2,050** individual / **$2,000** individual / **$4,100** individual **$4,100** family / **$4,000** family / **$8,200** family The **deductible** does not apply to preventive care. **Deductibles** are the same for Tier 1 and Tier 2 of the Standard and Enhanced Network benefit level. All **coinsurance** is subject to the annual **deductible** and accumulates towards meeting the **out-of-pocket limit**, unless stated otherwise. **Copayments** are not subject to the annual **deductible** but do accumulate towards meeting the **out-of-pocket limit**, unless stated otherwise. Non-covered services do not accumulate towards meeting the **out-of-pocket limit**. For covered members who qualify for the Enhanced Network benefit level, the **deductible** only has to be met for either the Enhanced or Standard Network benefit level—not both—and whichever one comes first.	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 below 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 below for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **Network** / **Enhanced*** / **Non-Network** **$6,600** individual / **$6,600** individual / **No Limit** individual **$13,200** family / **$13,200** family / **No Limit** family **Out-of-pocket limits** are the same for Tier 1 and Tier 2 of the Standard and Enhanced Network benefit level.	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.

Important Questions	Answers	Why this Matters:
	For covered members who qualify for the Enhanced Network benefit level, the **out-of-pocket limit** only has to be met for either the Enhanced or Standard Network benefit level—not both—and whichever one comes first.	
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, Non-Network **coinsurance** or **deductibles**, and excluded or health care services 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 below 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. See **www.COhealthOp.org or call 1-866-915-6619** for a list of participating providers.	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 below for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	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 the Excluded Services table below. See your policy or plan document for additional information about **excluded services**.

- **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 providing a lower maximum out-of-pocket amount by charging you lower **deductibles**, **copayments**, and/or **coinsurance** amounts.

∗ **Enhanced Benefits:** Enhanced benefits are incentives offered by your plan when required personal health actions are completed. Incentives are based on completion of the required personal health actions and not on the outcome of those actions.

Common Medical Event	Services You May Need	Your Cost If You Use a			Limitations & Exceptions
		Network Provider (Standard Benefits)	Network Provider (*Enhanced Benefits)	Non-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**Tier 1** First 2 visits free; subsequent visits are **$25** copayment/visit **Tier 2** **$40** copayment/visit	**Tier 1** **No Charge** **Tier 2** First 2 visits free; subsequent visits are **$20** copayment/visit	**50%** coinsurance	The first two primary care visits are free under the Enhanced benefit level only if the member has not already received the free visits under the Standard level.
	Specialist visit	**$60** copayment/visit Same copayment for Tier 1 and Tier 2 benefit levels.	**$60** copayment/visit Same copayment for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	---None---
	Other practitioner office visit	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	---None---

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Preventive care/screening/ immunization	**No Charge**	**No Charge**	**50%** coinsurance	---None---
If you have a test	Diagnostic test (x-ray, blood work)	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	---None---
	Imaging (CT/PET scans, MRIs)	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	---None---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.COhealthOp.org	Generic drugs	**Retail** **$15** copayment/ prescription **Mail Order** **$30** copayment/ prescription Same copayment for Tier 1 and Tier 2 benefit levels.	**No Charge**	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.COhealthOp.org	Preferred brand drugs	**Retail** **$40** copayment/ prescription **Mail Order** **$80** copayment/ prescription Same copayment for Tier 1 and Tier 2 benefit levels.	**Retail** **$40** copayment/ prescription **Mail Order** **$80** copayment/ prescription Same copayment for Tier 1 and Tier 2 benefit levels.	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Non-preferred brand drugs	**Retail** **40%** coinsurance not subject to deductible **Mail Order** **40%** coinsurance not subject to deductible Same coinsurance for Tier 1 and Tier 2 benefit levels.	**Retail** **40%** coinsurance not subject to deductible **Mail Order** **40%** coinsurance not subject to deductible Same coinsurance for Tier 1 and Tier 2 benefit levels.	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Specialty drugs	**Retail** **40%** coinsurance not subject to deductible **Mail Order** **40%** coinsurance not subject to deductible Same coinsurance for Tier 1 and Tier 2 benefit levels.	**Retail** **40%** coinsurance not subject to deductible **Mail Order** **40%** coinsurance not subject to deductible Same coinsurance for Tier 1 and Tier 2 benefit levels.	**Not Covered**	Covers up to a 30-day supply (retail prescription); 31 day supply (mail order prescription)

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.COhealthOp.org	Preventive drugs	**No Charge**	**No Charge**	**Same as Network**	Covers preventive drugs used in relation to the following five (5) conditions: asthma/COPD, blood pressure, cholesterol, diabetes, and prenatal care.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Physician/surgeon fees	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
If you need immediate medical attention	Emergency room services	**$500** copayment/visit Same copayment for Tier 1 and Tier 2 benefit levels.	**$500** copayment/visit Same copayment for Tier 1 and Tier 2 benefit levels.	**Same as Network**	---None---
	Emergency medical transportation	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	Transportation by other than a licensed ambulance.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Urgent care	**$150** copayment Same copayment for Tier 1 and Tier 2 benefit levels.	**$150** copayment Same copayment for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	Limited to services received at Urgent Care Centers. Services received from other provider types will be reimbursed according to the provider and service rendered.
If you have a hospital stay	Facility fee (e.g., hospital room)	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.
	Physician/surgeon fee	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**$60** copayment/visit Same copayment for Tier 1 and Tier 2 benefit levels.	**No Charge**	**50%** coinsurance	Early Intervention Services are limited to 45 visits per year. Autism-Applied Behavioral Analysis is limited to 550 sessions from birth to age 8 and 185 sessions age 9-19 (sessions being 25 minute increments) **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Mental/Behavioral health inpatient services	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.
	Substance use disorder outpatient services	**$60** copayment/visit Same copayment for Tier 1 and Tier 2 benefit levels.	**No Charge**	**50%** coinsurance	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Substance use disorder inpatient services	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	**Pre-certification required**. If the Pre-certification process is not followed per plan description, this could delay claim payment and/or possibly create a denial of services rendered.
If you are pregnant	Prenatal and postnatal care	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	---None---
	Delivery and all inpatient services	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
If you need help recovering or have other special health needs	Home health care	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	Limit 28 hours per week. **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Rehabilitation services	**Speech Therapy** **$60** copayment/visit **Occupational and Physical Therapy** **$60** copayment/visit Same copayment for Tier 1 and Tier 2 benefit levels.	**Speech Therapy** **$60** copayment/visit **Occupational and Physical Therapy** **$30** copayment/visit Same copayment for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	Combined Network/Non-Network limit of 20 therapy visits per year for **speech therapy**. Combined Network/Non-Network limit of 20 visits per therapy type for **physical therapy and occupational therapy**. Not limited for children up to age 5 with congenital defects. No therapy limitation for autism.
	Habilitation services	**Speech Therapy** **$60** copayment/visit **Occupational and Physical Therapy** **$60** copayment/visit Same copayment for Tier 1 and Tier 2 benefit levels.	**Speech Therapy** **$60** copayment/visit **Occupational and Physical Therapy** **$30** copayment/visit Same copayment for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	Combined Network/Non-Network limit of 20 therapy visits per year for **speech therapy**. Combined Network/Non-Network limit of 20 visits per therapy type for **physical therapy and occupational therapy**. Not limited for children up to age 5 with congenital defects. No therapy limitation for autism.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Skilled nursing care	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	Limited to 100 days per year. **Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
	Durable medical equipment	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	**Pre-authorization required** for items over $500; and the Colorado HealthOP will make a determination on whether the item(s) will be purchased or rented.
	Hospice service	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**40%** coinsurance Same coinsurance for Tier 1 and Tier 2 benefit levels.	**50%** coinsurance	**Pre-authorization required**. If the pre-authorization process is not followed, it could result in the delay or denial of claim payments.
If your child needs dental or eye care	Eye exam	**No Charge**	**No Charge**	**Not Covered**	Limited to 1 exam per year.
	Glasses	**Not Covered**	**Not Covered**	**Not Covered**	---None---

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Dental check-up	**No Charge**	**No Charge**	**Not Covered**	**Oral Exams**: Limit 2 visits per year. **Bitewings X-Ray**: Limit 1 set per year. **Full Mouth/Panoramic X-Ray**: Limit 1 every 60 months. **Intra-Oral X-Ray**: Limit 2 per year. **Cleaning**: Limit 2 per year. **Fluoride Applications**: Limit 2 per year. **Space Maintainer**: Limit 1 per lifetime. **Sealants**: Limit 1 per tooth per year. **Palliative Treatment**: Limit 1 per year. **Fillings**: (amalgam, resin and composite, or sedative): Limit 2 per year. **Crowns**: Limit 1 per year. **Pin Retention**: Limit 1 per year. **Surgical Extractions**: Limit 2 per year. **Periodontal Surgery**: Limit 1 per year. **Root Canal**: Limit 2 per year.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider (Standard Benefits)	Your Cost If You Use a Network Provider (*Enhanced Benefits)	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Dental check-up (continued)	**No Charge**	**No Charge**	**Not Covered**	**Orthodontia & Prosthodontic Treatment for Cleft Lip/Palate**: Limit 1 each.

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.)**

- Bariatric surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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.)**

- Acupuncture – If all Covered Persons complete their required health actions for the plan year. Coverage limits are combined with chiropractic and other similar services under the plan's Neuro/Musculo/Skeletal Manipulation and Acupuncture benefit provision.
- Spinal manipulation – If all Covered Persons complete their required health actions for the plan year. Coverage limits are combined with chiropractic and other similar services under the plan's Neuro/Musculo/Skeletal Manipulation and Acupuncture benefit provision.
- Cosmetic surgery – If it is to treat a medical condition or to improve or restore physiologic function.
- Hearing aids (minor) – If it is for eligible children under age 18 who have a hearing loss.
- Routine foot care – If it is related to diabetes and/or performed specifically for the purpose of treating pain related to functional limitations.

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact your Plan Administrator. You may also contact your state insurance department at 303-894-7499 or Toll Free 1-800-930-3745 or via FAX 303-894-7455 or e-mail at insurance@dora.state.co.us.

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: CO HealthOP Member Services at 1-866-915-6619, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa. You can also contact the State of Colorado Department of Regulatory Agencies Division of Insurance at 303-894-7490 or 1-800-930-3745.

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 1-866-915-6619.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-915-6619.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-866-915-6619.

Questions: Call 1-866-915-6619 or visit us at www.COhealthOp.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.COhealthOp.org or call 1-866-915-6619 to request a copy.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-915-6619.

Si desea más información en español sobre la cobertura y los precios, puede obtener los formas del plan o términos de la póliza, llamándonos al 1-866-915-6619.

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:** $7,540
- **Plan pays** $3,310
- **Patient pays** $4,230

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,050
Copays	$0
Coinsurance	$2,180
Limits or exclusions	$0
Total	**$4,230**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,970
- **Patient pays** $2,430

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,050
Copays	$360
Coinsurance	$20
Limits or exclusions	$0
Total	**$2,430**

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.

RM Summit HMO Bronze 4500/60 $55 Copay

Coverage Period Begins on or After: January 1, 2015

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?	$4,500 person /$9,000 family (In-Network) Doesn't apply to preventive care and other 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**. $6,350 person /$12,700 family (In-Network)	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**, visit 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**.

