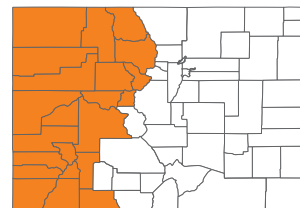




ROCKY MOUNTAIN HEALTH PLANS CHP+ BENEFITS BOOKLET

Child Health Plan Plus (CHP+)

Colorado Counties: Western Colorado



We are here to help and easy to reach.

Call Rocky Mountain Health Plans Customer Service at 970-244-7960 or 855-830-1563

Representatives are available Monday – Friday, 8:00 a.m. – 5:00 p.m.

If you are Deaf, hard of hearing, or have a speech disability, dial 711 for Relay Colorado or use our Live Chat on rmhp.org.

Email Rocky Mountain Health Plans at customer_service@rmhp.org

Receive a response within 24 business hours.

Live Chat with a Rocky Mountain Health Plans Representative on rmhp.org

Representatives are available Monday – Friday, 8 a.m. – 5 p.m.

Visit Rocky Mountain Health Plans at 2775 Crossroads Boulevard, Grand Junction

No appointment required. Representatives are available Monday – Friday, 8 a.m. – 5 p.m.

Para asistencia en español llame al 855-830-1563

For large print, call 855-830-1563

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Questions? Rocky Mountain Health Plans is here to help.

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You can also email us at customer_service@rmhp.org or visit rmhp.org.

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Para asistencia en español llame al 855-830-1563

Ask Rocky Mountain Health Plans

If you have a question, need help with your health care, or have a special need, please contact us. We're here to help.

This Member booklet has information about how your health plan works. A copy of your Rocky Mountain Health Plans Child Health Plan Plus (CHP+) Member Benefits Booklet is available to you each year or any time you want it. You can ask RMHP to mail it to you, or you can find it at rmhp.org. If you want someone to explain something from this Booklet, call us, and we can help. Or, you can visit us in person.

How to Contact Rocky Mountain Health Plans

- **Call Customer Service at 970-244-7960 or 855-830-1563 (toll free)** between the hours of 8:00 a.m. and 5:00 p.m. Monday through Friday, or visit us on the web at rmhp.org to learn more about your benefits, finding providers, authorizations, how to file a claim, and more.
- **Para asistencia en español, llame al 855-830-1563.** Español representantes de Servicio al Cliente están disponibles. Tenemos este libro en español. For callers who do not speak English or Spanish, RMHP uses Certified Languages International interpreters. RMHP provides interpretation services at no cost to Members. Tell us if you need interpreter services or help in other languages.
- **E-mail:** customer_service@rmhp.org
- **Online Chat:** rmhp.org, Monday-Friday, 8:00 a.m. – 5:00 p.m.
- **TTY and hearing impaired:** If you are Deaf, hard of hearing or have a speech disability, dial 711 for Relay Colorado You can use this service 24 hours a day 365 days a year. This service helps people that are hard-of-hearing communicate through a special state-sponsored service known as a relay center. Operators get calls from TTY users on their own TTY devices. The operator will speak the information to a hearing person using a telephone. When the hearing person replies, the relay operator types the response into their TTY phone and sends the response to the TTY user at the other end. If a hearing person needs to initiate a call to a TTY user, the hearing person will start the conversation and the relay center operator dials the hard-of hearing person's TTY device. The relay center can also help people with speech disabilities to communicate by phone. Sign language as well as oral interpretation services are available in any language to Members free of charge. To access these services, please contact Customer Service at the numbers listed above.

It is your choice to have RMHP CHP+. You can disenroll from this plan at any time for any reason. You will need to contact the county or organization that processed your CHP+ application and tell them that you want to disenroll. If you get other insurance, become covered by Medicaid, or move out of Colorado, you are no longer eligible for CHP+.

This Booklet is a guide to your CHP+ benefits. Please read it carefully to become familiar with your benefits, including limitations and exclusions. Ask us if you have any questions. You can get this benefits booklet in large print, a different language, or in another form that will work for you.

Questions? Rocky Mountain Health Plans is here to help.

Call us at 970-244-7960 / 855-830-1563 (TTY 711), Monday-Friday, 8:00 a.m. to 5:00 p.m.

You can also email us at customer_service@rmhp.org or visit rmhp.org.

Para asistencia en español llame al 855-830-1563

Welcome to Rocky Mountain Health Plans – How We Can Help

This booklet gives information about how Rocky Mountain Health Plans (RMHP) can help with your child's health. This CHP+ Member Benefits Booklet explains how to get medical and health care and how this health plan works, including limitations and exclusions. Covered services include medical, behavioral, vision, and oral health care services. If there are large changes we will let you know about them in writing 30 days before the change will take effect. The information will be sent to you by direct mail or published in our Newsletter. You may also find the information on our website. This includes changes about your rights, benefits, copayments, and any other changes to procedures that you need to follow as a Member of this plan.

RMHP has many health plans for people who live on the Western Slope. Each RMHP plan has the same network of providers. To be in this CHP+ plan you must have Child Health Plan Plus (CHP+) with RMHP as your health plan. Only children age 18 and under are eligible for RMHP's CHP+ plan.

RMHP recognizes the importance of accommodating the needs of all children and we strive to provide specialized care for each. All efforts will be taken to seek family or caretaker involvement for Members who may not be able to manage their own health care decisions, including children. RMHP provides alternative media formats for hearing and/or visually impaired Members as needed.

Do You Have Questions or Need Help With Your Health Care?

We are here to help and easy to reach. Contact RMHP to find answers to these questions and more.

- Have you not seen a doctor in more than a year?
- Do you need help finding a doctor?
- Do you need help getting health or medical care?
- Are you confused about your health care?
- Do you have an ongoing health condition?
- Do you need help with activities of daily living?
- Are you a loved one, caregiver, or family member of someone with health care needs?
- Do you smoke, drink, or use drugs and want help?
- Do you want to talk to a counselor?
- Do you want to know about other services in your community that can help you?
- Do you need help with life planning activities like an advanced care plan or advance directive?
- Do you need health care information in another language or format?
- Do you need large print?

Necesitas información en español? Para asistencia en español llame al 855-830-1563.

Questions? Rocky Mountain Health Plans is here to help.

Call us at 970-244-7960 / 855-830-1563 (TTY 711), Monday-Friday, 8:00 a.m. to 5:00 p.m.

You can also email us at customer_service@rmhp.org or visit rmhp.org.

Para asistencia en español llame al 855-830-1563

Important Community Phone Numbers and Links

Important Telephone Numbers

211 – for easy access to information about health and human services

911 – for emergency services

Colorado's CHP+ Customer Service for questions about Colorado's CHP+ program at 800-359-1991. This number is for all Colorado CHP+ Members, regardless of your CHP+ health plan.

Colorado's CHP+ Eligibility and Enrollment at 888-367-6557. This number is for all Colorado CHP+ Members, regardless of your CHP+ health plan.

Family Healthline (Information about health care programs and resources) at 800-688-7777 (toll free)

Rocky Mountain Poison Center at 800-332-3073

Delta Dental (Routine CHP+ dental benefits for children) at 800-610-0201

Important Websites

rmhp.org

This website has information about RMHP, including RMHP's providers, an electronic copy of this CHP+ Member Benefits Booklet, and more.

CHPplus.org

This Colorado CHP+ website offers information on benefits, how to apply for CHP+, and other information for CHP+ Members and families.

connectforhealthco.com

If you lose eligibility for Colorado CHP+ and need health insurance, go to Connect for Health Colorado or contact RMHP for help.

colorado.gov/peak

This website, called PEAK, is a quick and easy way for people in Colorado to apply for medical, food, and cash assistance programs. CHP+ Members can create an account in PEAK to update their contact information for CHP+.

Questions? Rocky Mountain Health Plans is here to help.

Call us at 970-244-7960 / 855-830-1563 (TTY 711), Monday-Friday, 8:00 a.m. to 5:00 p.m.

You can also email us at customer_service@rmhp.org or visit rmhp.org.

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Information for New Members

The following information is mailed to new Members:

- Getting Started Guide – this Member guide provides information and resources to help you get the care you need.
- Notice of CHP+ Copay – this one page document lists your CHP+ copayments.
- Rocky Mountain Health Plans ID card – this ID card shows your name and your RMHP plan name. Show this to providers so they know who to bill for your care.

The most current CHP+ Benefits Booklet and Provider Directory are at rmhp.org, where you can view or print these documents. You can also ask RMHP Customer Service to mail a copy to you at any time at no cost.

I am a New Member. What Do I Do Now?

Each year you should see a primary care doctor, even if you feel well. Primary care doctors are pediatricians, family practitioners, and for some older children, internal medicine doctors and gynecologists. This doctor will help with well-care exams and will refer you to other doctors or health care providers as necessary.

1) Pick a primary care provider (PCP)

We encourage all CHP+ Members to choose a primary care provider. This doctor is who you want to see for your yearly check-up, and who you want to call when you are sick. This doctor will help with well-care exams and will refer to other doctors or medical providers as needed.

Look in the RMHP Provider Directory. If you need a copy, go to rmhp.org, or call RMHP Customer Service. If you have a doctor or primary care provider, look to see if this clinic or medical provider is listed. If you do not have a doctor or clinic that you use for your well care, use the information in the directory to pick a primary care provider.

2) Make an appointment now with your PCP.

Call the doctor's office and make an appointment if you have not had a visit at the doctor's office in the past 12 months. Children should see a doctor at least once a year, and for younger children, even more frequently. It is important to see your doctor when you are well so the doctor knows you and can help when you are sick. When you feel sick, tell your doctor. Your doctor will see you or will refer you to other medical and health care providers who can help you. If you cannot make a visit, call and tell your doctor at least one day before the scheduled visit.

Questions? Rocky Mountain Health Plans is here to help.

Call us at 970-244-7960 / 855-830-1563 (TTY 711), Monday-Friday, 8:00 a.m. to 5:00 p.m.

You can also email us at customer_service@rmhp.org or visit rmhp.org.

Para asistencia en español llame al 855-830-1563

3) Do you need help with your health care needs now?

Ask RMHP for help. We work with doctors and people in your community who can help.

4) Show your Rocky Mountain Health Plans ID card

You were mailed an RMHP Member ID card. Show this ID card any time you go to the hospital, doctor, or get prescription drugs. This will tell people where to send the bill. If you need another card, ask RMHP.

The Importance of a Medical Home

RMHP encourages each Member to develop a relationship with a primary care provider. This is known as having a Medical Home. Having a medical home is an important step in helping you get healthy, stay healthy, and get the care you need when you are sick.

If you have prescriptions or you are getting care from a specialist, talk to your PCP about it. Your PCP needs to know everything about your health to help you get the care you need.

How Your Primary Care Provider (PCP) and Medical Home Can Help You

Your PCP and medical home can:

- Know you, care for you, and keep your medical records together
- Help you maintain overall health by providing preventive care, which can find health problems early
- Help you get care from specialists or connect you with services in your area when you need it
- Treat you as a whole person instead of focusing on a particular illness or injury
- Help you achieve the health goals you set for yourself
- Help you control ongoing health conditions, like asthma and diabetes
- Help you navigate the health care system, which can be complicated and confusing

In return, you should:

- See your PCP at least once a year for a wellness exam, more frequently for younger children
- Let your PCP know when you are ill or need medical care
- Keep scheduled appointments or let your PCP know you need to reschedule
- Let your PCP know how they can improve

Go to a primary care provider:

- For checkups and shots
- For care when sick or hurt
- To ask questions about your child's health and development

Questions? Rocky Mountain Health Plans is here to help.

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- For help finding a specialist if you need one
- For help getting the care ordered by specialty doctors; for example, surgery or therapy
- To admit you to a hospital if needed

How to Change Your PCP

If you want to change your PCP, follow the steps above for picking a PCP. You can change your PCP at any time. Information in the Provider Directory includes the names, titles, addresses and telephone numbers of providers that are in RMHP's network. This means you can see these providers without contacting RMHP first. If you need a Provider Directory or need help finding a PCP in your area, call RMHP Customer Service. RMHP's online provider directory at rmhp.org also gives you information about contracted providers in your area who speak languages other than English, and which providers accept new patients. If you are changing doctors because you moved, call RMHP and let us know so we have your new address. Call RMHP if you need help changing your PCP.

In-Network Providers

Make sure that any health care provider that you see is a participating RMHP provider. If you receive care from a provider who does not accept RMHP, you may have to pay for the services you get.

RMHP Member Identification Card (ID Card)

Your RMHP Member ID card shows that you are a Member of the RMHP CHP+ plan. An RMHP Member ID card is sent to all new Members. An updated Member ID card is also sent each time the information on your card changes. Bring this RMHP Member ID card with you when you get medical care. This includes all pharmacies (when you get prescription medications), doctors, hospitals, and any medical supplies. If you need a new RMHP Member ID card, or you did not receive your card, call RMHP Customer Service.

The Member named on the ID card is the only person authorized to use the card. To help protect your information, follow these easy steps:

- Guard your Member ID card. Sharing your card with someone can put you at risk. Don't share it with anyone. If someone gets health care using your name or information, you might not be able to get care when you need it.
- Treat your Member ID card like a credit card or driver's license. Keep it in a secure place.
- Don't let anyone borrow your Member ID card. Be sure to watch out for people looking over your shoulder when you use your card at a pharmacy, doctor's office, or other public place.
- Don't share your information in exchange for free gifts or services. If someone uses your information, money that should be used to pay for your care is being stolen.

