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

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$350 individual/$600 family (In-Network) $500 individual/$1,000 family (Out-of-Network)</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care, primary care and specialist visits, prescription drugs, labs, x-rays, hospice services, emergency room care, emergency medical transportation and urgent care are covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$3,000 individual/$5,000 family (In-Network) $4,000 individual/$6,000 family (Out-of-Network)</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, deductibles, durable medical equipment, copays on certain services, prescription drugs, balance-billing charges (unless balanced billing is prohibited), and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.rmhp.org">www.rmhp.org</a> or call 1-800-346-4643 for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>Network Provider (You will pay the least)</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-Network Provider (You will pay the most)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$30 copay/visit; deductible does not apply</td>
<td>$30 coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/Immunization</td>
<td>No charge; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No charge; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>$15 copay/visit; deductible does not apply</td>
<td>May require preauthorization. Please go to <a href="http://www.rmhp.org">www.rmhp.org</a> to find out if a service needs preauthorization. If you don't get preauthorization for out-of-network preventive care services, benefits will be denied.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$100 copay/visit; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Tier 1 (May contain generic and brand drugs)</td>
<td>Tier 1 - $15 (R)/ $30 (MO) copay/prescription; deductible does not apply</td>
<td>$0 copay for contraceptive drugs/devices noted as “Women’s Preventive Healthcare” in the formulary.</td>
</tr>
<tr>
<td></td>
<td>Tier 2 (Preferred drugs. Contains brand name and generic)</td>
<td>Tier 2 - $30 (R)/ $60 (MO) copay/prescription; deductible does not apply</td>
<td>Retail (R) and Mail Order (MO) 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. Tier 4 copay limited to $150 up to a 31-day supply to any network pharmacy/$300 for up to 90 day supply for retail or mail order pharmacy paid by Member. Tier 5 copay limited to $250 paid by Member. Retail copay shown 31-day supply, Mail order copay shown 90-day supply.</td>
</tr>
<tr>
<td></td>
<td>Tier 3 (Non-preferred drugs, including specialty drugs for cancer treatment. Contains brand name and generic)</td>
<td>Tier 3 - $45 (R)/ $90 (MO) copay/prescription; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 4 (Specialty drugs)</td>
<td>Tier 4 - 20% coinsurance/prescription; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 5 (Non-preferred specialty drugs)</td>
<td>Tier 5 - 30% coinsurance/prescription; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contains brand name and generic high cost drugs.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

More information about **prescription drug coverage** is available at [http://www.rmhp.org/formulary](http://www.rmhp.org/formulary).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Network Provider (You will pay the least): $250 copay/visit; deductible does not apply</td>
<td>May require preauthorization. Please go to <a href="http://www.rmhp.org">www.rmhp.org</a> to find out if a service needs preauthorization. If you don't get preauthorization for out-of-network services, benefits will be denied.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Non-Network Provider (You will pay the most): $150 copay/visit; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$150 copay/visit; deductible does not apply</td>
<td>Applies to the in-network out-of-pocket limit.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$150 copay/visit; deductible does not apply</td>
<td>Applies to the in-network out-of-pocket limit.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$50 copay/visit; deductible does not apply</td>
<td>None</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$500 copay/visit; deductible does not apply</td>
<td>May require preauthorization. Please go to <a href="http://www.rmhp.org">www.rmhp.org</a> to find out if a service needs preauthorization. If you don't get preauthorization for out-of-network services, benefits will be denied.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge after deductible</td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$30 copay/visit; deductible does not apply</td>
<td>May require preauthorization. Please go to <a href="http://www.rmhp.org">www.rmhp.org</a> to find out if a service needs preauthorization. If you don't get preauthorization for out-of-network services, benefits will be denied.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$500 copay/visit; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge; deductible does not apply</td>
<td>Cost sharing does not apply for preventive services including routine prenatal care in-network.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$500 copay/visit; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge after deductible</td>
<td>Coverage is limited to 60 visits/Member/year.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$30 copay/visit; deductible does not apply</td>
<td>Coverage is limited to 20 visits/therapy/Member/year.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$250 copay/visit; deductible does not apply</td>
<td>Coverage is limited to 60 days/Member/year.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>May require preauthorization. Please go to <a href="http://www.rmhp.org">www.rmhp.org</a> to find out if a service needs preauthorization. If you don't get preauthorization for out-of-network services, benefits will be denied.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------------------</td>
<td>--------------------------------------------------------</td>
<td>---------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Non-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>Hospice services</td>
<td>10% coinsurance; deductible does not apply</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s eye exam</td>
<td>$30 copay/visit; deductible does not apply</td>
<td>Not covered</td>
<td>Coverage is limited to one/Member/year.</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>Coverage is provided after covered eye surgery, or with a diagnosis of keratoconus.</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None</td>
</tr>
</tbody>
</table>

**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 | Dental care (Adult) | Long-term care |
| Bariatric surgery | Drugs not included in the formulary | Private-duty nursing |
| Children's dental check-up | Habilitation services | Routine foot care |
| Cosmetic Surgery | | Weight loss programs |

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

<table>
<thead>
<tr>
<th>Chiropractic care</th>
<th>Infertility treatment</th>
<th>Routine eye care (Adult)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing Aids (for children)</td>
<td>Non-emergency care when traveling outside the U.S.</td>
<td></td>
</tr>
</tbody>
</table>

**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, [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.ccio.cms.gov](http://www.ccio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](http://HealthCare.gov). For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:**

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

For group health coverage subject to ERISA, you can also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-ESBA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or the Colorado Department of Insurance at 303-894-7490 or [www.dora.state.co.us/insurance](http://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 plan provide Minimum Essential Coverage? Yes**
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-346-4643.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
## Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan’s overall deductible: $350
- Specialist copayment: $30
- Hospital (facility) copay: $500
- Other coinsurance: 10%