RM Summit HMO Bronze 4500/60 $55 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type:** HMO

- **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 participating **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	$55 Copay not subject to Deductible	Not Covered	None
	Specialist visit	40% Coinsurance after Deductible	Not Covered	None
	Other practitioner office visit	$55 Copay not subject to Deductible	Not Covered	None
	Preventive care screening/immunization/ Smoking Cessation	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	40% Coinsurance after Deductible/Lab	Not Covered	None
		40% Coinsurance after Deductible/X-Ray	Not Covered	None
	Imaging (CT/PET scans, MRIs)	40% Coinsurance after Deductible	Not Covered	None

RM Summit HMO Bronze 4500/60 $55 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type: HMO**

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	Tier 1 - $20 Copay after Deductible	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, Mail Order, and Preferred Network Pharmacy limited up to a 90-day supply. Specialty Pharmacy limited up to a 31-day supply. Tier 5 limited to 31-day supply only. Copays shown are for retail, up to a 31-day supply. Mail order is 2.5 times the retail copay or coinsurance amount.
	Preferred brand drugs	Tier 2 - 40% Coinsurance after Deductible	Not Covered	
	Non-preferred brand drugs	Tier 3 - 40% Coinsurance after Deductible	Not Covered	
	Specialty drugs	Tier 4 - 50% Coinsurance after Deductible	Not Covered	
		Tier 5 - 50% Coinsurance after Deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% Coinsurance after Deductible	Not Covered	None
	Physician/surgeon fees/Anesthesia	40% Coinsurance after Deductible	Not Covered	None
If you need immediate medical attention	Emergency room services	$350 Copay not subject to Deductible 40% Coinsurance after Deductible	$350 Copay not subject to Deductible 40% Coinsurance after Deductible	None
	Emergency medical transportation	40% Coinsurance after Deductible	40% Coinsurance after Deductible	None
	Urgent care	40% Coinsurance after Deductible	40% Coinsurance after Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40% Coinsurance after Deductible	Not Covered	None
	Physician/surgeon fee/Anesthesia	40% Coinsurance after Deductible	Not Covered	None

RM Summit HMO Bronze 4500/60 $55 Copay

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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$55 Copay not subject to Deductible	Not Covered	None
	Mental/Behavioral health inpatient services	40% Coinsurance after Deductible	Not Covered	None
	Substance use disorder outpatient services	$55 Copay not subject to Deductible	Not Covered	None
	Substance use disorder inpatient services	40% Coinsurance after Deductible	Not Covered	None
If you are pregnant	Prenatal and postnatal care	40% Coinsurance after Deductible	Not Covered	None
	Delivery and all inpatient services	40% Coinsurance after Deductible	Not Covered	None
If you need help recovering or have other special health needs	Home health care	40% Coinsurance after Deductible	Not Covered	None
	Rehabilitation services (Including Cardiac and Pulmonary Rehabilitation)	40% Coinsurance after Deductible	Not Covered	Coverage is limited to 20 visits/ Member/therapy/year for rehabilitative and 20 visits/Member/therapy/year for habilitative services. (Cardiac and Pulmonary are not limited)
	Habilitation services (Including Cardiac and Pulmonary Habilitation)	40% Coinsurance after Deductible	Not Covered	
	Skilled nursing care	40% Coinsurance after Deductible	Not Covered	Coverage is limited to 100 days/Member/year.
	Durable medical equipment	40% Coinsurance after Deductible	Not Covered	None
	Hospice service	40% Coinsurance after Deductible	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 your child needs dental or eye care	Eye exam	No Charge	Not Covered	Coverage is limited to children up to age 19, limited to one/Member/year.
	Glasses	Not Covered	Not Covered	None
	Dental check-up	No Charge	Not Covered	Coverage is limited to children up to age 19.

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
- Breast reconstruction (unless medically necessary or as part of a mastectomy)
- Cosmetic Surgery
- Drugs not included in the formulary
- Infertility treatment
- Long-term care
- Neuromusculoskeletal Services (unless purchased)
- Non-emergency care when traveling outside the U.S.
- 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.)

- Hearing Aids (for children)

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** $1770
- **Patient pays** $5770

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	$4500
Copays	$20
Coinsurance	$1100
Limits or exclusions	$150
Total	**$5770**

Managing Type 2 Diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5400
- **Plan pays** $50
- **Patient pays** $5350

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	$4100
Copays	$0
Coinsurance	$0
Limits or exclusions	$1250
Total	**$5350**

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.

RM Summit HMO HSA Bronze 5250/100

Coverage Period Begins on or After: January 1, 2015

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?	$5,250 person /$10,500 family (In-Network) Doesn't apply to preventive care.	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**. $5,250 person /$10,500 family (In-Network)	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**, visit 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**.

- **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 participating **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	No charge after Deductible	Not Covered	None
	Specialist visit	No charge after Deductible	Not Covered	None
	Other practitioner office visit	No charge after Deductible	Not Covered	None
	Preventive care screening/immunization/ Smoking Cessation	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	No charge after Deductible/Lab	Not Covered	None
		No charge after Deductible/X-Ray	Not Covered	None
	Imaging (CT/PET scans, MRIs)	No charge after Deductible	Not Covered	None

RM Summit HMO HSA Bronze 5250/100

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	Tier 1 - No charge after Deductible	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, Mail Order, and Preferred Network Pharmacy limited up to a 90-day supply. Specialty Pharmacy limited up to a 31-day supply. Tier 5 limited to 31-day supply only. Copays shown are for retail, up to a 31-day supply. Mail order is 2.5 times the retail copay or coinsurance amount.
	Preferred brand drugs	Tier 2 - No charge after Deductible	Not Covered	
	Non-preferred brand drugs	Tier 3 - No charge after Deductible	Not Covered	
	Specialty drugs	Tier 4 - No charge after Deductible	Not Covered	
		Tier 5 - No charge after Deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after Deductible	Not Covered	None
	Physician/surgeon fees/Anesthesia	No charge after Deductible	Not Covered	None
If you need immediate medical attention	Emergency room services	No charge after Deductible	No charge after Deductible	None
	Emergency medical transportation	No charge after Deductible	No charge after Deductible	None
	Urgent care	No charge after Deductible	No charge after Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after Deductible	Not Covered	None
	Physician/surgeon fee/Anesthesia	No charge after Deductible	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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge after Deductible	Not Covered	None
	Mental/Behavioral health inpatient services	No charge after Deductible	Not Covered	None
	Substance use disorder outpatient services	No charge after Deductible	Not Covered	None
	Substance use disorder inpatient services	No charge after Deductible	Not Covered	None
If you are pregnant	Prenatal and postnatal care	No charge after Deductible	Not Covered	None
	Delivery and all inpatient services	No charge after Deductible	Not Covered	None
If you need help recovering or have other special health needs	Home health care	No charge after Deductible	Not Covered	None
	Rehabilitation services (Including Cardiac and Pulmonary Rehabilitation)	No charge after Deductible	Not Covered	Coverage is limited to 20 visits/ Member/therapy/year for rehabilitative and 20 visits/Member/therapy/year for habilitative services. (Cardiac and Pulmonary are not limited)
	Habilitation services (Including Cardiac and Pulmonary Habilitation)	No charge after Deductible	Not Covered	
	Skilled nursing care	No charge after Deductible	Not Covered	Coverage is limited to 100 days/Member/year.
	Durable medical equipment	No charge after Deductible	Not Covered	None
	Hospice service	No charge after Deductible	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 your child needs dental or eye care	Eye exam	No Charge	Not Covered	Coverage is limited to children up to age 19, limited to one/Member/year.
	Glasses	Not Covered	Not Covered	None
	Dental check-up	No Charge	Not Covered	Coverage is limited to children up to age 19.

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
- Breast reconstruction (unless medically necessary or as part of a mastectomy)
- Cosmetic Surgery
- Drugs not included in the formulary
- Infertility treatment
- Long-term care
- Neuromusculoskeletal Services (unless purchased)
- Non-emergency care when traveling outside the U.S.
- 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.)**

- Hearing Aids (for children)

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** $2140
- **Patient pays** $5400

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	$5250
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$5400**

Managing Type 2 Diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5400
- **Plan pays** $70
- **Patient pays** $5330

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	$5250
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$5330**

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.

RM Summit HMO HSA Bronze 3250 $45 Copay

Coverage Period Begins on or After: January 1, 2015

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?	$3,250 person /$6,500 family (In-Network) Doesn't apply to preventive care.	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**. $6,350 person /$12,700 family (In-Network)	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**, visit 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**.

RM Summit HMO HSA Bronze 3250 $45 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type:** HMO

- **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 participating **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 after Deductible	Not Covered	None
	Specialist visit	$65 Copay after Deductible	Not Covered	None
	Other practitioner office visit	$45 Copay after Deductible	Not Covered	None
	Preventive care screening/immunization/ Smoking Cessation	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	30% Coinsurance after Deductible/Lab	Not Covered	None
		30% Coinsurance after Deductible/X-Ray	Not Covered	None
	Imaging (CT/PET scans, MRIs)	30% Coinsurance after Deductible	Not Covered	None

RM Summit HMO HSA Bronze 3250 $45 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type:** HMO

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	Tier 1 - $15 Copay after Deductible	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, Mail Order, and Preferred Network Pharmacy limited up to a 90-day supply. Specialty Pharmacy limited up to a 31-day supply. Tier 5 limited to 31-day supply only. Copays shown are for retail, up to a 31-day supply. Mail order is 2.5 times the retail copay or coinsurance amount.
	Preferred brand drugs	Tier 2 - $40 Copay after Deductible	Not Covered	
	Non-preferred brand drugs	Tier 3 -$55 Copay after Deductible	Not Covered	
	Specialty drugs	Tier 4 - 30% Coinsurance after Deductible	Not Covered	
		Tier 5 - 40% Coinsurance after Deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance after Deductible	Not Covered	None
	Physician/surgeon fees/Anesthesia	30% Coinsurance after Deductible	Not Covered	None
If you need immediate medical attention	Emergency room services	30% Coinsurance after Deductible	30% Coinsurance after Deductible	None
	Emergency medical transportation	30% Coinsurance after Deductible	30% Coinsurance after Deductible	None
	Urgent care	$65 Copay after Deductible	$65 Copay after Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance after Deductible	Not Covered	None
	Physician/surgeon fee/Anesthesia	30% Coinsurance after Deductible	Not Covered	None

RM Summit HMO HSA Bronze 3250 $45 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type: HMO**

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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$45 Copay after Deductible	Not Covered	None
	Mental/Behavioral health inpatient services	30% Coinsurance after Deductible	Not Covered	None
	Substance use disorder outpatient services	$45 Copay after Deductible	Not Covered	None
	Substance use disorder inpatient services	30% Coinsurance after Deductible	Not Covered	None
If you are pregnant	Prenatal and postnatal care	30% Coinsurance after Deductible	Not Covered	None
	Delivery and all inpatient services	30% Coinsurance after Deductible	Not Covered	None
If you need help recovering or have other special health needs	Home health care	30% Coinsurance after Deductible	Not Covered	None
	Rehabilitation services (Including Cardiac and Pulmonary Rehabilitation)	30% Coinsurance after Deductible	Not Covered	Coverage is limited to 20 visits/ Member/therapy/year for rehabilitative and 20 visits/Member/therapy/year for habilitative services. (Cardiac and Pulmonary are not limited)
	Habilitation services (Including Cardiac and Pulmonary Habilitation)	30% Coinsurance after Deductible	Not Covered	
	Skilled nursing care	30% Coinsurance after Deductible	Not Covered	Coverage is limited to 100 days/Member/year.
	Durable medical equipment	30% Coinsurance after Deductible	Not Covered	None
	Hospice service	30% Coinsurance after Deductible	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 your child needs dental or eye care	Eye exam	No Charge	Not Covered	Coverage is limited to children up to age 19, limited to one/Member/year.
	Glasses	Not Covered	Not Covered	None
	Dental check-up	No Charge	Not Covered	Coverage is limited to children up to age 19.

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
- Breast reconstruction (unless medically necessary or as part of a mastectomy)
- Cosmetic Surgery
- Drugs not included in the formulary
- Infertility treatment
- Long-term care
- Neuromusculoskeletal Services (unless purchased)
- Non-emergency care when traveling outside the U.S.
- 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.)

- Hearing Aids (for children)

Your Rights to Continue Coverage:

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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.