If you lose your Member ID card or if it is stolen, call Customer Service right away. We will order a new one for you. Your new card will come in the mail in a few weeks.

Questions? Rocky Mountain Health Plans is here to help.

Call us at 970-244-7960 / 855-830-1563 (TTY 711), Monday-Friday, 8:00 a.m. to 5:00 p.m.

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Keep Your Mailing Address Accurate

RMHP and the State CHP+ program mails important information. This includes important notices about when and how to renew your CHP+ coverage and any changes or important information about your health or benefits. If you move or change your address, let the CHP+ program know about this change as soon as possible.

- Tell the CHP+ program of your new address. Do this by calling CHP+ Eligibility and Enrollment at 888-637-6557 or go to PEAK at Colorado.gov/PEAK to change your address online.
- Call RMHP Customer Service at the number at the bottom of this page. If the change cannot be made over the phone, Customer Service staff will explain how to make the change.

If you do not receive a renewal notice because you did not report your address change (or for any other reason), this may affect your CHP+ coverage. You must submit a renewal application by your renewal date to continue coverage uninterrupted. When you move and need to find a primary care provider closer to you, RMHP Customer Service can help you to find a PCP closer to your new address.

Questions? Rocky Mountain Health Plans is here to help.

Call us at 970-244-7960 / 855-830-1563 (TTY 711), Monday-Friday, 8:00 a.m. to 5:00 p.m.

You can also email us at customer_service@rmhp.org or visit rmhp.org.

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Summary of Covered Benefits

This is a summary of covered benefits while enrolled in this CHP+ plan. This Booklet includes more information about what is covered and any exclusions. You may have to share in the cost of the health care you get. This cost sharing is called a copayment, or copay. See the copay table in this Booklet for more information. If you have any questions about your covered benefits, call RMHP Customer Service.

Service	Summary of Available Benefits See Benefit Booklet for More Detail
Alcohol and Substance Abuse	Coverage for medically necessary outpatient services.
Audiological Services	Coverage for age-appropriate preventive care visits.
Behavioral or Mental Health Care Services	Coverage for medically necessary services.
Dental Care provided by Delta Dental	Contact Delta Dental at 800-610-0201 or deltadentalco.com/chp.aspx for CHP+ dental benefits, such as cleanings, exams, x-rays, fillings, and benefit limits.
Dental Care for accidental injury and cleft palate	This plan provides coverage for accidental injury and limited cleft palate dental care.
Durable Medical Equipment	Maximum of \$2,000 per calendar year, excluding eyeglasses, contacts or hearing aids.
Emergency Room and Urgent/After-hours Care	Coverage for a life or limb-threatening emergency. Standard CHP+ copays may apply.
Emergency Transport/ Ambulance Services	Coverage for a life or limb-threatening emergency if transported in a licensed ambulance.
Home Health Care and Home Infusion Therapy	Coverage for skilled home nursing services.
Inpatient Hospital Stay	Coverage for inpatient hospital services
Lab, X-ray, and Diagnostic Services	Coverage for lab, x-ray, and diagnostic services
Maternity Care	Coverage for prenatal and delivery services
Medical Office Visit	Coverage for primary care provider (PCP) visits and specialty visits with in-network providers
Outpatient/ Ambulatory Surgery	Coverage for outpatient/ ambulatory surgery

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Service	<p align="center">Summary of Available Benefits See Benefit Booklet for More Detail</p>
Prescription Drugs (Medications)	Covered if included on RMHP’s Good Health prescription drug list.
Preventive Care	Covered in full when provided by a primary care provider that participates with RMHP. Includes immunizations (shots), checkups, and routine exams. Children need many preventive care services. If you are not sure if your child needs preventive care services, ask your child’s primary care provider if any care is needed.
Reproductive Health Care Services	Covered in full when provided by a family planning provider, a primary care provider, an obstetrician/ gynecologist, or other
Skilled Nursing Facility	Covered for up to 30 calendar days per benefit year or less than 30 days when your condition cannot be improved any further.
Therapy – Occupational, Physical, and Speech	Coverage for outpatient physical rehabilitation (physical, occupational, and/or speech therapy includes up to 30 visits per calendar year per diagnosis. For children ages 0 – 3, the benefit of physical, occupational, and speech therapy is unlimited through the Early Intervention Program.
Transplant Services	Coverage provided for limited transplants.
Vision Services	Coverage for age-appropriate preventive care and specialty care visits. Coverage includes a \$50 benefit for the purchase of lenses, frames or contacts per calendar year.

Exclusions: Services not shown above may not be covered. For more information, please call Customer Service at 970-244-7960 or 855-830-1563 (toll free) (TTY: 711). This is for summary purposes only and does not guarantee coverage or define cost share.

Questions? Rocky Mountain Health Plans is here to help.

Call us at 970-244-7960 / 855-830-1563 (TTY 711), Monday-Friday, 8:00 a.m. to 5:00 p.m.

You can also email us at customer_service@rmhp.org or visit rmhp.org.

Para asistencia en español llame al 855-830-1563

1: Getting Care

Your Doctor or Primary Care Provider is Important

The first thing you should do after joining RMHP is pick a doctor to see when you are sick and for routine care. This doctor may be called or known as your doctor, your primary care provider, or your PCP. If you have not seen a doctor in the past year, call this doctor and make an appointment. This doctor is very important. He or she provides or arranges for most of the care you will need. If you are new to RMHP and you have special health care needs and are seeing a doctor that is not on our list, you can:

- Keep seeing your previous primary care doctor for 60 calendar days. You can keep getting the same ongoing care you got before you joined RMHP.
- Keep seeing your other doctors for 75 calendar days. You can keep getting the same care you got before you joined RMHP.
- Keep seeing your previous primary care doctor if you are in your fourth through ninth month of pregnancy. You can keep seeing your previous primary care doctor until you finish the care you need following the birth of your child.

How to pick a doctor or PCP

1. RMHP has a Provider Directory that lists doctors in your county. Look for a doctor that you want to see when you are healthy and when you are sick. This doctor may have a focus on primary care, pediatrics, or general practice. If you do not know the doctors on the list, pick a doctor with an office close to your home.
2. If you pick a doctor you have not seen before, call the doctor's office. Ask the office if they are taking new patients. If they are open to new patients, tell them you are picking a PCP for an RMHP CHP+ Member. If the RMHP CHP+ Member has not seen a doctor in the past year, make an appointment. Keep the scheduled appointment, or let the doctor's office know if you need to reschedule. The doctor may have you sign a form that says you want them as your medical home.
3. Call RMHP Customer Service if you need help finding a PCP or if you need a Provider Directory. Each person in your family can have a different PCP.

How to change a doctor or PCP

If you want to change your primary care doctor or PCP, follow the steps above for picking a PCP. You can change your PCP at any time. It is important for all RMHP Members to have a primary care provider. If you are changing doctors because you moved, call RMHP and let us know too so we have your new address. Call RMHP if you need help changing your doctor or PCP.

Making an appointment with a primary care doctor or PCP

Call the doctor or PCP's office and tell them you are scheduling an appointment for an RMHP CHP+

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Call us at 970-244-7960 / 855-830-1563 (TTY 711), Monday-Friday, 8:00 a.m. to 5:00 p.m.

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Member. Give them the RMHP Member ID number from the Member ID card if asked. For non-urgent illness or injuries, you will get an appointment within 30 days of the day you call. If you are too sick to wait 30 days, you can be seen within 48 hours. For well-child physical exams, you should be able to get an appointment within 30 days of the day you call. You should also be able to schedule non-urgent substance abuse visits and non-urgent mental health visits within 14 calendar days. If you can't get in to see your PCP as fast as you think you should, call RMHP.

Canceling doctor appointments

If you can't make it to your doctor's appointment, you must call the doctor's office and tell them as soon as possible. You should call at least 12 hours before your appointment to tell them you need to cancel.

Changes to your plan and to your PCP

RMHP will let you know by mail about any changes to your plan or to your doctor. We will write you a letter if your primary care doctor leaves RMHP. Then, you will need to follow the directions in this book to pick another PCP. If you need help finding another PCP, call RMHP Customer Service. You can also leave RMHP if you want to stay with the PCP who is leaving RMHP.

About the Health Care Providers That Work With RMHP

You can find health care providers that work with RMHP in the Provider Directory. You will find names, addresses, phone numbers and any non-English languages that may be spoken at each provider location. You will also see if the provider is not accepting new patients. The directory is available on our website at rmhp.org, or you can get a printed copy by calling Customer Service. RMHP looks at information about the providers before we work with them. This includes their license, education and training. We also check their background and experience. Customer Service can also help you find out about a health care provider's professional qualifications such as their schooling and certifications. If you have a question about your doctor, call us.

Specialty care

Sometimes when you see your PCP, he or she will want you to get specialty care. You do not need a referral to see a specialist that works with RMHP. The specialty care you receive must be on the list of covered services in the "Covered Services" section in this booklet or you can call RMHP Customer Service to ask if the care is covered.

Call and make an appointment with the specialist. Be sure to show your RMHP Member ID card when you go to your appointment. Tell your specialist who your primary care doctor is so your specialist can work with your doctor and other members of your health care team.

Access

You should be able to get most of your health care from doctors within 30 miles or a 30-minute drive from your home. If you live out of town or in a small town, there may not be a doctor close by. In this case, you will be able to see the nearest available doctor who works with us. If you cannot find a doctor close to you, call Customer Service for help.

Questions? Rocky Mountain Health Plans is here to help.

Call us at 970-244-7960 / 855-830-1563 (TTY 711), Monday-Friday, 8:00 a.m. to 5:00 p.m.

You can also email us at customer_service@rmhp.org or visit rmhp.org.

Para asistencia en español llame al 855-830-1563

Mental and Behavioral Health Services

RMHP covers mental and behavioral health services under this plan. See the *Mental Health Care* section of this benefits booklet for more information.

Hospital care

RMHP will pay for your stay in a hospital when it is arranged by your doctor. Unless you need emergency care, you must go to a hospital that works with us. Remember to show your Rocky Mountain Health Plans ID card when you get to the hospital.

Care for pregnancy

You can go to any doctor in our Provider Directory for covered services. This includes women's services. It also includes care when you are pregnant. Some of these doctors are specialists like obstetricians, gynecologists, and certified nurse midwives. See the "Covered Services" section in this handbook for details.

Getting prescription drugs

You must get your drugs from a drugstore that is participating with RMHP. This includes most pharmacies in Colorado. Show your RMHP Member ID card at the drug store when you pick up your prescription. Some drugs are not covered. If you want a drug that isn't covered, you will have to pay for it yourself. Some drugs must be approved by RMHP before you get them. Your doctor should know how to ask RMHP to approve these drugs.

If you want a brand name drug when you could get the same drug in a generic form, you will pay a higher copayment plus the difference in cost between the brand name and generic drug. Your doctor might be able to give us records and other information we require that will show us you must have the brand name drug. If your doctor can prove to us the generic drug does not work for you, RMHP may approve for you to pay the brand name copayment only without having to pay the cost difference.

You can get your drug(s) from any drugstore if you have an emergency away from home. Send us the receipt within 120 days of buying the medicine and we will pay you back for it. We can't pay you back if you send us the receipt after 120 days.

Doctors that do not work with Rocky Mountain Health Plans

In general, care from doctors that do not work with RMHP is not covered and you must go to doctors, hospitals, and drugstores listed in our Provider Directory. This does not apply to Emergency Care, Urgent Care and family planning services. If you have questions about which doctors you can see, call Rocky Mountain Health Plans Customer Service.

Call Customer Service if you need care that you cannot get from a doctor that works with RMHP. You must have permission before going to a doctor that does not work with RMHP. If RMHP gives you permission to see a doctor that does not work with RMHP, you will not have to pay extra for the care you get.

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Pre-authorization

RMHP must approve some types of care before you receive it. This helps make sure the care you get will work for you and that the care is medically necessary. The best thing to do is to be sure all your care is arranged by your PCP. Your PCP knows what services need pre-authorization and how to ask RMHP for an approval. RMHP's Care Management department reviews requests from providers and determines medical necessity. This is also known as utilization management. Examples of services that need pre-authorization are some surgeries and prescription drugs, most services out of RMHP's network, and medical equipment like wheelchairs. If you have questions about RMHP's utilization management program, call Customer Service at the number below and ask to talk to someone in care management. You have the right to appeal any action that RMHP makes. For example, if RMHP denies a service that your doctor requested for you, you can ask RMHP to take a second look. More information about your rights to complain and appeal is included in this booklet, or call Customer Service for help.

Coverage is limited to the benefits outlined in this CHP+ Member Benefits Booklet. A pre-authorization does not guarantee payment. Fraud or abuse may cause a denial of payment. Also, when a claim (a bill from your health care provider) is received by RMHP, it is reviewed using this CHP+ Member Benefits Booklet as a tool for determining coverage. If the claim received describes a service that is not a covered benefit, the claim may be denied. The claim may also be denied if the service described on the claim is different than the service that was pre-authorized.

Rocky Mountain Health Plans Has People Who Can Help

Who can help me with my health care needs?

Primary Care Provider

Ask your child's primary care provider how frequently your child should visit the doctor's office. Children need a visit with a primary care provider at least once a year, even when they are well. Primary care providers will either provide the health and medical care that you need, or will refer you to another provider or to services and supports that can help you. Many primary care practices in RMHP's network have participated in activities to be an advanced primary care practice or are designated as a certified primary care medical home.

