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.cnichs.com **or** http://secure.healthx.com/cnic_new.aspx or by calling **1-800-426-7453.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,000/**person **$4,000/**family for in-network. **$4,000/**person **$8,000/**family for out-of-network. Doesn't apply to in-network preventive care, routine vision exam or prescription drugs. Your employer contributes up to $750 person/$1,500 family into an HRA account on your behalf which can be used to cover a portion of your deductible.	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 offers.
Is there an out–of–pocket limit on my expenses?	Yes. **$2,500/**person **$5,000/**family for In-Network. **$5,000/**person **$10,000/**family for Out-of-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, copayments, balance-billed charges, cost containment penalties, prescription drug 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. For a list of participating providers in Colorado see www.rmhp.org or call **1-800-426-7453**. For providers outside of Colorado see www.aetna.com/asa or call **1-800-426-7453**.	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 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 page 6. 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 charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	50% coinsurance	----------None----------
	Specialist visit	10% coinsurance	50% coinsurance	----------None----------
	Other practitioner office visit	10% coinsurance for chiropractic care	50% coinsurance for chiropractic care	Chiropractic care limited to 24 visits per calendar year.
	Preventive care/ screening/immunization	No charge	50% coinsurance	----------None----------
If you have a test	Diagnostic test (X-ray, blood work)	10% coinsurance	50% coinsurance	----------None----------
	Imaging (CT/PET scans, MRIs)	10% coinsurance	50% coinsurance	Precertification required. Benefit payment will be reduced by 50% if precertification is not obtained.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at: **1-800-546-5677**	Generic drugs	$10 copay/script (retail); $25 copay/script (mail order)	Not covered	Covers up to a 30-day supply (retail); Covers up to a 90-day supply (mail order). Contraceptive medications required as part of preventive care services are covered at 100% with no copayment or deductible.
	Preferred brand drugs	20% up to $50 maximum copay/script (retail); 20% up to $125 maximum copay/script (mail order)	Not covered	
	Non-preferred brand drugs	25% up to $60 maximum copay/script (retail) 25% up to a $150 maximum copay/script (mail order)	Not covered	
	Specialty drugs	25% up to $60 maximum copay/script (retail only)	Not covered	Specialty drugs are not available through mail order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	50% coinsurance	Precertification required. Benefit payment will be reduced by 50% if precertification is not obtained.
	Physician/surgeon fees	10% coinsurance	50% coinsurance	----------None----------
If you need immediate medical attention	Emergency room services	10% coinsurance	10% coinsurance	----------None----------
	Emergency medical transportation	10% coinsurance	10% coinsurance	Precertification required for non-emergency ambulance. Benefit payment will reduced by 50% if precertification is not obtained.
	Urgent care	10% coinsurance	10% coinsurance	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	50% coinsurance	Precertification required. Benefit payment will be reduced by 50% if precertification is not obtained.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Physician/surgeon fee	10% coinsurance	50% coinsurance	----------None----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	50% coinsurance	Precertification required for intensive outpatient services. Benefit payment will be reduced by 50% if precertification is not obtained.
	Mental/Behavioral health inpatient services	10% coinsurance	50% coinsurance	Precertification required. Benefit payment will be reduced by 50% if precertification is not obtained.
	Substance use disorder outpatient services	10% coinsurance	50% coinsurance	Precertification required for intensive outpatient services. Benefit payment will be reduced by 50% if precertification is not obtained.
	Substance use disorder inpatient services	10% coinsurance	50% coinsurance	Precertification required. Benefit payment will be reduced by 50% if precertification is not obtained.
If you are pregnant	Prenatal and postnatal care	10% coinsurance	50% coinsurance	Precertification requested in first trimester.
	Delivery and all inpatient services	10% coinsurance	50% coinsurance	Precertification required. Benefit payment will be reduced by 50% if precertification is not obtained.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	50% coinsurance	Limited to 60 days per calendar year. Limit includes outpatient private duty nursing visits if approved as medically necessary.
	Rehabilitation services	10% coinsurance	50% coinsurance	Includes therapy services such as occupational, physical, speech and cognitive therapies. Limited to 20 visits each per calendar year.
	Habilitation services	Not covered	Not covered	----------None----------

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Skilled nursing care	10% coinsurance	50% coinsurance	Precertification required. Benefit payment will be reduced by 50% if precertification is not obtained. Limited to 60 days per calendar year.
	Durable medical equipment	10% coinsurance	50% coinsurance	Precertification required for charges greater than $1,500. Benefit payment will be reduced by 50% if precertification is not obtained.
	Hospice service	10% coinsurance	50% coinsurance	Precertification required for inpatient hospice care. Benefit payment will be reduced by 50% if precertification is not obtained. No precertification required for outpatient hospice care. Includes bereavement counseling.
If your child needs dental or eye care	Eye exam	$10 copay	$10 copay	Limited to 1 routine eye exam every 24 months. Routine eye exams received from an in-network provider are subject to the provider contract amount. Plan will reimburse up to $75 maximum for eye exams received from out-of-network providers.
	Glasses	Not covered	Not covered	----------None----------
	Dental check-up	Not covered	Not covered	----------None----------

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)
- Habilitation services
- Infertility treatment
- Long-term care
- Routine foot care – except when associated with diabetes and peripheral vascular disease.
- 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).

- Chiropractic care – Limited to 24 visits per year.
- Hearing aids for children – Replacement every 5 years
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing – 60 days/year if medically necessary; combined with home health care.
- Routine eye care – 1 exam every 24 months.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on 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, contact the plan at 303-776-6200. 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.cms.gov/cciio/

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 303-776-6200 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-426-7453.

Does this Coverage Provide Minimum Essential Coverage and Meet the Minimum Value Standard?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage" and establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This plan or policy does provide minimum essential coverage. This health coverage does meet the minimum value standard for the benefits it provides.**

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: $4,950**
- **Patient pays: $2,590**

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 (Rx)	$70
Coinsurance	$520
Limits or exclusions	$0
Total	**$2,590**

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

- **Amount owed to providers:** $5,400
- **Plan pays: $3,250**
- **Patient pays: $2,150**

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 (Rx)	$450
Coinsurance	$1,700
Limits or exclusions	$0
Total	**$2,150**

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.