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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** $2920
- **Patient pays** $4620

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	$3250
Copays	$20
Coinsurance	$1200
Limits or exclusions	$150
Total	**$4620**

Managing Type 2 Diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5400
- **Plan pays** $670
- **Patient pays** $4730

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	$3250
Copays	$230
Coinsurance	$0
Limits or exclusions	$1250
Total	**$4730**

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.

NWF HMO Silver 2000/70 $45 Copay

Coverage Period Begins on or After: January 1, 2015

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 person /$4,000 family (In-Network) Doesn't apply to preventive care and other 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**. $6,350 person /$12,700 family (In-Network)	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**, visit 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**.

NWF HMO Silver 2000/70 $45 Copay

- **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 participating **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 not subject to Deductible	Not Covered	None
	Specialist visit	$65 Copay not subject to Deductible	Not Covered	None
	Other practitioner office visit	$45 Copay not subject to Deductible	Not Covered	None
	Preventive care screening/immunization/ Smoking Cessation	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	$40 Copay not subject to Deductible /Lab	Not Covered	None
		$55 Copay not subject to Deductible /X-Ray	Not Covered	None
	Imaging (CT/PET scans, MRIs)	30% Coinsurance after Deductible	Not Covered	None

NWF HMO Silver 2000/70 $45 Copay

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	Tier 1 - $15 Copay not subject to Deductible	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, Mail Order, and Preferred Network Pharmacy limited up to a 90-day supply. Specialty Pharmacy limited up to a 31-day supply. Tier 5 limited to 31-day supply only. Copays shown are for retail, up to a 31-day supply. Mail order is 2.5 times the retail copay or coinsurance amount.
	Preferred brand drugs	Tier 2 - $40 Copay not subject to Deductible	Not Covered	
	Non-preferred brand drugs	Tier 3 -$55 Copay not subject to Deductible	Not Covered	
	Specialty drugs	Tier 4 - 30% Coinsurance not subject to Deductible	Not Covered	
		Tier 5 - 40% Coinsurance not subject to Deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance after Deductible	Not Covered	None
	Physician/surgeon fees/Anesthesia	30% Coinsurance after Deductible	Not Covered	None
If you need immediate medical attention	Emergency room services	$250 Copay not subject to Deductible 30% Coinsurance after Deductible	$250 Copay not subject to Deductible 30% Coinsurance after Deductible	None
	Emergency medical transportation	30% Coinsurance after Deductible	30% Coinsurance after Deductible	None
	Urgent care	$65 Copay not subject to Deductible	$65 Copay not subject to Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance after Deductible	Not Covered	None
	Physician/surgeon fee/Anesthesia	30% Coinsurance after Deductible	Not Covered	None

NWF HMO Silver 2000/70 $45 Copay

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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$45 Copay not subject to Deductible	Not Covered	None
	Mental/Behavioral health inpatient services	30% Coinsurance after Deductible	Not Covered	None
	Substance use disorder outpatient services	$45 Copay not subject to Deductible	Not Covered	None
	Substance use disorder inpatient services	30% Coinsurance after Deductible	Not Covered	None
If you are pregnant	Prenatal and postnatal care	30% Coinsurance after Deductible	Not Covered	None
	Delivery and all inpatient services	30% Coinsurance after Deductible	Not Covered	None
If you need help recovering or have other special health needs	Home health care	30% Coinsurance after Deductible	Not Covered	None
	Rehabilitation services (Including Cardiac and Pulmonary Rehabilitation)	30% Coinsurance after Deductible	Not Covered	Coverage is limited to 20 visits/ Member/therapy/year for rehabilitative and 20 visits/Member/therapy/year for habilitative services. (Cardiac and Pulmonary are not limited)
	Habilitation services (Including Cardiac and Pulmonary Habilitation)	30% Coinsurance after Deductible	Not Covered	
	Skilled nursing care	30% Coinsurance after Deductible	Not Covered	Coverage is limited to 100 days/Member/year.
	Durable medical equipment	30% Coinsurance after Deductible	Not Covered	None
	Hospice service	30% Coinsurance after Deductible	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 your child needs dental or eye care	Eye exam	No Charge	Not Covered	Coverage is limited to children up to age 19, limited to one/Member/year.
	Glasses	Not Covered	Not Covered	None
	Dental check-up	No Charge	Not Covered	Coverage is limited to children up to age 19.

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
- Breast reconstruction (unless medically necessary or as part of a mastectomy)
- Cosmetic Surgery
- Drugs not included in the formulary
- Infertility treatment
- Long-term care
- Neuromusculoskeletal Services (unless purchased)
- Non-emergency care when traveling outside the U.S.
- 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.)

- Hearing Aids (for children)

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.

NWF HMO Silver 2000/70 $45 Copay

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** $3590
- **Patient pays** $3950

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	$400
Coinsurance	$1400
Limits or exclusions	$150
Total	**$3950**

Managing Type 2 Diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5400
- **Plan pays** $1550
- **Patient pays** $3850

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	$2000
Copays	$600
Coinsurance	$0
Limits or exclusions	$1250
Total	**$3850**

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.

RM Summit PPO Bronze 4500/60 $55 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type: PPO**

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?	$4,500 person /$9,000 family (In-Network) $9,000 person/$18,000 family (Out-of Network) Doesn't apply to preventive care and other 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**. $6,350 person /$12,700 family (In-Network) $12,700 person/$25,400 family (Out-ofNetwork)	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**, visit 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**.

RM Summit PPO Bronze 4500/60 $55 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type: PPO**

- **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 participating **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	$55 Copay not subject to Deductible	50% Coinsurance after Deductible	None
	Specialist visit	40% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Other practitioner office visit	$55 Copay not subject to Deductible	50% Coinsurance after Deductible	None
	Preventive care screening/immunization/ Smoking Cessation	No Charge	Varies	None
If you have a test	Diagnostic test (x-ray, blood work)	40% Coinsurance after Deductible/Lab	50% Coinsurance after Deductible	None
		40% Coinsurance after Deductible/X-Ray	50% Coinsurance after Deductible	None
	Imaging (CT/PET scans, MRIs)	40% Coinsurance after Deductible	50% Coinsurance after Deductible	None

RM Summit PPO Bronze 4500/60 $55 Copay

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	Tier 1 - $20 Copay after Deductible	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, Mail Order, and Preferred Network Pharmacy limited up to a 90-day supply. Specialty Pharmacy limited up to a 31-day supply. Tier 5 limited to 31-day supply only. Copays shown are for retail, up to a 31-day supply. Mail order is 2.5 times the retail copay or coinsurance amount.
	Preferred brand drugs	Tier 2 - 40% Coinsurance after Deductible	Not Covered	
	Non-preferred brand drugs	Tier 3 - 40% Coinsurance after Deductible	Not Covered	
	Specialty drugs	Tier 4 - 50% Coinsurance after Deductible	Not Covered	
		Tier 5 - 50% Coinsurance after Deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Physician/surgeon fees/Anesthesia	40% Coinsurance after Deductible	50% Coinsurance after Deductible	None
If you need immediate medical attention	Emergency room services	$350 Copay not subject to Deductible 40% Coinsurance after Deductible	$350 Copay not subject to Deductible 40% Coinsurance after Deductible	None
	Emergency medical transportation	40% Coinsurance after Deductible	40% Coinsurance after Deductible	None
	Urgent care	40% Coinsurance after Deductible	50% Coinsurance after Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Physician/surgeon fee/Anesthesia	40% Coinsurance after Deductible	50% Coinsurance after Deductible	None

RM Summit PPO Bronze 4500/60 $55 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type: PPO**

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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$55 Copay not subject to Deductible	50% Coinsurance after Deductible	None
	Mental/Behavioral health inpatient services	40% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Substance use disorder outpatient services	$55 Copay not subject to Deductible	50% Coinsurance after Deductible	None
	Substance use disorder inpatient services	40% Coinsurance after Deductible	50% Coinsurance after Deductible	None
If you are pregnant	Prenatal and postnatal care	40% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Delivery and all inpatient services	40% Coinsurance after Deductible	50% Coinsurance after Deductible	None
If you need help recovering or have other special health needs	Home health care	40% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Rehabilitation services (Including Cardiac and Pulmonary Rehabilitation)	40% Coinsurance after Deductible	50% Coinsurance after Deductible	Coverage is limited to 20 visits/ Member/therapy/year for rehabilitative and 20 visits/Member/therapy/year for habilitative services. (Cardiac and Pulmonary are not limited)
	Habilitation services (Including Cardiac and Pulmonary Habilitation)	40% Coinsurance after Deductible	50% Coinsurance after Deductible	
	Skilled nursing care	40% Coinsurance after Deductible	50% Coinsurance after Deductible	Coverage is limited to 100 days/Member/year.
	Durable medical equipment	40% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Hospice service	40% Coinsurance after Deductible	50% Coinsurance after Deductible	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 your child needs dental or eye care	Eye exam	No Charge	50% Coinsurance after Deductible	Coverage is limited to children up to age 19, limited to one/Member/year.
	Glasses	Not Covered	Not Covered	None
	Dental check-up	No Charge	Not Covered	Coverage is limited to children up to age 19.

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 (Adult)
- Drugs not included in the formulary
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Spinal manipulations (unless purchased)
- 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.)

- Hearing Aids (for children)
- Private-duty nursing

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.

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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** $1770
- **Patient pays** $5770

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	$4500
Copays	$20
Coinsurance	$1100
Limits or exclusions	$150
Total	**$5770**

Managing Type 2 Diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5400
- **Plan pays** $50
- **Patient pays** $5350

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	$4100
Copays	$0
Coinsurance	$0
Limits or exclusions	$1250
Total	**$5350**

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.

RM Summit PPO HSA Bronze 6000/100

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type: PPO**

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?	$6,000 person /$12,000 family (In-Network) $12,000 person/$24,000 family (Out-of Network) Doesn't apply to preventive care.	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 person /$12,000 family (In-Network) $15,000 person/$30,000 family (Out-ofNetwork)	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**, visit 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**.

- **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 participating **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	No charge after Deductible	50% Coinsurance after Deductible	None
	Specialist visit	No charge after Deductible	50% Coinsurance after Deductible	None
	Other practitioner office visit	No charge after Deductible	50% Coinsurance after Deductible	None
	Preventive care screening/immunization/ Smoking Cessation	No Charge	Varies	None
If you have a test	Diagnostic test (x-ray, blood work)	No charge after Deductible/Lab	50% Coinsurance after Deductible	None
		No charge after Deductible/X-Ray	50% Coinsurance after Deductible	None
	Imaging (CT/PET scans, MRIs)	No charge after Deductible	50% Coinsurance after Deductible	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	Tier 1 - No charge after Deductible	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, Mail Order, and Preferred Network Pharmacy limited up to a 90-day supply. Specialty Pharmacy limited up to a 31-day supply. Tier 5 limited to 31-day supply only. Copays shown are for retail, up to a 31-day supply. Mail order is 2.5 times the retail copay or coinsurance amount.
	Preferred brand drugs	Tier 2 - No charge after Deductible	Not Covered	
	Non-preferred brand drugs	Tier 3 - No charge after Deductible	Not Covered	
	Specialty drugs	Tier 4 - No charge after Deductible	Not Covered	
		Tier 5 - No charge after Deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after Deductible	50% Coinsurance after Deductible	None
	Physician/surgeon fees/Anesthesia	No charge after Deductible	50% Coinsurance after Deductible	None
If you need immediate medical attention	Emergency room services	No charge after Deductible	No charge after Deductible	None
	Emergency medical transportation	No charge after Deductible	No charge after Deductible	None
	Urgent care	No charge after Deductible	50% Coinsurance after Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after Deductible	50% Coinsurance after Deductible	None
	Physician/surgeon fee/Anesthesia	No charge after Deductible	50% Coinsurance after Deductible	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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge after Deductible	50% Coinsurance after Deductible	None
	Mental/Behavioral health inpatient services	No charge after Deductible	50% Coinsurance after Deductible	None
	Substance use disorder outpatient services	No charge after Deductible	50% Coinsurance after Deductible	None
	Substance use disorder inpatient services	No charge after Deductible	50% Coinsurance after Deductible	None
If you are pregnant	Prenatal and postnatal care	No charge after Deductible	50% Coinsurance after Deductible	None
	Delivery and all inpatient services	No charge after Deductible	50% Coinsurance after Deductible	None
If you need help recovering or have other special health needs	Home health care	No charge after Deductible	50% Coinsurance after Deductible	None
	Rehabilitation services (Including Cardiac and Pulmonary Rehabilitation)	No charge after Deductible	50% Coinsurance after Deductible	Coverage is limited to 20 visits/ Member/therapy/year for rehabilitative and 20 visits/Member/therapy/year for habilitative services. (Cardiac and Pulmonary are not limited)
	Habilitation services (Including Cardiac and Pulmonary Habilitation)	No charge after Deductible	50% Coinsurance after Deductible	
	Skilled nursing care	No charge after Deductible	50% Coinsurance after Deductible	Coverage is limited to 100 days/Member/year.
	Durable medical equipment	No charge after Deductible	50% Coinsurance after Deductible	None
	Hospice service	No charge after Deductible	50% Coinsurance after Deductible	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 your child needs dental or eye care	Eye exam	No Charge	50% Coinsurance after Deductible	Coverage is limited to children up to age 19, limited to one/Member/year.
	Glasses	Not Covered	Not Covered	None
	Dental check-up	No charge after Deductible	Not Covered	Coverage is limited to children up to age 19.