Rocky Mountain Health Plans Care Coordinator

RMHP Care Coordinators are Registered Nurses that are here to help Members. Care Coordinators:

- Know about health care and how to help you navigate the health care system
- Know about community services that can help get you the care you need
- Work with you and other health care providers to help reach health goals
- Can explain covered services
- Know how to deal with all types of medical problems

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- Can help with referrals for pregnant women and children with special needs
- Can help coordinate services with community partners

Our nurses can help you with any of your needs or answer questions about your care. Here are examples of how a Care Coordinator can help:

- You have a surgery scheduled and want more information about it.
- Your doctor ordered tests or medications that you have questions about.
- You have a disease or medical problem, and you have questions.

Care Coordinators at RMHP work with your doctors to make sure they talk to each other about your care. Care Coordinators also check to see if other services may work for you. This helps to make sure you are getting care that is medically necessary.

Having special health care needs can be frightening and difficult, but RMHP is here to help you. We want you to follow your doctor's treatment plan and learn about your special needs. Our nurses and Care Coordinators will work with you one-on-one.

If you are pregnant, Rocky Mountain Health Plans can help you have a healthy baby. We can talk to you to see if you are at risk of having your baby early. Our nurses can also help you with special issues such as: twins, breast-feeding, premature labor, diabetes, bed rest, and stop-smoking programs.

If your coverage ends, and you still need care, we can tell you about available options. We can help you with questions about our programs or your claims.

How to contact RMHP Care Coordination

Sometimes your doctor or hospital may tell RMHP that an RMHP Member needs a Care Coordinator. You can also call and ask us for help. Here is how to reach us.

- Call Customer Service at 970-244-7860 or 855-830-1563 and ask to speak to a Care Coordinator
- If you need language assistance you can call us
- If you are Deaf, hard of hearing, or have a speech disability, dial 711 for Relay Colorado or use our Live Chat on **rmhp.org**
- You can also send a fax to 970-254-5738 or toll-free 877-201-7302
- Care Coordination staff are available Monday through Friday, 8:00 a.m. to 5:00 p.m.
- After hours you can leave a message and we will call you back the next business day

Questions? Rocky Mountain Health Plans is here to help.

Call us at 970-244-7960 / 855-830-1563 (TTY 711), Monday-Friday, 8:00 a.m. to 5:00 p.m.

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Para asistencia en español llame al 855-830-1563

2: Member Rights & Responsibilities

As a Member, You Have the Right:

- To get information about RMHP and its services, doctors, and health care providers and to get information about your rights and responsibilities
- To be treated with respect and with recognition of your dignity and right of privacy
- To accept or refuse medical treatment to the extent provided by Colorado state law and to participate in making decisions about your health care
- To have open discussions with health care providers about appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage, and presented in a manner appropriate to your condition and ability to understand
- To make appeals, and to bring complaints to RMHP, the Insurance Commissioner of the State of Colorado, or the Department of Health Care Policy and Financing
- To be furnished health care services in accordance with federal health care regulations for access and availability, care coordination and quality
- To expect all communications regarding your care to be kept confidential as required by law
- To freely exercise your rights without being treated differently
- To be free from the use of physical restraint or being isolated. These methods may not be used to make you cooperate, to punish you, for the ease of the caregiver, or as a way of getting back at you
- To get family planning services from any Health First Colorado provider in or out of RMHP's network, with no referral
- To request and receive your medical records and to have them changed according to federal law
- To get a second opinion with no referral
- To be free from discrimination based on race, color, national origin, age, disability, sex, sexual orientation, or gender identity
- To make recommendations regarding RMHP's rights and responsibilities policy
- To use any hospital or other setting for emergency care

As a Member, You Have the Responsibility:

- To choose a Primary Care Physician (PCP) for each member of your family and to let that PCP know of any advance directive regarding your medical care
- To let your PCP direct your care with specialists and other health care providers, except in cases of medical emergencies, urgent care when outside the service area, obstetrical or gynecological care, and eye care

Questions? Rocky Mountain Health Plans is here to help.

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- To learn about your RMHP health care benefits, procedures, and limitations and to be cooperative and considerate with health care providers and staff
- To notify RMHP Customer Service of membership or address changes, marriage, birth of a child, or adoption of a child
- To take responsibility for copayments and costs for certain health care services and any services that are not covered by CHP+
- To provide the health care provider with all information needed for you to receive appropriate care and to follow the care and instructions agreed upon with your provider
- To follow the plans and instructions for care that you and your provider agreed on
- To tell your providers about any Advance Directives about your health care
- To follow any protocols of a responsible third party payor (such as other insurance) prior to receiving any non-emergency services
- To provide RMHP with written notice after filing a claim or action against a third party responsible for your illness or injury
- To understand your health problems and participate in making treatment goals
- To tell RMHP about any other insurance you may have, including Medicare
- To file a complaint or grievance, please follow the rules as described in the Appeal and Grievance section of this handbook

Your Right to Make Health Care Decisions - Advance Directives

What is an Advance Directive?

It is a type of written instruction about the health care to be followed if you become unable to make decisions about medical treatment. You prepare your Advance Directive when you are able to make these decisions. Then, if there is a time when you are unable to make health treatment decisions, the directive will be followed. These instructions do not take away your right to decide what you want, if you are able to do so at the time a decision is needed.

There are three kinds of Advance Directives:

- **A CPR Directive**, sometimes called a DNR or do not resuscitate order, tells emergency health care personnel and others not to do CPR on you. CPR is short for cardiopulmonary resuscitation.
- **A Medical Durable Power of Attorney** allows you to name a person who can make health decisions for you.
- **A Living Will** applies only in cases of terminal illness. This means a disease or injury that leads to death.

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If you decide to have an Advance Directive, it is important to talk to your doctor, family, and other people about your choices, or if you change them. Give copies of your Advance Medical Directive to your doctor, family members, and health care proxy if you have one.

Does RMHP require me to fill out an Advance Directive?

No. The law states that you will not be denied services, treatment, or being admitted to a facility if you chose not to sign an Advance Directive. The law applies to all adults, no matter their health problem or condition.

Know the law

At RMHP, we want you to know your rights when it comes to making decisions about your health.

You will not be refused treatment, services, or admission to a facility if you do not fill out an Advance Directive.

You have the right to accept or turn down any medical care and treatment, unless care is ordered by a court.

In an emergency, your consent to CPR, health care, and treatment is assumed. We will tell you about Colorado's laws regarding your right to make health care decisions.

You must be given information about Advance Directives each time you are admitted as a patient or become a resident of:

- Any health care facility that gets Medicare or Colorado Medicaid money
- A nursing home, an HMO, hospice, home health care, or a personal care program that gets Medicare or Colorado Medicaid money

You must also be given written information on the facility and provider policies about Advance Directives.

Colorado law states:

Before you are no longer able to make your own choices, you can fill out a Medical Durable Power of Attorney. This legal document names or appoints the person who will make legal and health care decisions if you are not able to do so.

Once you are no longer able to make your own choices, if you have not filled out an Advance Medical Directive:

- A person close to you can be a proxy. A proxy is a substitute decision maker.
- The doctor or the doctor's designee must make reasonable efforts to get in touch with those close to the patient. The goal is to find a proxy or substitute decision maker.

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How do I complain if my Advance Directive isn't followed?

Complaints about providers who are not following a Member's advance directive requirements may be filed with the Colorado Department of Public Health and Environment. Send the complaint to:

Health Facilities and Emergency Medical Services Division
Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South
Denver, CO 80246-1530
Call 303-692-2836.

Advance Directives Coalition

The booklet "Your Right to Make Health Care Decisions" was prepared by the Advance Directives Coalition in collaboration with the Colorado Hospital Association.

You can get a free single copy of the booklet from the Colorado Hospital Association.
Call 720-489-1630.

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3: What You Pay For Enrollment & Service

For Members enrolled in this plan, RMHP pays for health care for you under a contract with the Colorado Department of Health Care Policy and Financing. That contract and state and federal laws control the health care services you get. This handbook is not a contract and is subject to change.

Enrollment Fee

Families may pay an annual fee of \$0, \$25, or \$75 to enroll one child and \$0, \$35, or \$105 to enroll two or more children in CHP+. This enrollment fee is based on family size and income. Most families will not have to pay an annual enrollment fee or make copayments.

Copayments (Cost-Sharing)

Cost sharing refers to how Members share the cost of health care services. It defines what RMHP is responsible for paying and what you as the Member are responsible for paying. Members satisfy the cost-sharing requirements through the payment of copayments as described in this section.

A copayment is a dollar amount you pay in order to receive a specific service, medical supply or prescription medication. You are responsible for paying your copayment to your provider at the time of service or when getting a prescription medication.

Following federal rules, CHP+ Members who are American Indians or Alaskan Natives do not have to pay any copays or cost sharing. American Indians are members of a federally recognized Indian tribe, band, or group, or a descendant in the first or second degree of any such member. Alaskan Natives are an Eskimo, Aleut, or other Alaska Native enrolled by the Secretary of the Interior.

The standard CHP+ copayments range from \$0 to \$20 per visit. CHP+ Program copayments are based on family size and income. Your copayment amounts are listed on your RMHP Member ID card. There are no copayments for preventive visits. In addition, there are no copayments for family planning services or prenatal care services. The following table gives some examples of copayment amounts.

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Para asistencia en español llame al 855-830-1563

This plan's benefits	Copay			
	RMHP Copay Level L	RMHP Copay Level M	RMHP Copay Level H	RMHP Copay Level HS
Annual Deductible Individual Family	None	None	None	None
Out-of-Pocket Limit Individual Family	None	5% of annual family income adjusted for family size	5% of annual family income adjusted for family size	5% of annual family income adjusted for family size
Emergency Care	\$3	\$3	\$30	\$50
Urgent/After Hour Care	\$1	\$1	\$20	\$30
Emergency Transport/ Ambulance Services	\$0	\$2	\$15	\$25
Hospital/Other Facility Services <ul style="list-style-type: none"> • Inpatient • Physician • Outpatient/Ambulatory 	\$0 \$0 \$0	\$2 \$2 \$2	\$20 \$5 \$5	\$50 \$10 \$10
Routine Medical Office Visits	\$0	\$2	\$5	\$10
Fluoride Varnish Application	\$0	\$0	\$0	\$0
Laboratory and X-ray	\$0	\$0	\$5	\$10
Preventive, Routine, and Family Planning Services	\$0	\$0	\$0	\$0
Maternity Care <ul style="list-style-type: none"> • Prenatal • Delivery & Inpatient Well Baby Care 	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0
Mental Illness Care	\$0	\$2/office visit \$2/admission	\$5/office visit \$20/admission	\$10/office visit \$50/admission
Neurobiologically-based Mental Illness	\$0	\$2/office visit \$2/admission	\$5/office visit \$20/admission	\$10/office visit \$50/admission

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This plan's benefits	Copay			
	RMHP Copay Level L	RMHP Copay Level M	RMHP Copay Level H	RMHP Copay Level HS
Mental Disorders	\$0	\$2/office visit \$2/admission	\$5/office visit \$20/admission	\$10/office visit \$50/admission
All Other				
Inpatient	\$0	\$2	\$20	\$50
Outpatient	\$0	\$2	\$5	\$10
Outpatient Substance Abuse Treatment Services	\$0	\$2	\$5	\$10
Physical Therapy, Speech Therapy, and Occupational Therapy	\$0	\$2	\$5	\$10
Durable Medical Equipment	\$0	\$0	\$0	\$0
Transplants	\$0	\$0	\$0	\$0
Home Health Care	\$0	\$0	\$0	\$0
Hospice Care	\$0	\$0	\$0	\$0
Prescription Drugs	\$0	\$1/generic or brand name	\$3/generic \$10/brand name	\$5/generic \$15/brand name
Kidney Dialysis	\$0	\$0	\$0	\$0
Skilled Nursing Facility Care	\$0	\$0	\$0	\$0
Routine Vision Services	\$0	\$0	\$0	\$0
Specialty Vision Services	\$0	\$2	\$5	\$10
Audiology Services	\$0	\$0	\$0	\$0
Intractable Pain	\$0	\$2/office visit \$2/admission	\$5/office visit \$20/admission	\$10/office visit \$50/admission
Autism Coverage	\$0	\$2/office visit \$2/admission	\$5/office visit \$20/admission	\$10/office visit \$50/admission

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Para asistencia en español llame al 855-830-1563

This plan's benefits	Copay			
	RMHP Copay Level L	RMHP Copay Level M	RMHP Copay Level H	RMHP Copay Level HS
Case Management	\$0	\$0	\$0	\$0
Dietary Counseling/ Nutritional Services	\$0	\$0	\$0	\$0
Lifetime Maximum	None	None	None	None
Dental Related	None	None	None	None
Pre-existing Condition Limitations	Not applicable	Not applicable	Not applicable	Not applicable
Therapies: Chemotherapy and Radiation	\$0	\$0	\$0	\$0

Annual Out-of-Pocket Limit

The out-of-pocket annual maximum is designed to protect Members' families from catastrophic health care expenses. The annual out-of-pocket limit is 5 percent of your adjusted gross income. Once the copayments you have paid for covered medical services during a calendar year reaches the annual out-of-pocket limit, you do not pay a copayment for the rest of that calendar year.

It is your responsibility to keep track of all the money you spend toward the annual out-of-pocket limit. Follow these instructions to keep track:

- Save your copayment receipts from covered medical care and covered prescription medications.
- When you have reached your annual out-of-pocket limit, call Colorado's CHP+ Customer Service at 800-359-1991.
- CHP+ Eligibility and Enrollment will ask for proof that you have reached your annual out-of-pocket limit. Send copies of your receipts as proof.