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

**Total Example Cost:** $12,800

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$350</td>
</tr>
<tr>
<td>Copayments</td>
<td>$3000</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What isn’t covered</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
</tr>
<tr>
<td>The total Peg would pay is</td>
<td>$3410</td>
</tr>
</tbody>
</table>

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

- The plan’s overall deductible: $350
- Specialist copayment: $30
- Hospital (facility) copay: $500
- Other coinsurance: 10%

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

**Total Example Cost:** $7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$350</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1400</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$200</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What isn’t covered</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
</tr>
<tr>
<td>The total Joe would pay is</td>
<td>$2010</td>
</tr>
</tbody>
</table>

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

- The plan’s overall deductible: $350
- Specialist copayment: $30
- Hospital (facility) copay: $500
- Other coinsurance: 10%

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

**Total Example Cost:** $1,900

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$350</td>
</tr>
<tr>
<td>Copayments</td>
<td>$700</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What isn’t covered</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
</tr>
<tr>
<td>The total Mia would pay is</td>
<td>$730</td>
</tr>
</tbody>
</table>

---

**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.
### SUPPLEMENTAL INFORMATION REGARDING BENEFITS

**Important Note:** The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4. Annual Deductible Type</strong></td>
</tr>
<tr>
<td>INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid. Claims will not be paid for any other individual until their individual deductible or the family deductible has been met.</td>
</tr>
<tr>
<td>FAMILY – The maximum amount that the family will pay for the year. The family deductible can be met by [2] or more individuals.</td>
</tr>
<tr>
<td><strong>5. Out-of-Pocket Maximum</strong></td>
</tr>
<tr>
<td>INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid at 100%. Claims will not be paid at 100% for any other individual until their individual out-of-pocket or the family out-of-pocket has been met.</td>
</tr>
<tr>
<td>FAMILY – The maximum amount that the family will pay for the year. The family out-of-pocket can be met by [2] or more individuals.</td>
</tr>
<tr>
<td><strong>6. What is included in the In-Network Out-of-Pocket Maximum?</strong></td>
</tr>
<tr>
<td>Deductibles, copayments, and coinsurance, except as otherwise specified in the box entitled “What is not included in the out-of-pocket limit?” in the corresponding Summary of Benefits and Coverage document.</td>
</tr>
</tbody>
</table>
7. Is pediatric dental covered by this plan?
   No, the plan does not include pediatric dental.

8. What cancer screenings are covered by this plan?
   Subject to the parameters set forth below, cancer screening tests for the following items are covered subject to any applicable plan deductibles, copayments/coinsurance, and maximum benefit levels:
   - Breast – Mammogram
   - Cervical – PAP test
   - Colorectal – Colonoscopy, Sigmoidoscopy, Fecal Occult Blood
   - Ovarian – CA125
   - Prostate – PSA
   Coverage for these cancer screening tests are subject to the following parameters:
   a) the test must be ordered by your physician, and
   b) you must comply with plan procedures

<table>
<thead>
<tr>
<th>USING THE PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>IN-NETWORK</td>
</tr>
<tr>
<td>9. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?</td>
</tr>
<tr>
<td>10. Does the plan have a binding arbitration clause?</td>
</tr>
</tbody>
</table>

Questions: Call 1-800-346-4643 or visit us at www.rmhp.org.
Para obtener asistencia en Español, llame al 1-800-346-4643.

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

Colorado Division of Insurance
Consumer Services, Life and Health Section
1560 Broadway, Suite 850, Denver, CO 80202
Call: 303-894-7490 (in-state, toll-free: 800-930-3745)
Email: dora_insurance@state.co.us
<table>
<thead>
<tr>
<th>Language</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-346-4643 (TTY: 711).</td>
</tr>
<tr>
<td>Spanish</td>
<td>ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-346-4643 (TTY: 711).</td>
</tr>
<tr>
<td>Chinese</td>
<td>注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-346-4643 (TTY: 711)。</td>
</tr>
<tr>
<td>Russian</td>
<td>ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-346-4643 (телетайп: 711).</td>
</tr>
<tr>
<td>Amharic</td>
<td>ለማስታወሻ: ያቀረበው ከሚከተለው የሆኔ ከወንገሮችን እርዳታ የተወሰነ በሆኔ ከወንገሮችን እርዳታ 1-800-346-4643 (መስማት: 711).</td>
</tr>
<tr>
<td>Arabic</td>
<td>ملاحظة: إذا كنت تتحدث اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-346-4643-643-008-001 (رقم هاتف الصم والبكم: 711).</td>
</tr>
<tr>
<td>French</td>
<td>ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-346-4643 (ATS: 711).</td>
</tr>
<tr>
<td>Nepali</td>
<td>ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुस् भने तपाईको निमित्त भाषा सहायता सेवाहरू निम्नलिखित रुपमा उपलब्ध छ। फोन नम्बर 1-800-346-4643 (टिटिवाड़ा: 711)।</td>
</tr>
<tr>
<td>Japanese</td>
<td>注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-346-4643（TTY:711）まで、お電話にてご連絡ください。</td>
</tr>
</tbody>
</table>
Notice of Nondiscrimination


Yoruba: AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-800-346-4643 (TTY: 711).
Notice of Nondiscrimination

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

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

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

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

If you believe that RMHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: the RMHP EEO Officer at 800-346-4643, 970-244-7760, ext. 7883, or TTY 970-248-5019, 800-704-6370, Relay 711; para asistencia en español llame al 800-346-4643, or eeoofficer@rmhp.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the RMHP EEO Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).


RMHP is a Medicare-approved Cost plan. Enrollment in RMHP depends on contract renewal.