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 (Adult)
- Drugs not included in the formulary
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Spinal manipulations (unless purchased)
- 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.)

- Hearing Aids (for children)
- Private-duty nursing

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** $1390
- **Patient pays** $6150

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	$6000
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$6150**

Managing Type 2 Diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5400
- **Plan pays** $50
- **Patient pays** $5350

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	$5270
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$5350**

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.

NWF HMO Silver 1500/70 $35 Copay

Coverage Period Begins on or After: January 1, 2015

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?	$1,500 person /$3,000 family (In-Network) Doesn't apply to preventive care and other 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**. $6,350 person /$12,700 family (In-Network)	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**, visit 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**.

NWF HMO Silver 1500/70 $35 Copay

- **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 participating **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	$35 Copay not subject to Deductible	Not Covered	None
	Specialist visit	$50 Copay not subject to Deductible	Not Covered	None
	Other practitioner office visit	$35 Copay not subject to Deductible	Not Covered	None
	Preventive care screening/immunization/ Smoking Cessation	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	$30 Copay not subject to Deductible /Lab	Not Covered	None
		$50 Copay not subject to Deductible /X-Ray	Not Covered	None
	Imaging (CT/PET scans, MRIs)	30% Coinsurance after Deductible	Not Covered	None

NWF HMO Silver 1500/70 $35 Copay

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	Tier 1 - $15 Copay not subject to Deductible	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, Mail Order, and Preferred Network Pharmacy limited up to a 90-day supply. Specialty Pharmacy limited up to a 31-day supply. Tier 5 limited to 31-day supply only. Copays shown are for retail, up to a 31-day supply. Mail order is 2.5 times the retail copay or coinsurance amount.
	Preferred brand drugs	Tier 2 - $40 Copay not subject to Deductible	Not Covered	
	Non-preferred brand drugs	Tier 3 -$55 Copay not subject to Deductible	Not Covered	
	Specialty drugs	Tier 4 - 30% Coinsurance not subject to Deductible	Not Covered	
		Tier 5 - 40% Coinsurance not subject to Deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance after Deductible	Not Covered	None
	Physician/surgeon fees/Anesthesia	30% Coinsurance after Deductible	Not Covered	None
If you need immediate medical attention	Emergency room services	$250 Copay not subject to Deductible 30% Coinsurance after Deductible	$250 Copay not subject to Deductible 30% Coinsurance after Deductible	None
	Emergency medical transportation	30% Coinsurance after Deductible	30% Coinsurance after Deductible	None
	Urgent care	$50 Copay not subject to Deductible	$50 Copay not subject to Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance after Deductible	Not Covered	None
	Physician/surgeon fee/Anesthesia	30% Coinsurance after Deductible	Not Covered	None

NWF HMO Silver 1500/70 $35 Copay

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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 Copay not subject to Deductible	Not Covered	None
	Mental/Behavioral health inpatient services	30% Coinsurance after Deductible	Not Covered	None
	Substance use disorder outpatient services	$35 Copay not subject to Deductible	Not Covered	None
	Substance use disorder inpatient services	30% Coinsurance after Deductible	Not Covered	None
If you are pregnant	Prenatal and postnatal care	30% Coinsurance after Deductible	Not Covered	None
	Delivery and all inpatient services	30% Coinsurance after Deductible	Not Covered	None
If you need help recovering or have other special health needs	Home health care	30% Coinsurance after Deductible	Not Covered	None
	Rehabilitation services (Including Cardiac and Pulmonary Rehabilitation)	30% Coinsurance after Deductible	Not Covered	Coverage is limited to 20 visits/ Member/therapy/year for rehabilitative and 20 visits/Member/therapy/year for habilitative services. (Cardiac and Pulmonary are not limited)
	Habilitation services (Including Cardiac and Pulmonary Habilitation)	30% Coinsurance after Deductible	Not Covered	
	Skilled nursing care	30% Coinsurance after Deductible	Not Covered	Coverage is limited to 100 days/Member/year.
	Durable medical equipment	30% Coinsurance after Deductible	Not Covered	None
	Hospice service	30% Coinsurance after Deductible	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 your child needs dental or eye care	Eye exam	No Charge	Not Covered	Coverage is limited to children up to age 19, limited to one/Member/year.
	Glasses	Not Covered	Not Covered	None
	Dental check-up	No Charge	Not Covered	Coverage is limited to children up to age 19.

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
- Breast reconstruction (unless medically necessary or as part of a mastectomy)
- Cosmetic Surgery
- Drugs not included in the formulary
- Infertility treatment
- Long-term care
- Neuromusculoskeletal Services (unless purchased)
- Non-emergency care when traveling outside the U.S.
- 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.)

- Hearing Aids (for children)

Your Rights to Continue Coverage:

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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.

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Does this Coverage Provide Minimum Essential Coverage?

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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** $3980
- **Patient pays** $3560

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	$1500
Copays	$360
Coinsurance	$1550
Limits or exclusions	$150
Total	**$3560**

Managing Type 2 Diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5400
- **Plan pays** $1970
- **Patient pays** $3430

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	$1500
Copays	$680
Coinsurance	$0
Limits or exclusions	$1250
Total	**$3430**

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.

RM Summit PPO HSA Bronze 5250/100

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type: PPO**

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?	$5,250 person /$10,500 family (In-Network) $10,500 person/$21,000 family (Out-of Network) Doesn't apply to preventive care.	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**. $5,250 person /$10,500 family (In-Network) $15,000 person/$30,000 family (Out-ofNetwork)	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**, visit 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**.

- **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 participating **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	No charge after Deductible	50% Coinsurance after Deductible	None
	Specialist visit	No charge after Deductible	50% Coinsurance after Deductible	None
	Other practitioner office visit	No charge after Deductible	50% Coinsurance after Deductible	None
	Preventive care screening/immunization/ Smoking Cessation	No Charge	Varies	None
If you have a test	Diagnostic test (x-ray, blood work)	No charge after Deductible/Lab	50% Coinsurance after Deductible	None
		No charge after Deductible/X-Ray	50% Coinsurance after Deductible	None
	Imaging (CT/PET scans, MRIs)	No charge after Deductible	50% Coinsurance after Deductible	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	Tier 1 - No charge after Deductible	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, Mail Order, and Preferred Network Pharmacy limited up to a 90-day supply. Specialty Pharmacy limited up to a 31-day supply. Tier 5 limited to 31-day supply only. Copays shown are for retail, up to a 31-day supply. Mail order is 2.5 times the retail copay or coinsurance amount.
	Preferred brand drugs	Tier 2 - No charge after Deductible	Not Covered	
	Non-preferred brand drugs	Tier 3 - No charge after Deductible	Not Covered	
	Specialty drugs	Tier 4 - No charge after Deductible	Not Covered	
		Tier 5 - No charge after Deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after Deductible	50% Coinsurance after Deductible	None
	Physician/surgeon fees/Anesthesia	No charge after Deductible	50% Coinsurance after Deductible	None
If you need immediate medical attention	Emergency room services	No charge after Deductible	No charge after Deductible	None
	Emergency medical transportation	No charge after Deductible	No charge after Deductible	None
	Urgent care	No charge after Deductible	50% Coinsurance after Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after Deductible	50% Coinsurance after Deductible	None
	Physician/surgeon fee/Anesthesia	No charge after Deductible	50% Coinsurance after Deductible	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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge after Deductible	50% Coinsurance after Deductible	None
	Mental/Behavioral health inpatient services	No charge after Deductible	50% Coinsurance after Deductible	None
	Substance use disorder outpatient services	No charge after Deductible	50% Coinsurance after Deductible	None
	Substance use disorder inpatient services	No charge after Deductible	50% Coinsurance after Deductible	None
If you are pregnant	Prenatal and postnatal care	No charge after Deductible	50% Coinsurance after Deductible	None
	Delivery and all inpatient services	No charge after Deductible	50% Coinsurance after Deductible	None
If you need help recovering or have other special health needs	Home health care	No charge after Deductible	50% Coinsurance after Deductible	None
	Rehabilitation services (Including Cardiac and Pulmonary Rehabilitation)	No charge after Deductible	50% Coinsurance after Deductible	Coverage is limited to 20 visits/ Member/therapy/year for rehabilitative and 20 visits/Member/therapy/year for habilitative services. (Cardiac and Pulmonary are not limited)
	Habilitation services (Including Cardiac and Pulmonary Habilitation)	No charge after Deductible	50% Coinsurance after Deductible	
	Skilled nursing care	No charge after Deductible	50% Coinsurance after Deductible	Coverage is limited to 100 days/Member/year.
	Durable medical equipment	No charge after Deductible	50% Coinsurance after Deductible	None
	Hospice service	No charge after Deductible	50% Coinsurance after Deductible	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 your child needs dental or eye care	Eye exam	No Charge	50% Coinsurance after Deductible	Coverage is limited to children up to age 19, limited to one/Member/year.
	Glasses	Not Covered	Not Covered	None
	Dental check-up	No charge after Deductible	Not Covered	Coverage is limited to children up to age 19.

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 (Adult)
- Drugs not included in the formulary
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Spinal manipulations (unless purchased)
- 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.)

- Hearing Aids (for children)
- Private-duty nursing

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** $2140
- **Patient pays** $5400

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	$5250
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$5400**

Managing Type 2 Diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5400
- **Plan pays** $70
- **Patient pays** $5330

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	$5250
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$5330**

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.

RM Summit PPO HSA Bronze 3250 $45 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type: PPO**

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?	$3,250 person /$6,500 family (In-Network) $6,500 person/$13,000 family (Out-of Network) Doesn't apply to preventive care.	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**. $6,350 person /$12,700 family (In-Network) $12,700 person/$25,400 family (Out-ofNetwork)	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**, visit 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**.