Hold Harmless

The contracts between RMHP and its providers include a "hold harmless clause." This clause says that you cannot be billed by the provider beyond what is paid by RMHP or the CHP+ program in accordance with the fee schedule. The fee schedule is the amount the provider agrees to accept from RMHP for services provided to Members. If you are billed by an in-network provider, call RMHP Customer Service.

When You Can be Billed for Services

You might have to pay for services if:

- You receive non-emergency care from an out-of-network provider and the service is not authorized.

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- You receive any non-covered service.
- You receive services (for example, day surgery) without an authorization from RMHP.
- You receive services when you are not covered by CHP+ program coverage.

Claims Payment

Services from in-network providers

When an in-network provider bills RMHP for covered services, RMHP will pay the appropriate charges for the covered service directly to the provider. You are responsible for giving the in-network provider all necessary information, such as your ID card, so that the provider can submit a claim to RMHP. You are responsible for the applicable copayment when you receive covered services.

Services from out-of-network providers

Non-emergency services from out-of-network providers (one who is not contracted to provide services for RMHP CHP+ Members) are not covered unless they are authorized by RMHP. If services from an out-of-network provider are authorized, the copayments for these authorized services are the same as copayments for covered services received from an in-network provider.

You may be responsible for non-emergency and non-urgent care services received outside of the service area or from an out-of-network provider. It is your responsibility to make sure that the provider is in-network with RMHP before you receive services.

In the case of emergency or urgent care, let the hospital or urgent care provider know that the claim must be sent to the address on the back of your RMHP Member ID card. If you don't have your card, call RMHP Customer Service for help.

- If the out-of-network hospital accepts payment from RMHP, then the hospital is reimbursed directly. You will be responsible for any applicable copayment amount that may apply.
- If the hospital will not accept payment from RMHP, then you are responsible for paying the hospital directly.
- After you pay the hospital, you may request reimbursement from RMHP by submitting proof that you paid for the service. An example of proof of payment is a receipt from the hospital that shows the payment or payments you made.

Member Claims Payment

This section explains how to file a claim and to receive reimbursement for services. If you are billed for services and you have questions or concerns about if you are responsible, ask RMHP for help. Most providers will not bill you. Some non-participating or out-of-area providers may bill you.

Questions? Rocky Mountain Health Plans is here to help.

Call us at 970-244-7960 / 855-830-1563 (TTY 711), Monday-Friday, 8:00 a.m. to 5:00 p.m.

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Acceptable claims

Because participating providers handle the paperwork for you, RMHP does not have standard claim forms. However, if you receive covered services from a nonparticipating or out-of-area provider, you must submit itemized bills containing the following information: Your identification number; your name and address; your date of birth; date(s) of service or purchase; diagnosis and type of treatment; procedure and amount charged; accident or surgery date (when applicable); name and address of the provider; and copayment paid, if any.

When you receive an itemized bill from a nonparticipating hospital for emergency care or urgent care, send it to RMHP. RMHP requires proof of payment, such as a receipt, to reimburse you directly. Prescription drug bills must include the pharmacy name and address, drug name, prescription number,

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and amount charged. You can get your medicine from any drugstore if you have an emergency away from home.

If you want reimbursement for covered services that you have paid for, please submit proof of payment such as receipts and canceled checks, with the items listed above. Balance due statements are not acceptable. All information on the itemized statements must be readable. If information is missing or is not readable, then RMHP will return it to you or to the provider to furnish the missing information. If you provide proof that you have paid the provider, RMHP will reimburse you directly. Otherwise, RMHP will pay the provider, less the amount of your copayment, if applicable. You will be responsible for paying your copayment to the provider.

Where to send your claim

Make copies of the itemized bills for your own records and send the original bills to: Rocky Mountain Health Plans, Attn: Claims | PO Box 10600 | Grand Junction, CO 81502-5600

Overpayments

If RMHP pays you in error, RMHP reserves the right to recover the payment from you. Providers may also ask you to pay billed charges if RMHP had made an earlier payment for any services received and for which you received the payment by mistake. RMHP also reserves the right to refuse to pay new claims if RMHP has made an earlier payment in error. RMHP reserves the right to take legal action to correct payments made in error.

4: Membership

Enrollment Process

In order to obtain CHP+ coverage, you must follow the CHP+ enrollment process. This process includes completing required application instructions and forms. Information about how to apply can be found online at colorado.gov/hcpf/how-to-apply. Once CHP+ determines that you are eligible, your coverage begins on the date CHP+ receives your completed application.

When RMHP Coverage Begins

If you are eligible for CHP+, the State of Colorado will notify RMHP of your eligibility. Your coverage with RMHP will begin on the first day of the month following this notice. Enrollment in RMHP is voluntary. Contact Colorado's CHP+ Eligibility and Enrollment at 888-367-6557 to choose or change your health plan.

During the time span from your CHP+ application date until you are enrolled with RMHP, the CHP+ State Managed Care Network covers your services. Call Colorado's CHP+ Customer Service at 800-359-1991 for more information about receiving benefits before your RMHP enrollment is effective.

If you are an inpatient in a hospital on the effective date of CHP+ coverage and before your enrollment with RMHP, you will not be eligible to receive benefits from RMHP until you are discharged from the hospital. This plan does not cover any services received before your effective date of coverage with RMHP.

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Renewal Process

You will need to reapply for CHP+ each year. You will also need to reapply if you lose your coverage under CHP+ because you become eligible for another plan, such as Medicaid. If you have questions about when to reapply for CHP+ coverage, call Colorado's CHP+ Customer Service at 800-359-1991.

Termination Policy

Your CHP+ HMO coverage will end the first time of one of the following happens:

- You withheld information on your application or forms (committed fraud or misrepresented material facts) or you are being dishonest and trying to gain a financial or material advantage.
- You permanently move outside of Colorado.
- The State of Colorado gets a written letter sent by you or your representative to cancel coverage for any Member. Coverage will stop at the end of the month following the date the letter is received.
- You are unable to have a good patient-provider relationship with your primary care provider (PCP), or you are disruptive and make it hard to have normal business operations at RMHP or at your provider's office.
- You get other health insurance. If you get other insurance, or are found to have other insurance, you are no longer eligible for CHP+ for the time period the other insurance was effective.
- You are not eligible for the program, based on the eligibility rules in the Children's Basic Health Plan.
- You turn 19 years old. CHP+ coverage will end on the last day of the month of your 19th birthday.
- You die.

When Your CHP+ Coverage Ends

When coverage with CHP+ ends, the State of Colorado's eligibility vendor will send you a Certificate of Creditable Coverage. The Certificate of Creditable Coverage states the length of time you had coverage with CHP+. You may need this letter as proof of prior coverage when you enroll with other health plans.

The benefits under this plan ends on the date that your coverage ends as described above. Except as stated below, RMHP will not pay for services after your coverage ends.

If you are being treated at an inpatient facility when your coverage ends, RMHP will continue to cover your care until you are discharged from the facility or transferred to another level of care. This coverage is subject to the terms of the CHP+ Member Benefits Booklet and depends on the absence of fraud and abuse. Once you are discharged or transferred to another level of care, RMHP will no longer cover services.

You may be responsible for payments owed or made by RMHP for services provided after your coverage has ended.

You have the right to disenroll from RMHP at any time for any reason. Contact Colorado's CHP+ Eligibility and Enrollment at 888-367-6557 and let them know you want to disenroll.

Questions? Rocky Mountain Health Plans is here to help.

Call us at 970-244-7960 / 855-830-1563 (TTY 711), Monday-Friday, 8:00 a.m. to 5:00 p.m.

You can also email us at customer_service@rmhp.org or visit rmhp.org.

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Newborn Child Enrollment

If you become pregnant, call RMHP Customer Service. We can help make sure you get the care that you need when you are pregnant. We can also provide referrals to services you may need, and assistance with getting your newborn child covered. After you have your baby, it is very important that you call Colorado's CHP+ Eligibility and Enrollment at 888-367-6557 to let them know about the birth. Your baby will be covered under your coverage for 30 days only; you will then need to apply for coverage for your newborn child. A CHP+ Eligibility and Enrollment specialist can help you with that process. Most babies born to teen mothers are eligible for Medicaid; however some newborn children may qualify for CHP+.

Newborn Child Primary Care Provider (PCP)

Choose a pediatrician or family practice doctor as your child's PCP. If you need help finding a primary care provider for your baby, call RMHP Customer Service. Call this doctor once your baby is born and schedule a visit. It is very important for your new baby to see a pediatric provider many times in the first year of life, even when your baby is healthy. Your baby's doctor will check your baby's health and development. Ask your baby's doctor or RMHP Customer Service if you have any questions about how frequently you should see a doctor.

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5: Covered Services

This section describes the benefits and covered services of Colorado's CHP+ program and this RMHP CHP+ plan. In order to obtain covered services, Members should follow the directions in this CHP+ Member Benefits Booklet. Here are important points about this plan's coverage.

- This plan covers medically necessary and preventive services and supplies.
- This plan does not cover the services that are listed as excluded or as exclusion in this CHP+ Member Benefits Booklet.
- This plan covers services that are standard medical practice for the illness, injury or condition being treated, and that are legal in the United States of America.
- The fact that a provider prescribes, orders, recommends or approves a service, treatment or supply does not make it medically necessary or a covered service and does not guarantee payment by RMHP.
- If you have questions about a service or benefit, call RMHP Customer Service.

All covered services are subject to the exclusions listed in this section, in addition to the exclusions in other sections of this CHP+ Member Benefits Booklet, including those listed in the General Exclusions & Limitations section of this Booklet. All covered services are subject to other conditions and limitations of this CHP+ Member Benefits Booklet.

Audiology Services

Where can I get audiology services?

You must receive audiology (hearing) services from an in-network audiologist or hearing center.

What audiology services are covered?

The following audiology services are covered:

- Age-appropriate hearing screenings for preventive care.
- Newborn child hearing screening and follow-up for a failed screen.
- Initial hearing aids and replacement hearing aids no more frequently than every five years.
- A new hearing aid when alterations to the existing hearing aid cannot adequately meet your needs.
- Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

Dental-Related Services

Routine CHP+ program dental coverage – contact Delta Dental

For CHP+ Members enrolled in this plan, Delta Dental provides coverage for preventive and diagnostic

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and other dental-related services. Contact Delta Dental at toll free 800-610-0201 for questions about dental services by Delta Dental for RMHP CHP+ Members and to find a dentist near you. Ask Delta Dental about what dental services are covered for CHP+ Members – such as dental exams, cleanings and X-rays, and services such as fillings and crowns.

What dental-related services does this plan cover?

This plan provides coverage for accident and certain health-related dental conditions explained below. Most dental-related services for CHP+ Members are provided by Delta Dental, as noted above.

Accident-related dental services provided by RMHP under this plan:

- Coverage is provided for accident-related dental repairs to sound natural teeth or related body tissue within 72 hours of an accident.
- Dental services to stabilize the teeth after an accident or injury are covered if received within 72 hours of the accident.
- Coverage of accident-related dental services does not include dental restoration.
- If dental services are received after more than 72 hours following the accident, the services are not covered. This includes follow-up care.

Dental anesthesia – this plan covers the following dental anesthesia services:

- General anesthesia when provided in a hospital, outpatient surgical facility or other facility. The associated hospital or facility charges for dental care.
- In order for dental anesthesia services to be covered, you must:
 - Have a physical, mental, or medically compromising condition;
 - Have dental needs for which local anesthesia is not effective due to acute infection, anatomic variation or allergy;
 - Be considered extremely uncooperative, unmanageable, uncommunicative, or anxious by your provider and your dental needs must be deemed sufficiently important that dental care cannot be deferred; or
 - Have sustained extensive orofacial and dental trauma.

Inpatient admission for dental care

When medically necessary, this plan covers inpatient facility services related to dental care. Delta Dental covers eligible dental services; call Delta Dental for information about what dental services are covered.

Cleft lip and cleft palate

This plan covers the following services in connection with cleft lip and/or cleft palate when provided by

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or under the direction of a provider, and only when the services are medically necessary. Coverage is provided only if you do not have another dental insurance policy or plan at the time the following services are received:

- Oral and facial surgery, surgical management, and follow-up care by plastic surgeons or oral surgeons
- Prosthetic treatment such as obturators, speech appliances, and feeding appliances
- Medically necessary orthodontic treatment
- Medically necessary prosthodontic treatment
- Habilitative speech therapy
- Otolaryngology treatment for ear and throat problems
- Audiological (hearing) assessments and treatment
- Medically necessary speech therapy visits related to cleft palate or cleft lip condition are unlimited. These speech therapy visits are applied toward the 30 therapy visit maximum but are not limited to the maximum visits.

Fluoride varnish services

Fluoride varnish is when fluoride is painted on teeth to protect against cavities. This plan covers fluoride varnish service when provided by an RMHP participating primary care provider in his or her office. CHP+ Members can also get fluoride varnish from a dentist through their CHP+ dental benefit, administered by Delta Dental. Ask Delta Dental how to get fluoride varnish services from a dentist under the CHP+ Dental Benefit.

- For this plan to cover (pay for) fluoride varnish services, the fluoride varnish must be provided by an RMHP participating primary care provider. This service does not require pre-authorization.
- This plan covers up to two fluoride varnish treatments in a calendar year for children ages 0 – 4.
- Before your PCP provides the varnish, he or she will also perform a risk assessment.
- In order to be covered, your PCP must have received the appropriate training for the fluoride varnish treatment.

