ROCKY MOUNTAIN HEALTH PLANS®
A UnitedHealthcare Company

Colorado Doctors Plan Silver 3 Free Visits 4500-C $3 Walgreens RX Copay

Coverage for: Individual/Family | Plan Type: HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.rmhp.org or call 855-224-4169. For definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/or call 855-224-4169 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$200 individual /$400 family (In-Network)	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	**Yes.** Preventive care, outpatient prescription drugs, child eye exams and child dental check-ups are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**No.**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$2,900 individual/$5,800 family (In-Network)	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	**Yes.** See www.rmhp.org or call 855-224-4169 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	**No.**	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge for the first 3 visits; deductible does not apply, then 5% coinsurance	Not covered	None
	Specialist visit	5% coinsurance	Not covered	None
	Preventive care/screening/ immunization	No charge; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	5% coinsurance	Not covered	May require preauthorization. Please go to www.rmhp.org to find out if a service needs preauthorization. If you don't get preauthorization for out-of-network services, benefits will be denied.
	Imaging (CT/PET scans, MRIs)	5% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.rmhp.org.	Tier 1 (Preventive drugs.)	No charge; deductible does not apply (PN), (R) and (MO)	Not covered	There is no cost sharing for preventive drugs on tier 1 of the RMHP formulary. Retail Pharmacy (R) is limited up to a 30-day supply. Mail Order Pharmacy (MO) and Preferred Network Pharmacy (PN) are limited up to a 90-day supply. Specialty drugs on tiers 2-6 and drugs on tier 6 are limited up to a 30-day supply. This limitation doesn't apply to oral contraceptive drugs, patches and rings. You can get up to a 1 year supply after an initial 3 month supply for oral contraceptive drugs and patches. When a drug is packaged or designed to deliver in a manner that provides more than a consecutive 30-day supply, the cost sharing that applies will reflect the number of days dispensed or days the drug will be delivered. Cost sharing will not exceed $100 per 30 day supply of insulin, regardless of the amount or type of insulin needed to fill your prescription order(s).
	Tier 2 (Lower-cost. Mostly generic drugs, including drugs for cancer treatment.)	30-day supply: $3 (PN)/ $5 (R); copay/ prescription; deductible does not apply 90-day supply: $6 (PN)/ $15 (MO); copay/prescription; deductible does not apply	Not covered	
	Tier 3 (Mid-range cost. Mostly generic drugs, including drugs for cancer treatment.)	30-day supply: $10 (PN) and (R); copay/ prescription; deductible does not apply 90-day supply: $20 (PN)/ $30 (MO); copay/ prescription; deductible does not apply	Not covered	
	Tier 4 (Mid-range cost. A mix of brand-name and generic drugs, including drugs for cancer treatment.)	30-day supply: $30 copay/ prescription; deductible does not apply (PN) and (R) 90-day supply: $60 (PN)/ $90 (MO) copay/ prescription; deductible does not apply	Not covered	
	Tier 5 (Highest-cost. Mostly brand-name drugs, some generics, and Specialty drugs including drugs for cancer treatment.)	30-day supply: $100 copay/ prescription; deductible does not apply (PN) and (R) 90-day supply: $200 (PN)/ $300 (MO) copay/ prescription; deductible does not apply	Not covered	
	Tier 6 (Specialty drugs, including drugs for cancer treatment.)	30-day supply: $200 copay/ prescription; deductible does not apply (PN), (R) and (MO)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% coinsurance	Not covered	May require preauthorization. Please go to www.rmhp.org to find out if a service needs preauthorization. If you don't get preauthorization for out-of-network services, benefits will be denied.
	Physician/surgeon fees	5% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	None
	Emergency medical transportation	5% coinsurance	5% coinsurance	None
	Urgent care	First 3 visits $25 copay/visit; deductible does not apply, then 5% coinsurance	First 3 visits $25 copay/visit; deductible does not apply, then 5% coinsurance	Visits for behavioral, mental health and substance use disorders covered with no cost sharing.
If you have a hospital stay	Facility fee (e.g., hospital room)	5% coinsurance	Not covered	May require preauthorization. Please go to www.rmhp.org to find out if a service needs preauthorization. If you don't get preauthorization for out-of-network services, benefits will be denied.
	Physician/surgeon fees	5% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	5% coinsurance	Not covered	May require preauthorization. Please go to www.rmhp.org to find out if a service needs preauthorization. If you don't get preauthorization for out-of-network services, benefits will be denied.
	Inpatient services	5% coinsurance	Not covered	
If you are pregnant	Office visits	5% coinsurance	Not covered	Cost sharing does not apply for preventive services including routine prenatal care.
	Childbirth/delivery professional services	5% coinsurance	Not covered	
	Childbirth/delivery facility services	5% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	5% coinsurance	Not covered	Services may not exceed 28 hours per week combined over any number of days per week and must be for less than 8 hours per day. Additional time up to 35 hours per week but less than 8 hours per day may be approved by us on a case-by-case basis.
	Rehabilitation services	5% coinsurance	Not covered	Coverage is limited to 20 visits/ Member/therapy/year for rehabilitative and 20 visits/Member/therapy/year for habilitative services.
	Habilitation services	5% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Skilled nursing care	5% coinsurance	Not covered	Coverage is limited to 100 days/Member/ year.
	Durable medical equipment	5% coinsurance	Not covered	May require preauthorization. Please go to www.rmhp.org to find out if a service needs preauthorization. If you don't get preauthorization for out-of-network services, benefits will be denied.
	Hospice services	5% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	Not covered	Coverage is limited to children up to age 19, limited to one/Member/year.
	Children's glasses	5% coinsurance	Not covered	Coverage is limited to children up to age 19, or after covered eye surgery, or with a diagnosis of keratoconus.
	Children's dental check-up	No charge; deductible does not apply	Not covered	Coverage is limited to children up to age 19.