RM Summit PPO HSA Bronze 3250 $45 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type: PPO**

- **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 participating **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 after Deductible	50% Coinsurance after Deductible	None
	Specialist visit	$65 Copay after Deductible	50% Coinsurance after Deductible	None
	Other practitioner office visit	$45 Copay after Deductible	50% Coinsurance after Deductible	None
	Preventive care screening/immunization/ Smoking Cessation	No Charge	Varies	None
If you have a test	Diagnostic test (x-ray, blood work)	30% Coinsurance after Deductible/Lab	50% Coinsurance after Deductible	None
		30% Coinsurance after Deductible/X-Ray	50% Coinsurance after Deductible	None
	Imaging (CT/PET scans, MRIs)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None

RM Summit PPO HSA Bronze 3250 $45 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type: PPO**

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	Tier 1 - $15 Copay after Deductible	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, Mail Order, and Preferred Network Pharmacy limited up to a 90-day supply. Specialty Pharmacy limited up to a 31-day supply. Tier 5 limited to 31-day supply only. Copays shown are for retail, up to a 31-day supply. Mail order is 2.5 times the retail copay or coinsurance amount.
	Preferred brand drugs	Tier 2 - $40 Copay after Deductible	Not Covered	
	Non-preferred brand drugs	Tier 3 -$55 Copay after Deductible	Not Covered	
	Specialty drugs	Tier 4 - 30% Coinsurance after Deductible	Not Covered	
		Tier 5 - 40% Coinsurance after Deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Physician/surgeon fees/Anesthesia	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
If you need immediate medical attention	Emergency room services	30% Coinsurance after Deductible	30% Coinsurance after Deductible	None
	Emergency medical transportation	30% Coinsurance after Deductible	30% Coinsurance after Deductible	None
	Urgent care	$65 Copay after Deductible	50% Coinsurance after Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Physician/surgeon fee/Anesthesia	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None

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Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type: PPO**

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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$45 Copay after Deductible	50% Coinsurance after Deductible	None
	Mental/Behavioral health inpatient services	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Substance use disorder outpatient services	$45 Copay after Deductible	50% Coinsurance after Deductible	None
	Substance use disorder inpatient services	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
If you are pregnant	Prenatal and postnatal care	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Delivery and all inpatient services	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
If you need help recovering or have other special health needs	Home health care	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Rehabilitation services (Including Cardiac and Pulmonary Rehabilitation)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	Coverage is limited to 20 visits/ Member/therapy/year for rehabilitative and 20 visits/Member/therapy/year for habilitative services. (Cardiac and Pulmonary are not limited)
	Habilitation services (Including Cardiac and Pulmonary Habilitation)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	
	Skilled nursing care	30% Coinsurance after Deductible	50% Coinsurance after Deductible	Coverage is limited to 100 days/Member/year.
	Durable medical equipment	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Hospice service	30% Coinsurance after Deductible	50% Coinsurance after Deductible	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 your child needs dental or eye care	Eye exam	No Charge	50% Coinsurance after Deductible	Coverage is limited to children up to age 19, limited to one/Member/year.
	Glasses	Not Covered	Not Covered	None
	Dental check-up	No charge after Deductible	Not Covered	Coverage is limited to children up to age 19.

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 (Adult)
- Drugs not included in the formulary
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Spinal manipulations (unless purchased)
- Weight loss programs

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- Hearing Aids (for children)
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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.

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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** $2920
- **Patient pays** $4620

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	$3250
Copays	$20
Coinsurance	$1200
Limits or exclusions	$150
Total	**$4620**

Managing Type 2 Diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5400
- **Plan pays** $670
- **Patient pays** $4730

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	$3250
Copays	$230
Coinsurance	$0
Limits or exclusions	$1250
Total	**$4730**

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.

RM Summit HMO Silver 3000/80 $40 Copay

Coverage Period Begins on or After: January 1, 2015

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?	$3,000 person /$6,000 family (In-Network) Doesn't apply to preventive care and other 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**. $6,600 person /$13,200 family (In-Network)	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**, visit 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**.

RM Summit HMO Silver 3000/80 $40 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type:** HMO

- **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 participating **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	$40 Copay not subject to Deductible	Not Covered	None
	Specialist visit	$55 Copay not subject to Deductible	Not Covered	None
	Other practitioner office visit	$40 Copay not subject to Deductible	Not Covered	None
	Preventive care screening/immunization/ Smoking Cessation	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	$35 Copay not subject to Deductible /Lab	Not Covered	None
		$50 Copay not subject to Deductible /X-Ray	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance after Deductible	Not Covered	None

RM Summit HMO Silver 3000/80 $40 Copay

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	Tier 1 - $15 Copay not subject to Deductible	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, Mail Order, and Preferred Network Pharmacy limited up to a 90-day supply. Specialty Pharmacy limited up to a 31-day supply. Tier 5 limited to 31-day supply only. Copays shown are for retail, up to a 31-day supply. Mail order is 2.5 times the retail copay or coinsurance amount.
	Preferred brand drugs	Tier 2 - $40 Copay not subject to Deductible	Not Covered	
	Non-preferred brand drugs	Tier 3 -$70 Copay not subject to Deductible	Not Covered	
	Specialty drugs	Tier 4 - 30% Coinsurance not subject to Deductible	Not Covered	
		Tier 5 - 40% Coinsurance not subject to Deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance after Deductible	Not Covered	None
	Physician/surgeon fees/Anesthesia	20% Coinsurance after Deductible	Not Covered	None
If you need immediate medical attention	Emergency room services	$200 Copay not subject to Deductible 20% Coinsurance after Deductible	$200 Copay not subject to Deductible 20% Coinsurance after Deductible	None
	Emergency medical transportation	20% Coinsurance after Deductible	20% Coinsurance after Deductible	None
	Urgent care	$55 Copay not subject to Deductible	$55 Copay not subject to Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance after Deductible	Not Covered	None
	Physician/surgeon fee/Anesthesia	20% Coinsurance after Deductible	Not Covered	None

RM Summit HMO Silver 3000/80 $40 Copay

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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 Copay not subject to Deductible	Not Covered	None
	Mental/Behavioral health inpatient services	20% Coinsurance after Deductible	Not Covered	None
	Substance use disorder outpatient services	$40 Copay not subject to Deductible	Not Covered	None
	Substance use disorder inpatient services	20% Coinsurance after Deductible	Not Covered	None
If you are pregnant	Prenatal and postnatal care	20% Coinsurance after Deductible	Not Covered	None
	Delivery and all inpatient services	20% Coinsurance after Deductible	Not Covered	None
If you need help recovering or have other special health needs	Home health care	20% Coinsurance after Deductible	Not Covered	None
	Rehabilitation services (Including Cardiac and Pulmonary Rehabilitation)	$40 Copay not subject to Deductible	Not Covered	Coverage is limited to 20 visits/ Member/therapy/year for rehabilitative and 20 visits/Member/therapy/year for habilitative services. (Cardiac and Pulmonary are not limited)
	Habilitation services (Including Cardiac and Pulmonary Habilitation)	$40 Copay not subject to Deductible	Not Covered	
	Skilled nursing care	20% Coinsurance after Deductible	Not Covered	Coverage is limited to 100 days/Member/year.
	Durable medical equipment	20% Coinsurance after Deductible	Not Covered	None
	Hospice service	20% Coinsurance after Deductible	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 your child needs dental or eye care	Eye exam	No Charge	Not Covered	Coverage is limited to children up to age 19, limited to one/Member/year.
	Glasses	Not Covered	Not Covered	None
	Dental check-up	No Charge	Not Covered	Coverage is limited to children up to age 19.

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
- Breast reconstruction (unless medically necessary or as part of a mastectomy)
- Cosmetic Surgery
- Drugs not included in the formulary
- Infertility treatment
- Long-term care
- Neuromusculoskeletal Services (unless purchased)
- Non-emergency care when traveling outside the U.S.
- 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.)

- Hearing Aids (for children)

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** $3520
- **Patient pays** $4020

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	$3000
Copays	$20
Coinsurance	$850
Limits or exclusions	$150
Total	**$4020**

Managing Type 2 Diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5400
- **Plan pays** $1760
- **Patient pays** $3640

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	$3000
Copays	$440
Coinsurance	$120
Limits or exclusions	$80
Total	**$3640**

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.

RM Summit HMO Silver 2000/70 $45 Copay

Coverage Period Begins on or After: January 1, 2015

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 person /$4,000 family (In-Network) Doesn't apply to preventive care and other 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**. $6,350 person /$12,700 family (In-Network)	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**, visit 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**.

RM Summit HMO Silver 2000/70 $45 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type:** HMO

- **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 participating **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 not subject to Deductible	Not Covered	None
	Specialist visit	$65 Copay not subject to Deductible	Not Covered	None
	Other practitioner office visit	$45 Copay not subject to Deductible	Not Covered	None
	Preventive care screening/immunization/ Smoking Cessation	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	$40 Copay not subject to Deductible /Lab	Not Covered	None
		$55 Copay not subject to Deductible /X-Ray	Not Covered	None
	Imaging (CT/PET scans, MRIs)	30% Coinsurance after Deductible	Not Covered	None

RM Summit HMO Silver 2000/70 $45 Copay

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	Tier 1 - $15 Copay not subject to Deductible	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, Mail Order, and Preferred Network Pharmacy limited up to a 90-day supply. Specialty Pharmacy limited up to a 31-day supply. Tier 5 limited to 31-day supply only. Copays shown are for retail, up to a 31-day supply. Mail order is 2.5 times the retail copay or coinsurance amount.
	Preferred brand drugs	Tier 2 - $40 Copay not subject to Deductible	Not Covered	
	Non-preferred brand drugs	Tier 3 -$55 Copay not subject to Deductible	Not Covered	
	Specialty drugs	Tier 4 - 30% Coinsurance not subject to Deductible	Not Covered	
		Tier 5 - 40% Coinsurance not subject to Deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance after Deductible	Not Covered	None
	Physician/surgeon fees/Anesthesia	30% Coinsurance after Deductible	Not Covered	None
If you need immediate medical attention	Emergency room services	$250 Copay not subject to Deductible 30% Coinsurance after Deductible	$250 Copay not subject to Deductible 30% Coinsurance after Deductible	None
	Emergency medical transportation	30% Coinsurance after Deductible	30% Coinsurance after Deductible	None
	Urgent care	$65 Copay not subject to Deductible	$65 Copay not subject to Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance after Deductible	Not Covered	None
	Physician/surgeon fee/Anesthesia	30% Coinsurance after Deductible	Not Covered	None

RM Summit HMO Silver 2000/70 $45 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type: HMO**

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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$45 Copay not subject to Deductible	Not Covered	None
	Mental/Behavioral health inpatient services	30% Coinsurance after Deductible	Not Covered	None
	Substance use disorder outpatient services	$45 Copay not subject to Deductible	Not Covered	None
	Substance use disorder inpatient services	30% Coinsurance after Deductible	Not Covered	None
If you are pregnant	Prenatal and postnatal care	30% Coinsurance after Deductible	Not Covered	None
	Delivery and all inpatient services	30% Coinsurance after Deductible	Not Covered	None
If you need help recovering or have other special health needs	Home health care	30% Coinsurance after Deductible	Not Covered	None
	Rehabilitation services (Including Cardiac and Pulmonary Rehabilitation)	30% Coinsurance after Deductible	Not Covered	Coverage is limited to 20 visits/ Member/therapy/year for rehabilitative and 20 visits/Member/therapy/year for habilitative services. (Cardiac and Pulmonary are not limited)
	Habilitation services (Including Cardiac and Pulmonary Habilitation)	30% Coinsurance after Deductible	Not Covered	
	Skilled nursing care	30% Coinsurance after Deductible	Not Covered	Coverage is limited to 100 days/Member/year.
	Durable medical equipment	30% Coinsurance after Deductible	Not Covered	None
	Hospice service	30% Coinsurance after Deductible	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 your child needs dental or eye care	Eye exam	No Charge	Not Covered	Coverage is limited to children up to age 19, limited to one/Member/year.
	Glasses	Not Covered	Not Covered	None
	Dental check-up	No Charge	Not Covered	Coverage is limited to children up to age 19.