What fluoride varnish services are not covered (exclusions)?

The following fluoride varnish services are not covered:

- Fluoride varnish for children ages 5 and older.
- Fluoride varnish services obtained from an out-of-network provider.
- Fluoride varnish services obtained from a provider who is not a PCP.
- Fluoride varnish services provided by a dentist may be covered by the routine dental benefit. Call

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Delta Dental at toll free 800-610-0201 for information.

- Fluoride varnish treatment that does not include a risk assessment performed by your PCP.

What dental-related services are not covered (exclusions)?

The following dental-related services, supplies, and care are not covered:

- Restoring the mouth, teeth, or jaw due to injuries from biting or chewing.
- Restorations, supplies or appliances, including, but not limited to, cosmetic restorations, cosmetic replacement of serviceable restorations and materials (such as precious metal) that are not medically necessary to stabilize damaged teeth.
- Inpatient or outpatient services due to the age of the Member, the medical condition of the Member and/or the nature of the dental services, except as described above.
- Upper or lower jaw augmentation or reductions (orthognathic surgery) even if the condition is due to a genetic congenital or acquired characteristic.
- Artificial implanted devices and bone graft for denture wear.
- Temporomandibular (TMJ) joint therapy or surgery is not covered unless it has a medical basis.
- Administration of anesthesia for dental services, operating, and recovery room charges, and surgeon services except as allowed above.

Emergency and Urgent/After-Hours Care

Urgent/After-Hours Care

You can get urgent care anywhere in the United States. Urgent care is not the same as emergency care. Urgent care is for a sickness or injury that needs medical care quickly but is not life- or limb-threatening. **If you need urgent care, call your PCP's office** and follow what they tell you to do. If you need urgent medical care after normal business hours, you still have to call your PCP's office. This includes weekends and holidays. Your care will still be covered even if you are not able to call us and let us know about your urgent care visit.

There is always a doctor who will return your call and give you instructions. Doctors who care for RMHP patients are on call day and night, every day, for emergencies. If you need urgent care, you can call your PCP's office any time of the day or night and leave a message. Even if your PCP is not there, a doctor will call you back to tell you how to get care. For urgent care, you will get an appointment with a doctor within two days of the time you call your PCP's office.

What urgent/after-hours care is covered?

- Benefits are provided for accident or medical care received from an urgent care center or other

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facility, such as a provider's office.

- Urgent and after-hours care received within the RMHP service area is covered only when it is provided by an in-network PCP or urgent care center or an urgent care provider.
- When you are temporarily out of the RMHP CHP+ service area, urgent/after- hours care is covered.
- If you are sick, please visit your PCP before you leave town. If you receive care away from home, call your doctor within 48 hours.

Emergency Care

You can get emergency care anywhere in the United States. You can get care 24 hours a day. You can get care every day of the year. You do not need an okay from RMHP to go to the emergency room for a true emergency. If you are not able to call us and let us know about your emergency room visit or urgent care visit, your care will still be covered.

Emergency room services are expensive. Many doctors will take care of you in their offices after hours or on weekends. Some hospitals even have convenience rooms or urgent care near the emergency room where you can get care. There may also be an urgent care center near you. These cost less than going to the emergency room. You may have to pay a copay if you go to the emergency room when you don't have a true emergency.

When you have a true medical emergency, call 911. You can go to the nearest emergency room. The emergency room is the wrong place to go for routine care, like a check up or for a cold. It's the wrong place to get care you could get from your doctor.

When to use the emergency room

Go to the emergency room only when you have a true medical emergency. An emergency is when a person with average knowledge of health and medicine believes that by not getting health care right away, the following could happen: your health or the health of your unborn child would be harmed; your body would not work the right way; or an organ or part of your body would not work the right way.

Some examples for when you should go to the emergency room:

- Your primary care provider tells you to go to the emergency room
- You have severe bleeding
- You have chest pain
- You have difficulty breathing
- You think your condition may endanger the life of your unborn child
- You have sudden and/or severe pain
- You have sudden vision changes
- You have loss of consciousness

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- You have a head injury

Here's what to do if you have a life- or limb-threatening emergency

- Go to the closest emergency room, call 911, or call the local emergency phone number.
- Tell the emergency room staff you are an RMHP Member.
- Call your PCP as soon as you can.
- Show your Rocky Mountain Health Plans ID card at the hospital.

Here's what to do if you have a non-life-threatening emergency

- Call your PCP, if you can, and tell them about your illness or injury.
- Follow what your doctor tells you about whether to go to the hospital or to the doctor's office.
- If you can't reach your doctor, go to the nearest emergency room.
- Show your Rocky Mountain Health Plans ID card at the hospital.

Here's what to do if you get sick or injured but it's not an emergency

- Call your PCP at any time.
- The office telephone message may give you a number to call for a doctor who can take care of you. This may happen if your doctor is not there. This may also happen when the office is closed. There will always be someone to answer your call. You can always get help.
- Tell the doctor you are an RMHP Member and tell them about your illness or injury.
- Follow the doctor's instructions about whether to go to the hospital or to the doctor's office

What emergency care services are covered?

This plan covers emergency care that is necessary to screen and stabilize, if a prudent layperson having average knowledge of health services and medicine acting reasonably would have believed that an emergency medical condition or life- or limb-threatening emergency existed. This means that you believe that your life was in danger because of the illness or emergency, or that one of your limbs was in danger (for example, you thought that you broke your leg).

Post-stabilization care services are also covered. You do not need to get preauthorization for post-stabilization care. These are services that the provider who saw you in an emergency says you need before you can go home or go to another place for care. The cost-sharing amount for post-stabilization services must be the same or lower for out-of-network providers as for in-network providers. Post-stabilization care services are covered services that are:

- Related to an emergency medical condition;
- Provided after a Member is stabilized; and

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- Provided to maintain the stabilized condition, or under certain circumstances (see below), to improve or resolve the Member's condition.

What happens if I am admitted to the hospital after I receive emergency care?

If you are admitted into the hospital, you will not need to pay for the emergency room copayment.

If you are treated at an out-of-network hospital in an urgent situation or for an emergency, let the hospital know that the itemized bill from the hospital must be sent to the information on the back of your RMHP Member ID card. If you or the provider has any questions, call RMHP Customer Service.

Once you are stabilized, ongoing care and treatment is not emergency care. Care from an out-of-network provider beyond what is needed to evaluate and/or stabilize your condition will be denied unless RMHP authorizes continued inpatient care by the out-of-network provider. A care manager may help transfer you to an in-network facility once you are medically stable.

What emergency care services are NOT covered?

The following services, supplies, and care are not covered (exclusions):

- Do not use an emergency center for non-emergency services. It is not covered.
- Follow-up care, including but not limited to, removal of stitches or dressing changes, received in an emergency room or urgent care center are not considered emergency care. You should get any follow-up care from your Primary Care Provider (PCP).

Travel Outside the Country

Health care services provided outside of the country are covered for emergency care only. If you have an emergency outside of the country, you should go to the nearest medical facility. Let the hospital know that the itemized bill from the hospital must be sent to the address on the back of your RMHP ID card. If you or the provider has any questions, contact RMHP Customer Service.

When you return home, contact RMHP Customer Service. RMHP may require medical records for the services received. You are responsible for providing these medical records and it may be necessary to provide an English translation of the medical records.

Family Planning/Reproductive Health

Who should I see for family planning/reproductive health services?

Family planning/reproductive health services do not require pre-authorization or referral for any provider regardless of whether they are in-network or not. This could be a PCP or an OB/GYN.

What family planning/reproductive health services are covered?

Family planning helps you decide if you will have children and when to have them. Covered family planning/reproductive health services include:

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- Injection (shot) of Depo-Provera for birth control purposes.
- Fitting of a diaphragm or cervical cap.
- Surgical implantation and removal of an implantable contraceptive device.
- Fitting, inserting, or removing Intrauterine Device (IUD).
- The purchase of IUDs, diaphragms, implantable contraceptive devices, and cervical caps given in a provider's office.
- Tests to diagnose a possible genetic illness/disease.
- STI (Sexually Transmitted Infections) and HIV testing and treatment.
- Prescription birth control pills.

What family planning/reproductive health services are not covered?

The following family planning/reproductive health services are not covered (exclusions):

- Surgical sterilization (for example, tubal ligation or vasectomy) and related services.
- Reversal of sterilization procedures.
- Over-the-counter contraceptive products such as condoms and spermicide.
- Preconception, paternity, or court-ordered genetic counseling and testing (for example, tests to determine the sex or physical characteristics of an unborn child).
- Elective termination of pregnancy, unless the elective termination is to save the life or the mother or if the pregnancy is the result of an act of rape or incest.

Home Health Care/Home Infusion Therapy

Who can provide home health care/home infusion therapy?

Benefits are provided for services performed by a home health agency that can arrange and provide nursing services, home health aide services and other therapeutic services. Home infusion therapy is when a nurse comes to your home to give you a medication intravenously (through an IV) or with a shot.

What home health care/home infusion therapy services are covered?

Home health care services are covered only when they are necessary as alternatives to hospitalization.

- Prior hospitalization is not required for home health care services.
- In order to receive home health services, you must have a written order from your provider. Your provider will work with the home health agency to establish a care plan. A registered nurse from the home health agency will coordinate the services in the care plan.

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- All home health care/home infusion therapy services require pre-authorization from RMHP. RMHP reserves the right to review treatment plans at any time while you are receiving home health care or home infusion therapy.

Covered home health care services include the following:

- Professional nursing services performed by a registered nurse (RN) or a licensed practical nurse (LPN) on a defined schedule of visits.
- Certified nurse aide services if under the supervision of a registered nurse or a qualified therapist with professional nursing services.
- Physical therapy provided by a licensed physical therapist.
- Occupational therapy provided by a licensed occupational therapist or a certified occupational therapy assistant.
- Respiratory and inhalation therapy services.
- Speech and hearing therapy and audiology services.
- Medical/social services.
- Medical supplies (including respiratory supplies), durable medical equipment (rental or purchase), oxygen, appliances, prostheses, and orthopedic appliances.
- Formulas for metabolic disorders, total parenteral nutrition, enteral nutrition and nutrition products, and formulas for gastrostomy tubes are covered for documented medical needs including attainment of normal growth and development.
- Intravenous (IV) medications and other prescription medications that are not ordinarily available through a retail pharmacy.
- Nutritional counseling by a nutritionist or dietitian.

Home infusion therapy is also known as home IV therapy or home injection therapy. Benefits for home infusion therapy include a combination of nursing, durable medical equipment, and pharmaceutical services in the home. Covered home infusion therapy services include, but are not limited to:

- Antibiotic therapy, hydration therapy, and chemotherapy.
- Intra-muscular, subcutaneous, and continuous subcutaneous injections (shots).

See the *Nutrition and Food Services* section for information about Total Parenteral Nutrition (TPN) and enteral nutrition.

What home health care/home infusion therapy services are not covered (exclusions)?

The following services, supplies, and care are not covered:

- Custodial care, which is when someone comes to your house to help with bathing, dressing or other self-care activities.

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- Care provided by a nurse who ordinarily lives in your home or is an immediate family member.
- Services or supplies for personal comfort or convenience, such as homemaker services for house cleaning.
- Food services, meals, formulas and supplements, other than listed above or dietary counseling, even if the food, meal, formula or supplement is the sole source of nutrition.
- Pastoral/religious or spiritual counseling.

Hospice Care

Who can provide covered hospice services?

Hospice care may be provided in the Member's home or in an inpatient facility. Hospice services must be received through an in-network hospice program.

What hospice services are covered?

To be eligible for home or inpatient hospice benefits, the Member must have a life expectancy of six months or less, as certified by the attending provider. Hospice care includes medical, physical, social, psychological, and spiritual services that stress palliative care for patients. Inpatient or home hospice service providers must receive pre-authorization prior to providing care. RMHP initially approves hospice care for a period of three months.

- Benefits may continue for up to two additional, three month periods for a total of nine months. These do not have to be consecutive three month periods.
- After the exhaustion of three benefit periods, RMHP will work with the provider and the hospice provider to determine the appropriateness of continuing hospice care.
- RMHP reserves the right to review treatment plans while the Member is receiving hospice care.

Coverage for hospice care is available for the following services in the Member's home:

- Provider visits by hospice providers.
- Skilled nursing services performed by a registered nurse (RN) or a licensed practical nurse (LPN).
- Medical supplies and equipment supplied by the hospice provider that is used during a covered visit. If the equipment is not supplied by the hospice provider, see the *Medical Supplies and Equipment* section.
- Drugs and medications for a terminally ill child that are supplied by the hospice provider. If the medications are not supplied by the hospice provider, see the *Prescription Medications* section.
- Services from a licensed or certified therapist for physical, occupational, respiratory, and speech therapy.
- Medical social services provided by a qualified individual with a degree in social work, psychology, or

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counseling, or the documented equivalent in a combination of education, training, and experience. Such services must be provided, at the recommendation of a provider, to assist you in coping with a specified medical condition.

- Services of a home health aide under the supervision of a registered nurse.
- Nutrition assessment, counseling, and support, such as intravenous feeding, hyperalimentation and enteral feeding.

Benefits are also available for inpatient hospice accommodations and services.

Respite care

Respite care is total care that is provided to terminally ill patients for a short period of time so that the family of the patient can have a short break. Mental health respite care is not a covered benefit.

- The patient may be placed in respite care for a period not to exceed five continuous days for every 60 days of hospice care.
- The patient may not be placed in respite care for more than two respite care stays during a hospice benefit period (one hospice care period is equal to three months).