Excluded services & Other Covered Services:

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

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

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

- Abortions (cases of rape, incest, or to save the life of the mother)
- Bariatric surgery (covered according to our clinical guidelines and subject to prior authorization)
- Chiropractic care
- Hearing Aids (for children)
- Infertility treatment
- Private-duty nursing

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: you can contact RMHP at 855-224-4169.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Not Applicable

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 855-224-4169.

Si usted lo solicita, hay disponible una versión de este aviso completamente traducida en español.

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

About these Coverage Examples:

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

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

The plan's overall deductible	**$200**
Specialist coinsurance	**5%**
Hospital (facility) coinsurance	**5%**
Other coinsurance	**5%**

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$10
Coinsurance	$600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$870**

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

The plan's overall deductible	**$200**
Specialist coinsurance	**5%**
Hospital (facility) coinsurance	**5%**
Other coinsurance	**5%**

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$1,400
Coinsurance	$70
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,690**

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

The plan's overall deductible	**$200**
Specialist coinsurance	**5%**
Hospital (facility) coinsurance	**5%**
Other coinsurance	**5%**

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$100
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$390**

ROCKY MOUNTAIN HEALTH PLANS®
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Notice of Nondiscrimination

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

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

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

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

If you believe that RMHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with: the RMHP EEO Officer. You can file a grievance in person or by phone, mail, fax, or email.

- Phone: 800-346-4643, 970-244-7760, ext. 7883, or TTY 970-248-5019, 800-704-6370, Relay 711; para asistencia en español llame al 800-346-4643
- Mail: ATTN: EEO Officer, Rocky Mountain Health Plans, PO Box 10600, Grand Junction, CO 81502-5600
- Fax: ATTN: EEO Officer, 970-244-7909
- Email: eeoofficer@rmhp.org

If you need help filing a grievance, the RMHP EEO Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Multi-Language Insert

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en la portada de esta guía.

請注意：如果您說中文(Chinese)，我們免費為您提供語言協助服務。請撥打本手冊封面所列的免付 費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Xin vui lòng gọi số điện thoại miễn phí dành cho hội viên trên trang bìa của tập sách này.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 이 책자 앞 페이지에 기재된 무료 회원 전화번호로 문의하십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ngtulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nakalista sa harapan ng booklet na ito.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русским (Russian). Позвоните по бесплатному номеру телефона, указанному на лицевой стороне данной брошюры.

تنبيه: إذا كنت تتحدث العربية ، فهناك خدمات مساعدة لغوية مجانية متاحة. اتصل بالرقم المجاني على غلاف هذا الدليل.

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo telefòn gratis pou manm yo ki sou kouvèti ti liv sa a.

ATTENTION : Si vous parlez français (French), des services d’aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone sans frais pour les affiliés figurant au début de ce guide.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny członkowski numer telefonu podany na okładce tej broszury.

Multi-Language Insert

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número do membro encontrado na frente deste folheto.

ATTENZIONE: in caso la lingua parlata sia l'italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero verde per i membri indicato all'inizio di questo libretto.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer für Mitglieder auf der Vorderseite dieser Broschüre an.

注意事項：日本語(Japanese) を話される場合、無料の言語支援サービスをご利用いただけます。本冊子の表紙に記載されているメンバー用フリーダイヤルにお電話ください。

توجه: اگر به فارسی صحبت می کنید ، خدمات کمک به زبان رایگان در دسترس است. با شماره تلفن رایگان روی جلد این راهنما تماس بگیرید.

ध्यानदें:ल्यदि पहिंदी ल हैं,ल नि:ल ल्क । । हाय । । उपलब्धहैं। । कल्क रपर ल-लिनं रपरक लकरें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu tus tswv cuab xov tooj hu dawb teev nyob ntawm sab xub ntiag ntawm phau ntawv no.

ចំណាប់អារម្មណ៍:េបើសិនអ្នកនិយាយភាសាែខរម៉ង(Khmer)ែអេសវាជំនួយភាសាេដាយឥតគិតៃថ្លគឺមានសំរាប់អ្នក។ែអ សូមទូរស័ព្ទេទៅេលខសមាជិកឥតគៃថ្លដានកត់េនៅខាងមុខនកូនេសៀវេភៅេនះ។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Pakitawagan iti miyembro toll-free nga number nga nakasurat iti sango ti libro.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí díí naaltsoos bidáahgi t'áá jiik'eh naaltsoos báha'dít'éhígíí béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka xubinta ee telefonka bilaashka ah ee ku qoran xagga hore ee buugyaraha.