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
- Breast reconstruction (unless medically necessary or as part of a mastectomy)
- Cosmetic Surgery
- Drugs not included in the formulary
- Infertility treatment
- Long-term care
- Neuromusculoskeletal Services (unless purchased)
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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.

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Does this Coverage Provide Minimum Essential Coverage?

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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** $3590
- **Patient pays** $3950

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	$400
Coinsurance	$1400
Limits or exclusions	$150
Total	**$3950**

Managing Type 2 Diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5400
- **Plan pays** $1550
- **Patient pays** $3850

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	$2000
Copays	$600
Coinsurance	$0
Limits or exclusions	$1250
Total	**$3850**

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.

RM Summit HMO Silver 2000/70 $40 Copay

Coverage Period Begins on or After: January 1, 2015

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 person /$4,000 family (In-Network) Doesn't apply to preventive care and other 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 person /$12,000 family (In-Network)	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**, visit 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**.

RM Summit HMO Silver 2000/70 $40 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type:** HMO

- **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 participating **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	$40 Copay not subject to Deductible	Not Covered	None
	Specialist visit	$60 Copay not subject to Deductible	Not Covered	None
	Other practitioner office visit	$40 Copay not subject to Deductible	Not Covered	None
	Preventive care screening/immunization/ Smoking Cessation	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	$40 Copay not subject to Deductible /Lab	Not Covered	None
		$55 Copay not subject to Deductible /X-Ray	Not Covered	None
	Imaging (CT/PET scans, MRIs)	30% Coinsurance after Deductible	Not Covered	None

RM Summit HMO Silver 2000/70 $40 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type:** HMO

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	Tier 1 - $15 Copay not subject to Deductible	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, Mail Order, and Preferred Network Pharmacy limited up to a 90-day supply. Specialty Pharmacy limited up to a 31-day supply. Tier 5 limited to 31-day supply only. Copays shown are for retail, up to a 31-day supply. Mail order is 2.5 times the retail copay or coinsurance amount.
	Preferred brand drugs	Tier 2 - $40 Copay not subject to Deductible	Not Covered	
	Non-preferred brand drugs	Tier 3 -$55 Copay not subject to Deductible	Not Covered	
	Specialty drugs	Tier 4 - 30% Coinsurance not subject to Deductible	Not Covered	
		Tier 5 - 40% Coinsurance not subject to Deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance after Deductible	Not Covered	None
	Physician/surgeon fees/Anesthesia	30% Coinsurance after Deductible	Not Covered	None
If you need immediate medical attention	Emergency room services	$250 Copay not subject to Deductible 30% Coinsurance after Deductible	$250 Copay not subject to Deductible 30% Coinsurance after Deductible	None
	Emergency medical transportation	30% Coinsurance after Deductible	30% Coinsurance after Deductible	None
	Urgent care	$60 Copay not subject to Deductible	$60 Copay not subject to Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance after Deductible	Not Covered	None
	Physician/surgeon fee/Anesthesia	30% Coinsurance after Deductible	Not Covered	None

RM Summit HMO Silver 2000/70 $40 Copay

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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 Copay not subject to Deductible	Not Covered	None
	Mental/Behavioral health inpatient services	30% Coinsurance after Deductible	Not Covered	None
	Substance use disorder outpatient services	$40 Copay not subject to Deductible	Not Covered	None
	Substance use disorder inpatient services	30% Coinsurance after Deductible	Not Covered	None
If you are pregnant	Prenatal and postnatal care	30% Coinsurance after Deductible	Not Covered	None
	Delivery and all inpatient services	30% Coinsurance after Deductible	Not Covered	None
If you need help recovering or have other special health needs	Home health care	30% Coinsurance after Deductible	Not Covered	None
	Rehabilitation services (Including Cardiac and Pulmonary Rehabilitation)	30% Coinsurance after Deductible	Not Covered	Coverage is limited to 20 visits/ Member/therapy/year for rehabilitative and 20 visits/Member/therapy/year for habilitative services. (Cardiac and Pulmonary are not limited)
	Habilitation services (Including Cardiac and Pulmonary Habilitation)	30% Coinsurance after Deductible	Not Covered	
	Skilled nursing care	30% Coinsurance after Deductible	Not Covered	Coverage is limited to 100 days/Member/year.
	Durable medical equipment	30% Coinsurance after Deductible	Not Covered	None
	Hospice service	30% Coinsurance after Deductible	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 your child needs dental or eye care	Eye exam	No Charge	Not Covered	Coverage is limited to children up to age 19, limited to one/Member/year.
	Glasses	Not Covered	Not Covered	None
	Dental check-up	No Charge	Not Covered	Coverage is limited to children up to age 19.

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
- Breast reconstruction (unless medically necessary or as part of a mastectomy)
- Cosmetic Surgery
- Drugs not included in the formulary
- Infertility treatment
- Long-term care
- Neuromusculoskeletal Services (unless purchased)
- Non-emergency care when traveling outside the U.S.
- 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.)

- Hearing Aids (for children)

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** $3590
- **Patient pays** $3950

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	$400
Coinsurance	$1400
Limits or exclusions	$150
Total	**$3950**

Managing Type 2 Diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5400
- **Plan pays** $1570
- **Patient pays** $3830

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	$2000
Copays	$580
Coinsurance	$0
Limits or exclusions	$1250
Total	**$3830**

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.

RM Summit HMO Silver 1500/70 $35 Copay

Coverage Period Begins on or After: January 1, 2015

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?	$1,500 person /$3,000 family (In-Network) Doesn't apply to preventive care and other 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**. $6,350 person /$12,700 family (In-Network)	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**, visit 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**.

RM Summit HMO Silver 1500/70 $35 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type:** HMO

- **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 participating **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	$35 Copay not subject to Deductible	Not Covered	None
	Specialist visit	$50 Copay not subject to Deductible	Not Covered	None
	Other practitioner office visit	$35 Copay not subject to Deductible	Not Covered	None
	Preventive care screening/immunization/ Smoking Cessation	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	$30 Copay not subject to Deductible /Lab	Not Covered	None
		$50 Copay not subject to Deductible /X-Ray	Not Covered	None
	Imaging (CT/PET scans, MRIs)	30% Coinsurance after Deductible	Not Covered	None

RM Summit HMO Silver 1500/70 $35 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type: HMO**

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	Tier 1 - $15 Copay not subject to Deductible	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, Mail Order, and Preferred Network Pharmacy limited up to a 90-day supply. Specialty Pharmacy limited up to a 31-day supply. Tier 5 limited to 31-day supply only. Copays shown are for retail, up to a 31-day supply. Mail order is 2.5 times the retail copay or coinsurance amount.
	Preferred brand drugs	Tier 2 - $40 Copay not subject to Deductible	Not Covered	
	Non-preferred brand drugs	Tier 3 -$55 Copay not subject to Deductible	Not Covered	
	Specialty drugs	Tier 4 - 30% Coinsurance not subject to Deductible	Not Covered	
		Tier 5 - 40% Coinsurance not subject to Deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance after Deductible	Not Covered	None
	Physician/surgeon fees/Anesthesia	30% Coinsurance after Deductible	Not Covered	None
If you need immediate medical attention	Emergency room services	$250 Copay not subject to Deductible 30% Coinsurance after Deductible	$250 Copay not subject to Deductible 30% Coinsurance after Deductible	None
	Emergency medical transportation	30% Coinsurance after Deductible	30% Coinsurance after Deductible	None
	Urgent care	$50 Copay not subject to Deductible	$50 Copay not subject to Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance after Deductible	Not Covered	None
	Physician/surgeon fee/Anesthesia	30% Coinsurance after Deductible	Not Covered	None

RM Summit HMO Silver 1500/70 $35 Copay

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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 Copay not subject to Deductible	Not Covered	None
	Mental/Behavioral health inpatient services	30% Coinsurance after Deductible	Not Covered	None
	Substance use disorder outpatient services	$35 Copay not subject to Deductible	Not Covered	None
	Substance use disorder inpatient services	30% Coinsurance after Deductible	Not Covered	None
If you are pregnant	Prenatal and postnatal care	30% Coinsurance after Deductible	Not Covered	None
	Delivery and all inpatient services	30% Coinsurance after Deductible	Not Covered	None
If you need help recovering or have other special health needs	Home health care	30% Coinsurance after Deductible	Not Covered	None
	Rehabilitation services (Including Cardiac and Pulmonary Rehabilitation)	30% Coinsurance after Deductible	Not Covered	Coverage is limited to 20 visits/ Member/therapy/year for rehabilitative and 20 visits/Member/therapy/year for habilitative services. (Cardiac and Pulmonary are not limited)
	Habilitation services (Including Cardiac and Pulmonary Habilitation)	30% Coinsurance after Deductible	Not Covered	
	Skilled nursing care	30% Coinsurance after Deductible	Not Covered	Coverage is limited to 100 days/Member/year.
	Durable medical equipment	30% Coinsurance after Deductible	Not Covered	None
	Hospice service	30% Coinsurance after Deductible	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 your child needs dental or eye care	Eye exam	No Charge	Not Covered	Coverage is limited to children up to age 19, limited to one/Member/year.
	Glasses	Not Covered	Not Covered	None
	Dental check-up	No Charge	Not Covered	Coverage is limited to children up to age 19.

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
- Breast reconstruction (unless medically necessary or as part of a mastectomy)
- Cosmetic Surgery
- Drugs not included in the formulary
- Infertility treatment
- Long-term care
- Neuromusculoskeletal Services (unless purchased)
- Non-emergency care when traveling outside the U.S.
- 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.)

- Hearing Aids (for children)

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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.

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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.

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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** $3980
- **Patient pays** $3560

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	$1500
Copays	$360
Coinsurance	$1550
Limits or exclusions	$150
Total	**$3560**

Managing Type 2 Diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5400
- **Plan pays** $1970
- **Patient pays** $3430

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	$1500
Copays	$680
Coinsurance	$0
Limits or exclusions	$1250
Total	**$3430**

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.

RM Summit HMO HSA Silver 3000/100

Coverage Period Begins on or After: January 1, 2015

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?	$3,000 person /$6,000 family (In-Network) Doesn't apply to preventive care.	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**. $3,000 person /$6,000 family (In-Network)	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**, visit 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**.

- **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 participating **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	No charge after Deductible	Not Covered	None
	Specialist visit	No charge after Deductible	Not Covered	None
	Other practitioner office visit	No charge after Deductible	Not Covered	None
	Preventive care screening/immunization/ Smoking Cessation	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	No charge after Deductible/Lab	Not Covered	None
		No charge after Deductible/X-Ray	Not Covered	None
	Imaging (CT/PET scans, MRIs)	No charge after Deductible	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	Tier 1 - No charge after Deductible	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, Mail Order, and Preferred Network Pharmacy limited up to a 90-day supply. Specialty Pharmacy limited up to a 31-day supply. Tier 5 limited to 31-day supply only. Copays shown are for retail, up to a 31-day supply. Mail order is 2.5 times the retail copay or coinsurance amount.
	Preferred brand drugs	Tier 2 - No charge after Deductible	Not Covered	
	Non-preferred brand drugs	Tier 3 - No charge after Deductible	Not Covered	
	Specialty drugs	Tier 4 - No charge after Deductible	Not Covered	
		Tier 5 - No charge after Deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after Deductible	Not Covered	None
	Physician/surgeon fees/Anesthesia	No charge after Deductible	Not Covered	None
If you need immediate medical attention	Emergency room services	No charge after Deductible	No charge after Deductible	None
	Emergency medical transportation	No charge after Deductible	No charge after Deductible	None
	Urgent care	No charge after Deductible	No charge after Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after Deductible	Not Covered	None
	Physician/surgeon fee/Anesthesia	No charge after Deductible	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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge after Deductible	Not Covered	None
	Mental/Behavioral health inpatient services	No charge after Deductible	Not Covered	None
	Substance use disorder outpatient services	No charge after Deductible	Not Covered	None
	Substance use disorder inpatient services	No charge after Deductible	Not Covered	None
If you are pregnant	Prenatal and postnatal care	No charge after Deductible	Not Covered	None
	Delivery and all inpatient services	No charge after Deductible	Not Covered	None
If you need help recovering or have other special health needs	Home health care	No charge after Deductible	Not Covered	None
	Rehabilitation services (Including Cardiac and Pulmonary Rehabilitation)	No charge after Deductible	Not Covered	Coverage is limited to 20 visits/ Member/therapy/year for rehabilitative and 20 visits/Member/therapy/year for habilitative services. (Cardiac and Pulmonary are not limited)
	Habilitation services (Including Cardiac and Pulmonary Habilitation)	No charge after Deductible	Not Covered	
	Skilled nursing care	No charge after Deductible	Not Covered	Coverage is limited to 100 days/Member/year.
	Durable medical equipment	No charge after Deductible	Not Covered	None
	Hospice service	No charge after Deductible	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 your child needs dental or eye care	Eye exam	No Charge	Not Covered	Coverage is limited to children up to age 19, limited to one/Member/year.
	Glasses	Not Covered	Not Covered	None
	Dental check-up	No Charge	Not Covered	Coverage is limited to children up to age 19.