What hospice services are not covered?

The following services are not covered services (exclusions):

- Food services and meals, other than nutritional assessment, counseling, and support listed above.
- Services or supplies for personal comfort or convenience, such as homemaker and housekeeping services.
- Private duty nursing.
- Pastoral/religious and spiritual counseling outside of the hospice setting.
- Grief counseling for family Members outside of the hospice setting.

Human Organ and Tissue Transplant Services

Who can provide human organ and tissue transplant services?

Covered transplant services must be performed at designated transplant facilities.

What human organ and tissue transplant services are covered?

- Coverage is available for transplant services that are medically necessary and are not experimental procedures. Benefits are provided for services directly related to the following transplants:
- Heart
- Lung (single or double) for end stage pulmonary disease only
- Heart-lung

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- Kidney
- Kidney-pancreas
- Liver
- Bone marrow for a Member with Hodgkin's disease, aplastic anemia, leukemia, severe combined immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II or III breast cancer or Wiskott-Aldrich syndrome.
- Peripheral blood stem cell for a Member with Hodgkin's disease, aplastic anemia, leukemia, severe combined immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II or III breast cancer or Wiskott-Aldrich syndrome.
- Cornea

Services are covered based on standards established by the medical community and by RMHP. A referral from your PCP and pre-authorization from RMHP is needed before human organ and tissue transplant services. The following guidelines must be met in order to obtain covered human organ or tissue transplant services:

- All human organ and tissue transplants must be performed at a hospital designated and approved by RMHP for each specific covered service provided under this section.
- RMHP and the approved hospital must determine that a Member is a candidate for any of the covered services specified in this section.
- All human organ and tissue transplants must be pre-authorized based on the clinical criteria and guidelines established, adopted or endorsed by RMHP or its designee. Approval for such covered services will be at the sole discretion of RMHP.
- Pre-authorization is required for non-emergency hospital admissions related to human organ and tissue transplants. If the services must be performed based on a medical emergency, RMHP must be notified within one business day after admission.

Hospital, medical, surgical, and other services for transplants

The following hospital, surgical, medical, and other services are covered services if they are pre-authorized by RMHP. See the *Getting Care* section for information on pre-authorization requirements.

Hospital covered services for transplants

- Room and board for a semi-private room. If a private room is used, this benefit program will only provide benefits for covered services up to the cost of the semi-private room rate unless RMHP determines that a private room is medically necessary.
 - Services and supplies furnished by the hospital.
 - Prescribed medications used in the hospital.

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- Whole blood, administration of blood and blood processing.
- Medical and surgical dressings and supplies.
- Care provided in a special care unit, which includes all facilities, equipment, and supportive services necessary to provide an intensive level of care for critically ill patients.
- Use of operating and treatment rooms.
- Diagnostic services, including a referral for evaluation.
- Rehabilitative and restorative physical therapy services.

Medical covered services for transplants

- Inpatient and/or outpatient professional services.
- Intensive medical care given when a condition requires a provider's constant attendance and treatment for a prolonged period of time.
- Medical care by a provider other than the operating surgeon rendered concurrently during the hospital stay for treatment of a medical condition separate from the condition for which the surgery was performed.
- Medical care by two or more providers given concurrently during the hospital stay when the nature or severity of your condition requires the skills of separate providers.
- Consultation services rendered by another provider at the request of the attending provider, other than staff consultations required by hospital rules and regulations.
- Home, office, and other outpatient medical care visits for examination and treatment.

Surgical covered services for transplants

- Surgical services in connection with covered human organ and tissue transplants, separate payment will not be made for pre-operative and post-operative services, or for more than one surgical procedure performed at the same time.
- Services of a surgical assistant in the performance of such covered surgery as allowed by RMHP.
- Administration of anesthesia ordered by the provider.

Other covered services for transplants

- Medically necessary immunosuppressant drugs to help keep the organ healthy prescribed for outpatient use in connection with a covered human organ and tissue transplant, and which are dispensed only by written prescription and approved for general use by the Food and Drug Administration.
- Transportation of the donor organ or tissue.
- Evaluation and surgical removal of the donor organ or tissue and related supplies.

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- Transportation costs to and from the hospital for the recipient and for one adult. If you must temporarily relocate outside of your city of residence to receive a covered organ transplant, coverage is available for travel to the city where the transplant will be performed. Coverage is also available for the cost of reasonable lodging for you and one adult. Travel and lodging expenses for you and the accompanying adult are limited to a lifetime maximum benefits of \$10,000 per transplant – which is part of the maximum lifetime benefit for organ transplants under this “Organ Transplant” provision. The cost of lodging is limited to \$100 per day. Travel expenses incurred by a donor are not applied to your lifetime travel and lodging expenses, but are applied to the maximum lifetime benefit for these transplants. Coverage is not available for travel costs associated with a pre-transplant evaluation if the travel occurs more than five days prior to the actual transplant.
- As used in this section, donor refers to the person who furnishes a human organ or organ tissue for transplantation. If a donor provides a human organ or organ tissue to a transplant recipient, the following apply:
 - When both the recipient and the donor are Members of this RMHP CHP+ plan, each is entitled to the covered services specified in this section.
 - When only the recipient is a Member, both the donor and the recipient are entitled to the covered services specified in this section.
 - The donor benefits are limited to those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, grants, foundations, and government programs.
 - If the donor is a Member of this plan, and the recipient is not, benefits will not be provided for the donor or recipient expenses.
 - Donor expenses are paid only after a Member’s initial claims for the transplant have been processed. No coverage is available to the donor after he or she has been discharged from the transplant facility.
 - No benefits will be provided for procurement of a donor organ or organ tissue which is not used in a covered transplant procedure, unless the transplant is cancelled due to the Member’s medical condition or death and the organ cannot be transplanted to another person.
 - No benefits will be provided for procurement of a donor organ or organ tissue that has been sold rather than donated.

Maximum lifetime benefit for organ transplants

- Coverage for all covered organ transplants and all transplant-related services, including travel, lodging, and donor expenses, or organ procurement is limited to a maximum lifetime benefit for major organ transplants of \$1,000,000 per Member.
- Amounts applied toward the maximum lifetime benefit for organ transplants include all covered

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charges for transplant-related services, such as hospitalizations and medical services related to the transplant, and any subsequent hospitalizations and medical services related to the transplant. The travel, lodging, and donor expense coverage also apply toward maximum lifetime benefit for organ transplants.

- A service or supply is considered transplant-related if it directly relates to a transplant covered under this CHP+ Member Benefits Booklet, and is received during the transplant benefit period (up to five days before, or within one year following the transplant).
- **Exception:** A pre-transplant evaluation may be received more than five days before a transplant and may be considered transplant-related (this exception does not extend to travel required to receive a transplant evaluation). Covered services received during the evaluation will be subject to the maximum lifetime benefit for organ transplants and subject to the limitations of this “Organ Transplant” benefit.
- If a Member receives an RMHP CHP+ plan covered transplant (for example, heart transplant) and later requires another transplant of the same type (for example, another heart transplant), the covered charges for the new transplant are applied to the remaining (if any) maximum lifetime benefit available per Member.
- Payments under the organ transplant benefit are not applied to other specified benefit maximums.
- Expenses for covered transplant-related services in excess of the maximum lifetime benefit for organ transplants are not payable under this provision or any other portion of this CHP+ Member Benefits Booklet.

What human organ and tissue transplant services are not covered?

The following services, supplies and care are not covered (exclusions):

- Services performed at any hospital that RMHP has not designated and approved to provide human organ and tissue transplant services for the organ or tissue being transplanted.
- Services performed if you are not a suitable transplant candidate as determined by the hospital RMHP has designated and approved to provide such services.
- Services for donor searches or tissue matching, or personal living expenses related to donor searches or tissue matching, for the recipient or donor, or their respective family or friends.
- Any experimental or investigational transplant, treatment, procedure, facility, equipment, drug, device, service or supply, including any associated or follow-up service or supply.
- Any transplant, treatment, procedure, facility, equipment, drug, device, service or supply that requires federal or other governmental agency approval which is not granted at the time services are provided and any associated or follow-up service or supply.
- Transplants of organs other than those listed previously in this section, including, non-human

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organs.

- Services and supplies related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition that are in any way related to the artificial and/or mechanical heart or ventricular/atrial assist devices or the failure of those devices as long as any of the specified devices remain in place. This exclusion includes services for implantation, removal, and complications. This exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

Inpatient Facility Services - Hospital and Ancillary Professional

Where can I get inpatient facility services?

All acute inpatient hospital admission must be at an in-network facility. Acute inpatient services may be obtained at the following locations:

- An acute care hospital,
- A long-term acute care hospital,
- A rehabilitation hospital, or
- Other covered inpatient facility.

This plan does not cover services at an out-of-network facility unless the services are for an emergency care or otherwise authorized by RMHP.

What inpatient facility services are covered?

Inpatient facility services that are covered include:

- Facility Services - Many services are provided in the inpatient hospital setting. Some of the covered services include, but are not limited to, the following examples:
 - Charges for a semi-private room (with two or more beds) and general nursing services for the treatment of medical conditions and rehabilitation care, which is part of an acute care hospital stay.
 - Use of an operating room, recovery room, and related equipment.
 - Medical and surgical dressings, supplies, surgical trays, casts, and splints when supplied by the facility as part of an inpatient admission.
 - Prescribed medications and medicines given during an inpatient admission.
- A room in a special care unit approved by RMHP. The unit must have facilities, equipment and supportive services for the intensive care of critically ill patients.
- Inpatient Rehabilitation Services
 - Inpatient rehabilitation for non-acute hospital admissions are covered for medically necessary

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care to restore and/or improve lost functions following an injury or illness.

- These inpatient rehabilitation benefits are limited to 30 days per calendar year.
- These services must be received within six months from the date on which the illness or injury occurred.
- Ancillary Services during an inpatient admission – Many providers work together in the inpatient hospital setting to provide comprehensive care to patients. Some covered ancillary services include, but are not limited to, the following examples:
 - Diagnostic services such as laboratory and X-ray tests (for example, CT scan, MRI).
 - Chemotherapy and radiation therapy.
 - Dialysis treatment.
 - Respiratory therapy.
 - Physical, occupational, and/or speech therapy.
 - Charges for processing, transportation, handling, and administration of blood.
- Professional Services during an inpatient admission – Professional services are the surgical and medical care provided during an inpatient admission. Some of the covered professional services include, but are not limited to, the following examples:
 - Provider services for the medical condition(s) during an inpatient admission.
 - Surgical services, which include normal post-operative care.
 - Anesthesia and anesthesia supplies and services for a covered surgery.
 - Intensive medical care for constant attendance and treatment when the Member's condition requires it for a prolonged period of time.
 - Surgical assistants or assistant surgeons as determined by RMHP medical policy. Surgical assistants for all surgical procedures are not covered.
 - Surgical services for the treatment of morbid obesity. These services are subject to meeting the criteria included in RMHP's medical policy. The hospital performing the morbid obesity surgery must be designated and approved to perform specific covered services provided under this benefit.
- Consultations (including second opinions)
 - Medical care by two or more providers at the same time because of multiple illnesses.
 - Medical care for an eligible newborn (also see the *Maternity and Newborn Child Care* section).
- Long-Term Acute Care Facility
 - Long-term acute care facilities provide long-term critical care services to Members with serious

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illnesses or injuries.

- Long-term acute care is provided for Members with complex medical needs, including Members with high-risk pulmonary disease with ventilator or tracheostomy needs, Members who are medically unstable, Members needing extensive wound care or who have post-operative surgery wounds, and Members with closed head or brain injuries.
- RMHP requires pre-authorization for admission and for continued stay. See the *Getting Care* section of this Booklet for information about pre-authorization guidelines.
- Skilled Nursing Facility
 - Skilled nursing facilities provide skilled nursing care, therapies, and protective supervision for patients who have uncontrolled, unstable, or chronic conditions.
 - Skilled nursing care is provided under medical supervision for the non-surgical treatment of chronic conditions or care during the recovery from an acute disease or injury.
 - When skilled nursing care is pre-authorized by RMHP, benefits are available for up to 30 days per calendar year, or until RMHP determines that the Member has reached maximum medical improvement, whichever is sooner. Authorization for admission and for continued stay is required. See the *Getting Care* section of this Booklet for information on pre- authorization guidelines.

What inpatient facility services are not covered?

The following inpatient facility services are not covered services (exclusions):

- Consultations or visits related to any non-covered service.
- Inpatient provider services received on a day for which facility charges were denied.
- Telephone consultations.
- Private room expenses when semi-private rooms are available, unless the Member's medical condition requires isolation to protect the Member from exposure to dangerous bacteria and diseases (conditions that require isolation include, but are not limited to, severe burns and those according to public health laws).
- Admissions related to non-covered services or procedures. See the Dental-Related Services section for exceptions.
- Room and board and related services in a nursing home.
- Custodial care facility admissions or admissions to similar institutions.
- Charges related to the non-compliance of care if the Member leaves a hospital or other facility against the medical advice of the provider.
- Facility room and board charges for the day of discharge.

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- Surgical benefits for subsequent procedures to correct further injury or illness resulting from noncompliance with prescribed medical treatment. An example of a non-covered subsequent procedure is the removal of infected tissue directly caused by not taking prescribed medication after a tonsillectomy.
- Procedures that are solely cosmetic in nature.
- Custodial and/or maintenance care (this is care that helps you with activities of daily living, like dressing or bathing).
- Any services or care for the treatment of sexual dysfunction.
- Personal comfort and convenience items, such as televisions, telephones, guest meals, articles for personal hygiene and other similar services and supplies.
- Surgical services for refractive keratoplasty, including radial keratotomy or Lasik, or any procedure to correct visual refractive defect.
- Additional procedures not routinely performed during the course of the main surgery.

For more information

- All inpatient services are subject to unscheduled admission notification guidelines.
- See the *Substance Abuse Care* section for services, including acute medical detoxification. For accident or emergency medical care, see the *Emergency and Urgent/After-Hours Care* section.
- For dental services, see the *Dental-Related Services* heading in this section.

Maternity and Newborn Child Care

Who should I see for maternity and newborn baby care?

You should see an OB/GYN, certified nurse-midwife or family practice doctor who delivers babies. For prenatal care (care during your pregnancy), you can see an OB/GYN or a certified nurse-midwife without a referral from your PCP. You may also see a family practice doctor who provides prenatal care. Please work with your primary care provider (PCP) to coordinate care with specialists. If you need help finding a doctor or certified nurse-midwife, call RMHP Customer Service.

What maternity and newborn child care services are covered?

Benefits are provided for maternity and newborn baby care, including diagnosis, care during a pregnancy, and delivery services. Covered services include:

- Inpatient, outpatient and provider office services (including prenatal care, such as prescription prenatal vitamins) for vaginal delivery, cesarean section and complications of pregnancy.
- Anesthesia services.
- Routine nursery care for a covered newborn child, including provider services.

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- For newborn children, all medically necessary care and treatment of injury and sickness including medically diagnosed congenital defects and birth abnormalities.
- Tests to diagnose a possible genetic illness/disease.
- Circumcision of a covered newborn male.
- Laboratory services related to prenatal care, postnatal care or termination of a pregnancy.
- Spontaneous termination of pregnancy prior to full term.
- Elective termination of pregnancy, only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.
- Two (2) antenatal (while you are still pregnant) ultrasounds are covered. After the second ultrasound, pre-authorization is needed. The care management department will review the pre-authorization request for a pending high-risk pregnancy.
- At-home, post-delivery, follow-up care visits are covered at your residence by a provider, nurse or certified nurse-midwife when performed no later than 72 hours following you and your newborn child's discharge from the hospital. Coverage for this visit includes, but is not limited to:
 - Parent education,
 - Physical assessments,
 - Assessment of the home support system, and
 - Assistance and training in breast or bottle feeding.
- Performance of any maternal or neonatal tests routinely performed during the usual course of inpatient care for the mother or newborn child, including the collection of an adequate sample for the hereditary disease and metabolic newborn child screening. At the mother's discretion, this visit may occur at the provider's office.
- This plan covers services performed by a participating certified nurse-midwife or a direct-entry midwife. This plan covers the advising, attending or assisting of a woman during pregnancy, labor, and natural childbirth at home, and during the postpartum period in accordance with C.R.S. 12-27-101 et. al. seq. that includes one metabolic screening, one postpartum visit, one prescreening visit, and the actual delivery and labor.
- RMHP will not limit coverage for a hospital stay related to childbirth for the mother and newborn child to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. If the delivery occurs between 8:00 p.m. and 8:00 a.m., coverage will continue until 8:00 a.m. on the morning following the 48-hour or 96-hour coverage period. The mother's attending provider, after consulting with the mother, may discharge the mother and newborn child earlier, if appropriate.

Please see the Membership section of this Booklet for more information about newborn child coverage

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and enrollment.

What maternity and newborn child care services are not covered?

The following services, supplies and care are not covered (exclusions):

- Services including, but not limited to:
 - Preconception counseling,
 - Paternity testing,
 - Genetic counseling and testing (unless related to the determination of disease or other circumstances not excluded above),
 - Testing for inherited disorders,
 - Screening for disorders, and
 - Discussion of family history or test results to determine the sex or physical characteristics of an unborn child.
 - Storage costs for umbilical blood.

Medical Supplies and Equipment

This section describes covered services and exclusions for medical supplies, durable medical equipment (DME), oxygen and its equipment, and orthopedic and prosthetic devices.

Where can I get medical supplies and equipment?

The supplies, equipment and appliances described in this section are covered benefits only if supplied by an in-network provider. A list of in-network providers of medical supplies and equipment is in RMHP's Provider Directory, which can be found online at rmhp.org, or by calling RMHP Customer Service.

What supplies and equipment are covered and apply towards the \$2,000 limit?

The benefits described in this section are allowed up to the maximum benefit payment of \$2,000 per calendar year.

- Medical supplies and equipment are subject to pre-authorization requirements. See the Getting Care section for information about pre-authorization requirements.
- Covered supplies and equipment must meet this plan's medical policy criteria.

Durable medical equipment

This is sometimes called DME. Durable medical equipment is covered under this plan if it is medically necessary and prescribed by an in-network provider. Durable medical equipment generally can withstand repeated use and must serve a medical purpose.

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- Examples of durable medical equipment are items like: crutches, wheelchairs and supplies, breathing equipment such as nebulizers, hospital beds, and pumps and related supplies (other than insulin pumps).
- Durable medical equipment can be rented or purchased. This decision is up to RMHP.
- Rental costs must not be more than the purchase price and will be applied to the purchase price.
- Medical equipment repair, maintenance and adjustment due to normal usage are covered if RMHP purchased the equipment or if it would have been approved. RMHP will review other situations on a case-by-case basis.
- During the repair or maintenance of durable medical equipment, this plan will provide coverage for the rental of a replacement.
- Durable medical equipment used during inpatient admission is covered as part of the inpatient hospital admission.

Orthopedic appliances

Orthopedic appliance benefits are provided for the purchase, fitting and repairs of and the needed adjustments to orthopedic appliances.

- An orthopedic appliance is a rigid or semi-rigid supportive device that helps increase the use of a malfunctioning body part, limb or extremity, or limiting or stopping the motion of a weak or poorly functioning body part. An example is a knee brace.
- This plan covers the most appropriate appliances that adequately meets your medical needs.

Prosthetic devices

Prosthetic device benefits are provided for the purchase, fitting, repair and replacement of and the needed adjustments to prosthetic devices. A prosthetic device replaces all or part of a missing body part or extremity (leg or arm) to increase the Member's ability to function. The purchase, fitting, repair and replacement and the need for adjustments of prosthetics for arms and legs are excluded from the annual dollar amount DME benefit limit. All other prosthetic devices, unless specifically listed in the CHP+ Member Benefits Booklet are subject to the annual dollar amount DME benefit limit.

Other appliances

Benefits for other appliances include the following:

- Either one set of standard prescription eyeglasses or one set of contact lenses (whichever is appropriate for the medical condition) when necessary to replace human lenses absent at birth or lost through intraocular surgery, ocular injury or for the treatment of keratoconus or aphakia.
- Breast prostheses and prosthetic bras following a mastectomy.

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Medical supplies – covered services that do not apply toward \$2,000 payment limit

If your doctor has ordered the following medically necessary items, the following items will not be subject to the maximum payment of \$2,000

- Durable medical equipment used during a covered admission or covered outpatient visit that is owned by the facility.
- Medical supplies (including casts, dressings, and splints used in lieu of casts) used during covered outpatient visits.
- Surgically implanted prosthetics or devices authorized by RMHP before you receive the device (including cochlear implants).
- Insulin pumps and related supplies.
- Disposable items received from an in-network provider and required for the treatment of an illness or injury on an inpatient or outpatient basis are covered. Benefits are provided for the following examples, but not limited to: syringes, insulin pumps and supplies, needles, surgical dressings, splints, other similar items that treat a medical condition.
- Orthotic shoes with the diagnosis of diabetes.
- Oxygen and Oxygen Equipment - benefits are provided for oxygen and the rental of the equipment needed to administer oxygen (one stationary and one portable unit per Member). Your provider will need to get pre-authorization from RMHP.

What medical services and supplies are not covered?

The following services, supplies, and care are not covered (exclusions):

- Comfort, luxury or convenience item supplies, equipment, and appliances (for example, wheelchair sidecars or a cryocuff unit). Equipment or appliances that include more features than needed for the medical condition are considered luxury, deluxe, and convenience items (for example, motorized equipment, such as electric wheelchairs or electric scooters, when manually operated equipment can be used).
- Items available without a prescription, such as over-the-counter items and items usually stocked in the home for general use. This includes but is not limited to, bandages, gauze, tape, cotton swabs, dressing, thermometers, heating pads, and petroleum jelly.
- Air conditioners, purifiers, humidifiers, dehumidifiers, special lighting or other environmental modifiers, surgical supports and corsets or other articles of clothing, whirlpools, hot tubs, saunas, flotation mattresses, and biofeedback equipment.
- Self-help devices that are not medical in nature, regardless of the relief or safety they may provide for a medical condition, including, but not limited to, bath accessories (including bathtub lifts), telephone arms, home modifications to accommodate wheelchairs, wheelchair convenience items,

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wheelchair lifts, and vehicle modifications.

- Dental prostheses, hair/cranial prostheses, penile prostheses or other prostheses for cosmetic purposes.
- Orthotic shoe inserts (except for Members with diabetes).
- Home exercise and therapy equipment.
- Consumer beds, adjustable beds or waterbeds
- Repairs or replacements needed due to misuse or abuse of any covered medical supply or equipment that is identified in this section.
- Orthopedic shoes not attached to a brace (except for Members with diabetes).

Mental Health Care

How do I get mental health services?

You do not need a referral (approval in advance) from your Primary Care Provider (PCP) to get mental or behavioral health services from a specialist, hospital, or other provider that is in RMHP's network. Your mental health service provider may need to get approval in advance from RMHP for some services.

Counselors who know sign language and sign language interpreters are available.

What mental health services are covered?

Outpatient treatment

This plan covers outpatient mental health services, which are services you get outside of a hospital or residential facility. Covered outpatient treatments do not require pre-authorization if the provider is in-network with RMHP. Covered services include, but are not limited to:

- Individual counseling;
- Family counseling;
- Group counseling; and
- Case management services.

Medication management

This plan covers medication management of mental health conditions by a psychiatrist, medical provider or nurse with prescriptive authority (this is a nurse that is legally allowed to write prescriptions).

Day treatment

Day treatment services are for specific mental health and educational needs and are sometimes part of the child's Individual Education Plan (IEP). Covered day treatment services require pre-authorization. Day treatment services can include, but are not limited to:

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- Individual counseling;
- Family counseling;
- Group counseling; and
- Educational support services.

Care management

An RMHP Care Manager can help you:

- Get the right care from doctors, providers, schools, and other programs.
- Find resources (such as food, clothing, and housing).
- If you would like information about care management, call RMHP Customer Service.
- Care management services are provided at no cost to you

Mental health emergency services

If you have a mental health emergency or crisis, go directly to the nearest emergency room or call 911. Emergency services are available 24 hours a day, 7 days a week. See the *Emergency and Urgent/After-Hours Care* section for more details.

Inpatient services for mental health conditions

This plan covers medically necessary inpatient stays to treat mental health conditions. Covered services include:

- Provider visits received during a covered admission;
- Inpatient semi-private room or ancillary services;
- Group psychotherapy; and
- Medication management.

Residential treatment service

The same services covered as inpatient services are also covered for residential treatment services. Residential treatment services are services in a licensed residential treatment facility that can provide day services and 24-hour supervision after day program. Residential treatment requires pre- authorization and is approved only if the charges are equal to or less than partial hospitalization.

Specialized mental health home-based services

These are specialized mental health services that you get in your home when traditional mental health services have not been effective. Your provider may need to get pre-authorization.

Mental health evaluations/assessments

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An evaluation (also called an assessment) is a way to find out your mental health needs and to find out the best kind of care for you. Your provider may need to get pre-authorization.

Other mental health services

If you have questions about other mental health services that are not listed, call RMHP Customer Service.

Autism spectrum disorder

Treatment for the diagnosis of autism spectrum disorder is a covered benefit when the treatment is medically necessary, appropriate, effective or efficient. Such treatment includes evaluation and assessment, habilitative or rehabilitative care such as occupational therapy, physical therapy, and speech therapy for fine and gross motor delays, and psychiatric/psychological services.

What mental health services are not covered?

The following services, supplies and care are not covered (exclusions):

- Private room expenses.
- Vocational services (includes but is not limited to, resume writing, interview skills, work skills training, and career development).
- Psychosocial treatment (includes, but is not limited to, home and budget skills).
- Biofeedback.
- Psychoanalysis or psychotherapy that a Member may use as credit toward earning a degree or furthering the Member's education.
- Hypnotherapy.
- Religious, marital, and social counseling.
- The cost of any damages to a treatment facility caused by the Member.
- Recreational, sex, primal scream, sleep, and Z therapies.
- Self-help and weight-loss programs.
- Transactional analysis, encounter groups, and transcendental meditation.
- Sensitivity training and assertiveness training.
- Rebirthing therapy.
- Custodial care.
- Domiciliary care.
- Court or police-ordered treatment that would not otherwise be covered.
- Services not authorized by RMHP.
- Applied Behavioral Analysis (ABA) therapy is not a covered benefit.

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Nutrition and Food Services

Who can supply food and nutrition services?

An in-network licensed therapist or home health agency must provide the nutrition services. Covered medical foods require a prescription from your provider and must be obtained through an in-network pharmacy and are subject to the pharmacy copayment.

What food and nutrition services are covered?

This plan covers enteral (tube feeding) therapy and Total Parenteral Nutrition (TPN) and includes a combination of nursing, durable medical equipment, and pharmaceutical services.