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
- Breast reconstruction (unless medically necessary or as part of a mastectomy)
- Cosmetic Surgery
- Drugs not included in the formulary
- Infertility treatment
- Long-term care
- Neuromusculoskeletal Services (unless purchased)
- Non-emergency care when traveling outside the U.S.
- 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.)

- Hearing Aids (for children)

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** $4390
- **Patient pays** $3150

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	$3000
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$3150**

Managing Type 2 Diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5400
- **Plan pays** $2320
- **Patient pays** $3080

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	$3000
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$3080**

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.

RM Summit PPO Silver 3000/80 $40 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type: PPO**

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?	$3,000 person /$6,000 family (In-Network) $6,000 person/$12,000 family (Out-of Network) Doesn't apply to preventive care and other 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**. $6,600 person /$13,200 family (In-Network) $13,200 person/$26,400 family (Out-ofNetwork)	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**, visit 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**.

RM Summit PPO Silver 3000/80 $40 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type: PPO**

- **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 participating **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	$40 Copay not subject to Deductible	50% Coinsurance after Deductible	None
	Specialist visit	$55 Copay not subject to Deductible	50% Coinsurance after Deductible	None
	Other practitioner office visit	$40 Copay not subject to Deductible	50% Coinsurance after Deductible	None
	Preventive care screening/immunization/ Smoking Cessation	No Charge	Varies	None
If you have a test	Diagnostic test (x-ray, blood work)	$35 Copay not subject to Deductible /Lab	50% Coinsurance after Deductible	None
		$50 Copay not subject to Deductible /X-Ray	50% Coinsurance after Deductible	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance after Deductible	50% Coinsurance after Deductible	None

RM Summit PPO Silver 3000/80 $40 Copay

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	Tier 1 - $15 Copay not subject to Deductible	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, Mail Order, and Preferred Network Pharmacy limited up to a 90-day supply. Specialty Pharmacy limited up to a 31-day supply. Tier 5 limited to 31-day supply only. Copays shown are for retail, up to a 31-day supply. Mail order is 2.5 times the retail copay or coinsurance amount.
	Preferred brand drugs	Tier 2 - $40 Copay not subject to Deductible	Not Covered	
	Non-preferred brand drugs	Tier 3 -$70 Copay not subject to Deductible	Not Covered	
	Specialty drugs	Tier 4 - 30% Coinsurance not subject to Deductible	Not Covered	
		Tier 5 - 40% Coinsurance not subject to Deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Physician/surgeon fees/Anesthesia	20% Coinsurance after Deductible	50% Coinsurance after Deductible	None
If you need immediate medical attention	Emergency room services	$200 Copay not subject to Deductible 20% Coinsurance after Deductible	$200 Copay not subject to Deductible 20% Coinsurance after Deductible	None
	Emergency medical transportation	20% Coinsurance after Deductible	20% Coinsurance after Deductible	None
	Urgent care	$55 Copay not subject to Deductible	50% Coinsurance after Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Physician/surgeon fee/Anesthesia	20% Coinsurance after Deductible	50% Coinsurance after Deductible	None

RM Summit PPO Silver 3000/80 $40 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type: PPO**

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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 Copay not subject to Deductible	50% Coinsurance after Deductible	None
	Mental/Behavioral health inpatient services	20% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Substance use disorder outpatient services	$40 Copay not subject to Deductible	50% Coinsurance after Deductible	None
	Substance use disorder inpatient services	20% Coinsurance after Deductible	50% Coinsurance after Deductible	None
If you are pregnant	Prenatal and postnatal care	20% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Delivery and all inpatient services	20% Coinsurance after Deductible	50% Coinsurance after Deductible	None
If you need help recovering or have other special health needs	Home health care	20% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Rehabilitation services (Including Cardiac and Pulmonary Rehabilitation)	$40 Copay not subject to Deductible	50% Coinsurance after Deductible	Coverage is limited to 20 visits/ Member/therapy/year for rehabilitative and 20 visits/Member/therapy/year for habilitative services. (Cardiac and Pulmonary are not limited)
	Habilitation services (Including Cardiac and Pulmonary Habilitation)	$40 Copay not subject to Deductible	50% Coinsurance after Deductible	
	Skilled nursing care	20% Coinsurance after Deductible	50% Coinsurance after Deductible	Coverage is limited to 100 days/Member/year.
	Durable medical equipment	20% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Hospice service	20% Coinsurance after Deductible	50% Coinsurance after Deductible	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 your child needs dental or eye care	Eye exam	No Charge	50% Coinsurance after Deductible	Coverage is limited to children up to age 19, limited to one/Member/year.
	Glasses	Not Covered	Not Covered	None
	Dental check-up	No Charge	Not Covered	Coverage is limited to children up to age 19.

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 (Adult)
- Drugs not included in the formulary
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Spinal manipulations (unless purchased)
- 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.)

- Hearing Aids (for children)
- Private-duty nursing

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** $3520
- **Patient pays** $4020

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	$3000
Copays	$20
Coinsurance	$850
Limits or exclusions	$150
Total	**$4020**

Managing Type 2 Diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5400
- **Plan pays** $1760
- **Patient pays** $3640

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	$3000
Copays	$440
Coinsurance	$120
Limits or exclusions	$80
Total	**$3640**

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.

RM Summit PPO Silver 2000/70 $45 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type: PPO**

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 person /$4,000 family (In-Network) $4,000 person/$8,000 family (Out-of Network) Doesn't apply to preventive care and other 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**. $6,350 person /$12,700 family (In-Network) $12,700 person/$25,400 family (Out-ofNetwork)	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**, visit 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**.

RM Summit PPO Silver 2000/70 $45 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type: PPO**

- **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 participating **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 not subject to Deductible	50% Coinsurance after Deductible	None
	Specialist visit	$65 Copay not subject to Deductible	50% Coinsurance after Deductible	None
	Other practitioner office visit	$45 Copay not subject to Deductible	50% Coinsurance after Deductible	None
	Preventive care screening/immunization/ Smoking Cessation	No Charge	Varies	None
If you have a test	Diagnostic test (x-ray, blood work)	$40 Copay not subject to Deductible /Lab	50% Coinsurance after Deductible	None
		$55 Copay not subject to Deductible /X-Ray	50% Coinsurance after Deductible	None
	Imaging (CT/PET scans, MRIs)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None

RM Summit PPO Silver 2000/70 $45 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type:** PPO

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	Tier 1 - $15 Copay not subject to Deductible	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, Mail Order, and Preferred Network Pharmacy limited up to a 90-day supply. Specialty Pharmacy limited up to a 31-day supply. Tier 5 limited to 31-day supply only. Copays shown are for retail, up to a 31-day supply. Mail order is 2.5 times the retail copay or coinsurance amount.
	Preferred brand drugs	Tier 2 - $40 Copay not subject to Deductible	Not Covered	
	Non-preferred brand drugs	Tier 3 -$55 Copay not subject to Deductible	Not Covered	
	Specialty drugs	Tier 4 - 30% Coinsurance not subject to Deductible	Not Covered	
		Tier 5 - 40% Coinsurance not subject to Deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Physician/surgeon fees/Anesthesia	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
If you need immediate medical attention	Emergency room services	$250 Copay not subject to Deductible 30% Coinsurance after Deductible	$250 Copay not subject to Deductible 30% Coinsurance after Deductible	None
	Emergency medical transportation	30% Coinsurance after Deductible	30% Coinsurance after Deductible	None
	Urgent care	$65 Copay not subject to Deductible	50% Coinsurance after Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Physician/surgeon fee/Anesthesia	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None

RM Summit PPO Silver 2000/70 $45 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type: PPO**

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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$45 Copay not subject to Deductible	50% Coinsurance after Deductible	None
	Mental/Behavioral health inpatient services	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Substance use disorder outpatient services	$45 Copay not subject to Deductible	50% Coinsurance after Deductible	None
	Substance use disorder inpatient services	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
If you are pregnant	Prenatal and postnatal care	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Delivery and all inpatient services	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
If you need help recovering or have other special health needs	Home health care	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Rehabilitation services (Including Cardiac and Pulmonary Rehabilitation)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	Coverage is limited to 20 visits/ Member/therapy/year for rehabilitative and 20 visits/Member/therapy/year for habilitative services. (Cardiac and Pulmonary are not limited)
	Habilitation services (Including Cardiac and Pulmonary Habilitation)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	
	Skilled nursing care	30% Coinsurance after Deductible	50% Coinsurance after Deductible	Coverage is limited to 100 days/Member/year.
	Durable medical equipment	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Hospice service	30% Coinsurance after Deductible	50% Coinsurance after Deductible	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 your child needs dental or eye care	Eye exam	No Charge	50% Coinsurance after Deductible	Coverage is limited to children up to age 19, limited to one/Member/year.
	Glasses	Not Covered	Not Covered	None
	Dental check-up	No Charge	Not Covered	Coverage is limited to children up to age 19.

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 (Adult)
- Drugs not included in the formulary
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Spinal manipulations (unless purchased)
- 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.)

- Hearing Aids (for children)
- Private-duty nursing

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:

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See the next page for important information about these examples.

Having a Baby
(normal delivery)

- **Amount owed to providers:** $7540
- **Plan pays** $3590
- **Patient pays** $3950

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	$400
Coinsurance	$1400
Limits or exclusions	$150
Total	**$3950**

Managing Type 2 Diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5400
- **Plan pays** $1550
- **Patient pays** $3850

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	$2000
Copays	$600
Coinsurance	$0
Limits or exclusions	$1250
Total	**$3850**

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.
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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?

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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.

RM Summit PPO Silver 2000/70 $40 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type: PPO**

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 person /$4,000 family (In-Network) $4,000 person/$8,000 family (Out-of Network) Doesn't apply to preventive care and other 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 person /$12,000 family (In-Network) $12,000 person/$24,000 family (Out-ofNetwork)	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**, visit 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**.

RM Summit PPO Silver 2000/70 $40 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type: PPO**

- **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 participating **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	$40 Copay not subject to Deductible	50% Coinsurance after Deductible	None
	Specialist visit	$60 Copay not subject to Deductible	50% Coinsurance after Deductible	None
	Other practitioner office visit	$40 Copay not subject to Deductible	50% Coinsurance after Deductible	None
	Preventive care screening/immunization/ Smoking Cessation	No Charge	Varies	None
If you have a test	Diagnostic test (x-ray, blood work)	$40 Copay not subject to Deductible /Lab	50% Coinsurance after Deductible	None
		$55 Copay not subject to Deductible /X-Ray	50% Coinsurance after Deductible	None
	Imaging (CT/PET scans, MRIs)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None

RM Summit PPO Silver 2000/70 $40 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type: PPO**

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	Tier 1 - $15 Copay not subject to Deductible	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, Mail Order, and Preferred Network Pharmacy limited up to a 90-day supply. Specialty Pharmacy limited up to a 31-day supply. Tier 5 limited to 31-day supply only. Copays shown are for retail, up to a 31-day supply. Mail order is 2.5 times the retail copay or coinsurance amount.
	Preferred brand drugs	Tier 2 - $40 Copay not subject to Deductible	Not Covered	
	Non-preferred brand drugs	Tier 3 -$55 Copay not subject to Deductible	Not Covered	
	Specialty drugs	Tier 4 - 30% Coinsurance not subject to Deductible	Not Covered	
		Tier 5 - 40% Coinsurance not subject to Deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Physician/surgeon fees/Anesthesia	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
If you need immediate medical attention	Emergency room services	$250 Copay not subject to Deductible 30% Coinsurance after Deductible	$250 Copay not subject to Deductible 30% Coinsurance after Deductible	None
	Emergency medical transportation	30% Coinsurance after Deductible	30% Coinsurance after Deductible	None
	Urgent care	$60 Copay not subject to Deductible	50% Coinsurance after Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Physician/surgeon fee/Anesthesia	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None

RM Summit PPO Silver 2000/70 $40 Copay

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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 Copay not subject to Deductible	50% Coinsurance after Deductible	None
	Mental/Behavioral health inpatient services	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Substance use disorder outpatient services	$40 Copay not subject to Deductible	50% Coinsurance after Deductible	None
	Substance use disorder inpatient services	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
If you are pregnant	Prenatal and postnatal care	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Delivery and all inpatient services	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
If you need help recovering or have other special health needs	Home health care	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Rehabilitation services (Including Cardiac and Pulmonary Rehabilitation)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	Coverage is limited to 20 visits/ Member/therapy/year for rehabilitative and 20 visits/Member/therapy/year for habilitative services. (Cardiac and Pulmonary are not limited)
	Habilitation services (Including Cardiac and Pulmonary Habilitation)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	
	Skilled nursing care	30% Coinsurance after Deductible	50% Coinsurance after Deductible	Coverage is limited to 100 days/Member/year.
	Durable medical equipment	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Hospice service	30% Coinsurance after Deductible	50% Coinsurance after Deductible	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 your child needs dental or eye care	Eye exam	No Charge	50% Coinsurance after Deductible	Coverage is limited to children up to age 19, limited to one/Member/year.
	Glasses	Not Covered	Not Covered	None
	Dental check-up	No Charge	Not Covered	Coverage is limited to children up to age 19.

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 (Adult)
- Drugs not included in the formulary
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Spinal manipulations (unless purchased)
- 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.)

- Hearing Aids (for children)
- Private-duty nursing

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** $3590
- **Patient pays** $3950

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	$400
Coinsurance	$1400
Limits or exclusions	$150
Total	**$3950**

Managing Type 2 Diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5400
- **Plan pays** $1570
- **Patient pays** $3830

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	$2000
Copays	$580
Coinsurance	$0
Limits or exclusions	$1250
Total	**$3830**

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.

RM Summit PPO Silver 1500/70 $35 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type: PPO**

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?	$1,500 person /$3,000 family (In-Network) $3,000 person/$6,000 family (Out-of Network) Doesn't apply to preventive care and other 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**. $6,350 person /$12,700 family (In-Network) $12,700 person/$25,400 family (Out-ofNetwork)	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**, visit 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**.

RM Summit PPO Silver 1500/70 $35 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type: PPO**

- **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 participating **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	$35 Copay not subject to Deductible	50% Coinsurance after Deductible	None
	Specialist visit	$50 Copay not subject to Deductible	50% Coinsurance after Deductible	None
	Other practitioner office visit	$35 Copay not subject to Deductible	50% Coinsurance after Deductible	None
	Preventive care screening/immunization/ Smoking Cessation	No Charge	Varies	None
If you have a test	Diagnostic test (x-ray, blood work)	$30 Copay not subject to Deductible /Lab	50% Coinsurance after Deductible	None
		$50 Copay not subject to Deductible /X-Ray	50% Coinsurance after Deductible	None
	Imaging (CT/PET scans, MRIs)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None

RM Summit PPO Silver 1500/70 $35 Copay

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type:** PPO

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	Tier 1 - $15 Copay not subject to Deductible	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, Mail Order, and Preferred Network Pharmacy limited up to a 90-day supply. Specialty Pharmacy limited up to a 31-day supply. Tier 5 limited to 31-day supply only. Copays shown are for retail, up to a 31-day supply. Mail order is 2.5 times the retail copay or coinsurance amount.
	Preferred brand drugs	Tier 2 - $40 Copay not subject to Deductible	Not Covered	
	Non-preferred brand drugs	Tier 3 -$55 Copay not subject to Deductible	Not Covered	
	Specialty drugs	Tier 4 - 30% Coinsurance not subject to Deductible	Not Covered	
		Tier 5 - 40% Coinsurance not subject to Deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Physician/surgeon fees/Anesthesia	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
If you need immediate medical attention	Emergency room services	$250 Copay not subject to Deductible 30% Coinsurance after Deductible	$250 Copay not subject to Deductible 30% Coinsurance after Deductible	None
	Emergency medical transportation	30% Coinsurance after Deductible	30% Coinsurance after Deductible	None
	Urgent care	$50 Copay not subject to Deductible	50% Coinsurance after Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Physician/surgeon fee/Anesthesia	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None

RM Summit PPO Silver 1500/70 $35 Copay

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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 Copay not subject to Deductible	50% Coinsurance after Deductible	None
	Mental/Behavioral health inpatient services	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Substance use disorder outpatient services	$35 Copay not subject to Deductible	50% Coinsurance after Deductible	None
	Substance use disorder inpatient services	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
If you are pregnant	Prenatal and postnatal care	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Delivery and all inpatient services	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
If you need help recovering or have other special health needs	Home health care	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Rehabilitation services (Including Cardiac and Pulmonary Rehabilitation)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	Coverage is limited to 20 visits/ Member/therapy/year for rehabilitative and 20 visits/Member/therapy/year for habilitative services. (Cardiac and Pulmonary are not limited)
	Habilitation services (Including Cardiac and Pulmonary Habilitation)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	
	Skilled nursing care	30% Coinsurance after Deductible	50% Coinsurance after Deductible	Coverage is limited to 100 days/Member/year.
	Durable medical equipment	30% Coinsurance after Deductible	50% Coinsurance after Deductible	None
	Hospice service	30% Coinsurance after Deductible	50% Coinsurance after Deductible	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 your child needs dental or eye care	Eye exam	No Charge	50% Coinsurance after Deductible	Coverage is limited to children up to age 19, limited to one/Member/year.
	Glasses	Not Covered	Not Covered	None
	Dental check-up	No Charge	Not Covered	Coverage is limited to children up to age 19.

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 (Adult)
- Drugs not included in the formulary
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Spinal manipulations (unless purchased)
- Weight loss programs

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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.**

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See the next page for important information about these examples.

Having a Baby
(normal delivery)

- **Amount owed to providers:** $7540
- **Plan pays** $3980
- **Patient pays** $3560

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	$1500
Copays	$360
Coinsurance	$1550
Limits or exclusions	$150
Total	**$3560**

Managing Type 2 Diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5400
- **Plan pays** $1970
- **Patient pays** $3430

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	$1500
Copays	$680
Coinsurance	$0
Limits or exclusions	$1250
Total	**$3430**

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.

RM Summit PPO HSA Silver 3000/100

Coverage Period Begins on or After: January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Member/Family | **Plan Type: PPO**

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?	$3,000 person /$6,000 family (In-Network) $6,000 person/$12,000 family (Out-of Network) Doesn't apply to preventive care.	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**. $3,000 person /$6,000 family (In-Network) $12,000 person/$24,000 family (Out-ofNetwork)	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**, visit 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**.

RM Summit PPO HSA Silver 3000/100

- **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 participating **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	No charge after Deductible	50% Coinsurance after Deductible	None
	Specialist visit	No charge after Deductible	50% Coinsurance after Deductible	None
	Other practitioner office visit	No charge after Deductible	50% Coinsurance after Deductible	None
	Preventive care screening/immunization/ Smoking Cessation	No Charge	Varies	None
If you have a test	Diagnostic test (x-ray, blood work)	No charge after Deductible/Lab	50% Coinsurance after Deductible	None
		No charge after Deductible/X-Ray	50% Coinsurance after Deductible	None
	Imaging (CT/PET scans, MRIs)	No charge after Deductible	50% Coinsurance after Deductible	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	Tier 1 - No charge after Deductible	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, Mail Order, and Preferred Network Pharmacy limited up to a 90-day supply. Specialty Pharmacy limited up to a 31-day supply. Tier 5 limited to 31-day supply only. Copays shown are for retail, up to a 31-day supply. Mail order is 2.5 times the retail copay or coinsurance amount.
	Preferred brand drugs	Tier 2 - No charge after Deductible	Not Covered	
	Non-preferred brand drugs	Tier 3 - No charge after Deductible	Not Covered	
	Specialty drugs	Tier 4 - No charge after Deductible	Not Covered	
		Tier 5 - No charge after Deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after Deductible	50% Coinsurance after Deductible	None
	Physician/surgeon fees/Anesthesia	No charge after Deductible	50% Coinsurance after Deductible	None
If you need immediate medical attention	Emergency room services	No charge after Deductible	No charge after Deductible	None
	Emergency medical transportation	No charge after Deductible	No charge after Deductible	None
	Urgent care	No charge after Deductible	50% Coinsurance after Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after Deductible	50% Coinsurance after Deductible	None
	Physician/surgeon fee/Anesthesia	No charge after Deductible	50% Coinsurance after Deductible	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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge after Deductible	50% Coinsurance after Deductible	None
	Mental/Behavioral health inpatient services	No charge after Deductible	50% Coinsurance after Deductible	None
	Substance use disorder outpatient services	No charge after Deductible	50% Coinsurance after Deductible	None
	Substance use disorder inpatient services	No charge after Deductible	50% Coinsurance after Deductible	None
If you are pregnant	Prenatal and postnatal care	No charge after Deductible	50% Coinsurance after Deductible	None
	Delivery and all inpatient services	No charge after Deductible	50% Coinsurance after Deductible	None
If you need help recovering or have other special health needs	Home health care	No charge after Deductible	50% Coinsurance after Deductible	None
	Rehabilitation services (Including Cardiac and Pulmonary Rehabilitation)	No charge after Deductible	50% Coinsurance after Deductible	Coverage is limited to 20 visits/ Member/therapy/year for rehabilitative and 20 visits/Member/therapy/year for habilitative services. (Cardiac and Pulmonary are not limited)
	Habilitation services (Including Cardiac and Pulmonary Habilitation)	No charge after Deductible	50% Coinsurance after Deductible	
	Skilled nursing care	No charge after Deductible	50% Coinsurance after Deductible	Coverage is limited to 100 days/Member/year.
	Durable medical equipment	No charge after Deductible	50% Coinsurance after Deductible	None
	Hospice service	No charge after Deductible	50% Coinsurance after Deductible	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 your child needs dental or eye care	Eye exam	No Charge	50% Coinsurance after Deductible	Coverage is limited to children up to age 19, limited to one/Member/year.
	Glasses	Not Covered	Not Covered	None
	Dental check-up	No charge after Deductible	Not Covered	Coverage is limited to children up to age 19.

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 (Adult)
- Drugs not included in the formulary
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Spinal manipulations (unless purchased)
- 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.)

- Hearing Aids (for children)
- Private-duty nursing

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** $4390
- **Patient pays** $3150

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	$3000
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$3150**

Managing Type 2 Diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5400
- **Plan pays** $2320
- **Patient pays** $3080

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	$3000
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$3080**

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.