The durable medical equipment and supplies related to food and nutrition services are subject to the payment limit described in the Medical Supplies and Equipment section.

Your provider must contact RMHP for pre-authorization of services. See the Getting Care section for information about pre-authorization guidelines.

Enteral therapy and Total Parenteral Nutrition (TPN)

- Enteral nutrition is delivery of nutrients by a tube into the gastrointestinal tract.
- Medically necessary and non-custodial nursing visits to assist with enteral nutrition are covered under the home health benefits. These services are usually provided by a home health agency. For more information, see the Home Health Care/Home Infusion Therapy and the Hospice Care sections.
- TPN is the delivery of nutrients through an intravenous (IV) line directly into the bloodstream.
- Medically necessary TPN received in the home is a covered benefit for the first 21 days following a hospital discharge.
- If medically necessary, additional days may be allowed, up to a maximum of 42 days per calendar year as determined to be medically necessary and when pre-authorized by RMHP.

Medical foods

- This plan covers medical foods for home use for metabolic disorders.
- Covered medical foods must be prescribed by your provider.
- This plan covers medical foods that are appropriate for inherited enzymatic disorders involved in the metabolism of amino, organic, and fatty acids. Such disorders include phenylketonuria, maternal phenylketonuria, maple syrup urine disease, tyrosinemia, homocystinuria,
- histidinemia, urea cycle disorders, hyperlysinemia, glutaric acidemias, methylmalonic acidemia, and propionic acidemia.
- This benefit does not include medical foods for Members with lactose or soy intolerance.

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Other medical nutrition

This plan also covers the following services:

- Diagnosis of diabetes – inpatient nutrition counseling, outpatient nutrition and self- management training and follow-up visits for Members diagnosed as diabetic.
- Hospice care – nutrition assessment, counseling and support, such as intravenous feeding, hyperalimentation, and enteral feeding.
- Formulas for metabolic disorders, total parenteral nutrition, enteral nutrition and nutrition products, and formulas for gastrostomy tubes are covered for documented medical needs including attainment of normal growth and development. Enteral formula is covered under the Home Health Care benefit. Payment for formula must be pre-authorized and will be considered only if there is a gastrointestinal disorder (including the oral cavity), malabsorption syndrome, or a condition that affects growth pattern or the normal absorption of nutrition. Cost of pumps, tubing and other supplies for administration of formulas administered by tube or vein are included.
- Nutrition assessment and therapy for infants and children requiring special formulas, feeding by enteral tube or by parenteral route, or with documented medical need, including attainment of normal growth and development, including growth failure.
- Feeding appliances and feeding evaluations that are medically necessary in conditions where oral/esophageal conditions make normal food intake inadequate.
- Obesity/overweight – nutrition assessment and therapy using pediatric weight management standards. Obesity is defined as greater than the 95th percentile weight for height, or greater than 95th percentile Body Mass Index (BMI) for age (using the DCD/NCHS Growth Grids).
- Nutrition assessment and therapy when medically indicated, including but not limited to conditions such as spina bifida, cystic fibrosis, cerebral palsy, dysphagia, cleft lip/palate, food allergies and intolerance, hyperlipoproteinemia, seizure disorders, eating disorders, congenital heart disease, renal failure, cancer, AIDS, Prader-Willi Syndrome, and Rett Syndrome.
- Human breast milk from a milk bank when it is required for the survival of the infant. Breastfeeding equipment such as breast pumps and a Supplemental Nutrition System (SNS) when a fragile infant's growth is failing and it is considered in the best interest of the infant to continue breastfeeding.

What food and nutrition services are not covered (exclusions)?

The following services, supplies and care are not covered:

- Enteral (tube) feedings, except as provided previously in this section.
- Tube feeding formula except as provided previously in this section.
- Weight loss programs, exercise equipment, exercise classes, health club memberships, personal

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trainers, prescription or over-the-counter medications for weight loss, or obesity treatment (except medically necessary surgical treatment or as provided previously in this section), even if the extra weight or obesity aggravates another condition.

- Food, meals, formulas and supplements other than those listed previously in this section, even if the food, meal, formula or supplement is the sole source of nutrition, except as provided previously in this section.
- Breast feeding education and baby formulas.
- Feeding clinics.

Outpatient Facility Services

Where can I get outpatient facility services?

All outpatient facility services must be at an in-network facility. Outpatient facility services at an out-of-network facility, unless services are for an emergency or otherwise authorized by RMHP, are not covered.

Outpatient facility services may be obtained at the following locations:

- An acute hospital outpatient department
- An ambulatory surgery center
- A radiology center
- A dialysis center
- An outpatient hospital clinic

What outpatient facility services are covered?

Covered outpatient facility services include:

- Facility Services – A number of health care services are provided in an outpatient facility setting. Some of the covered services include, but are not limited to, the following:
 - Use of an operating room, recovery room, and related equipment.
 - Medical and surgical dressings, supplies, surgical trays, casts, and splints when supplied by the facility during an outpatient admission.
 - Drugs and medicines given during an outpatient admission.
- Ancillary Services – Some of the covered ancillary services include, but are not limited to, the following:
 - Diagnostic services such as laboratory and x-ray tests (for example, CT scan, MRI).
 - Medical and surgical dressings, supplies, surgical trays, casts, and splints when supplied by an in-network provider at an outpatient facility.

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- Chemotherapy and radiation therapy.
- Dialysis treatment.
- Respiratory therapy.
- Charges for processing, transportation, handling, and administration of blood.
- Therapeutic Dialysis services are covered:
 - When the Member is not eligible for Medicare or is covered by Medicare but does not have a Medicare supplemental insurance policy (see the Other Insurance, Coordination of Benefits & Subrogation section), and
 - When services are performed by an in-network dialysis provider.
- Home dialysis services require pre-authorization by RMHP. Covered dialysis services include:
 - Hemodialysis,
 - Peritoneal dialysis, and
 - The cost of equipment rentals and supplies for in-home dialysis
- Professional Services – Professional services are the surgical and medical care provided during an outpatient admission. Some of the covered professional services include, but are not limited to the following:
 - Provider services for the medical condition(s) while you are in an outpatient facility.
 - Surgical services. The surgical fee includes normal post-operative care.
 - Anesthesia and anesthesia supplies and services for a covered surgery.
 - Surgical assistants or assistant surgeons as determined by RMHP medical policy. RMHP does not cover surgical assistants for all surgical procedures.
 - Consultation by another provider when requested by the Member's provider.
- Staff consultations required by facility rules are not covered.

What outpatient facility services are not covered?

The following services, supplies, and care are not covered (exclusions):

- Surgical benefits will not be provided for subsequent procedures to correct further injury or illness resulting from noncompliance with prescribed medical treatment. An example of a non-covered subsequent procedure is the removal of infected tissue directly caused by not taking the medication that was prescribed after a tonsillectomy.
- Procedures that are solely cosmetic in nature.
- Any services or care for the treatment of sexual dysfunction.

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- Personal comfort and convenience items such as televisions, telephones, guest meals, articles for personal hygiene and other similar services and supplies.
- Surgical services for refractive keratoplasty, including radial keratotomy or Lasik, or any procedure to correct visual refractive defect.
- Additional procedures routinely performed during the course of the main surgery.
- Peripheral bone density scans.

For more information

- Some outpatient facility services require a pre-authorization. See the *Getting Care* section of this Booklet for information about pre-authorization guidelines.
- See the *Mental Health Care* section for covered mental health and *Substance Abuse Care* for substance abuse treatments.
- See the *Emergency and Urgent/After-Hours Care* section for information about emergency care.
- For covered dental services covered, see the *Dental-Related Services* section.

Prescription Medications

Where can I get prescription medications?

This plan includes a nationwide network of retail pharmacies. The pharmacy network is large and includes most pharmacies in Colorado. A list of in-network pharmacies can be found online at rmhp.org. You can also call RMHP Customer Service.

To get prescription medications, go to an in-network retail pharmacy. Give the written prescription from your provider and your RMHP ID card to the pharmacist. You can also get prescriptions through RMHP's mail-order pharmacy service.

What prescription medications are covered?

The most up-to-date list of prescription medications covered under this plan is on RMHP's website at rmhp.org. A paper copy is available by calling RMHP Customer Service. The name of the document that lists covered prescription medications for this plan is RMHP PRIME & CHP+ formulary. The RMHP PRIME & CHP+ formulary also provides information about coverage guidelines, quantity limits, which medications require pre-authorization, and what to do if you are prescribed a medication that is not on the list. This plan covers a 30-day supply of a prescription medication from an in-network pharmacy or up to a 90-day supply from the mail order service.

Prescription medication preauthorization

- Certain prescription medications or the prescribed quantity of a particular medication may require

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pre-authorization. A list of prescription medications that require pre-authorization can be found on the formulary list.

- If you need a prescription medication that requires pre-authorization, the provider who prescribed the medication should contact RMHP. If the pre-authorization is denied, you can appeal the decision by following the instructions in the *Complaints, Appeals & Grievances* section of this Booklet.
- If your doctor does not get the pre-authorization, and you try to fill the prescription, the in-network retail pharmacist will let you know that the medication requires pre-authorization. You should then contact the provider who prescribed the medication and ask him or her to send information to RMHP. If you need help, call RMHP Customer Service.

Inpatient pharmacy benefits

This plan covers medications provided during a covered inpatient stay when the medications are billed by a hospital or other facility.

How do I fill a prescription through RMHP's home delivery pharmacy service?

You can use the RMHP home delivery pharmacy service to fill prescriptions for what are called "maintenance drugs." These are medications that you take on a regular basis, for a chronic or long-term medical condition.

RMHP uses OptumRx for pharmacy home delivery services. If you have medications you would like to fill through OptumRx home delivery, you can:

- Visit **rmhp.org** to access the OptumRx portal or download the OptumRx mobile app.
- Ask your doctor to send an electronic prescription to OptumRx.
- Call OptumRx home delivery at 855-473-8889.
- Download and complete the OptumRx new prescription mail-in order form found at **rmhp.org** and mail it to OptumRx with your prescription.

When you sign up, be sure to set up your credit card or billing preference with OptumRx. Make sure your provider writes the prescription for a three-month supply of medicine with refills as appropriate. Ask RMHP Customer Service if you need help.

For continued mail order service, three weeks before you run out of medicine, order a refill through the OptumRx portal or app, or by calling OptumRx home delivery at 855-473-8889.

Do I have a prescription medication copayment?

Some Members of this plan have a prescription medication copayment.

- If you have a copayment, your copayment amount will be listed on your RMHP Member ID card.
- If you have a prescription medication copayment, the retail pharmacy will ask for it before they give you the medication.

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- If you are filling more than one prescription, a separate copayment is required for each covered medication or supply.
- If the retail price of the medication is less than your copayment amount, you will pay the retail price. The copayment will not be reduced by any discounts or rebates.
- This plan does not pay for any covered medication or supply unless the negotiated rate exceeds any applicable copayment for which the Member is responsible.

What do I do if I pay for a medication that is covered by this plan?

- If you do not have your RMHP Member ID card when you go to an in-network pharmacy, or if you have an emergency away from home and fill a prescription at an out-of-network pharmacy, you may be charged for the full cost of the prescription medication. If you pay the full charge for a covered prescription medication, follow these steps:
 - Ask the pharmacist for an itemized receipt that shows that you paid for the covered prescription medication. This receipt must include the pharmacy name and address, prescribing physician's name, drug name, prescription number, and amount charged. The bill or receipts must be issued by the pharmacy.
 - Mail the itemized receipt along within 120 days of buying the medicine. RMHP can't pay you back if you send us the receipt after 120 days, or if you purchased a medicine not covered under this plan.
 - Mail the receipt and request for reimbursement to: OptumRx Claims Department | PO Box 29044 | Hot Springs, AR 71903
- If your request is approved, you will be reimbursed 100 percent of the approved amount for the covered medication, minus any applicable copayment. Prescription medications dispensed in excess of a 30-day supply are not reimbursable.

What prescription medications are not covered?

The following services, supplies and care are not covered (exclusions):

- Prescription medications and supplies received from an out-of-network pharmacy.
- Unless specifically noted above or in the formulary list, non-prescription and over-the-counter medications are not covered. This includes herbal or homeopathic preparations; prescription medications with an over-the-counter bioequivalent, even if it is written as a prescription; and medications not requiring a prescription by federal law (including medications requiring a prescription by state law, but not federal law), except for injectable insulin. Some prescription medications may not be covered if the Member receives a prescription order from a provider.
- Medications prescribed for weight control or appetite suppression.
- Medications or preparation used for cosmetic purposes to promote or prevent hair growth, or growth

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or medicated cosmetics, including, but not limited to, Rogaine®, Vaniqa®, and Tretinoin (sold under such brand names as Retin-A®).

- Any medication, product or technology within six months of the Food and Drug Administration (FDA) approval. RMHP may, at its sole discretion, waive this exclusion in whole or in part for a specific new FDA-approved medication product or technology.
- Any medications used to treat infertility.
- Standard RMHP CHP+ plan benefits do not cover special formulas, food or food supplements (unless for metabolic disorders); see the Nutrition and Food Services section for benefit information.
- This plan does not cover vitamin or mineral supplements, except for prenatal vitamins.
- Delivery charges for prescriptions.
- Charges for the administration of any medication, unless it is dispensed in the provider's office or through home health services.
- Medications provided as samples to the provider.
- Antibacterial soap/detergent, toothpaste/gel, shampoo or mouthwash/rinse.
- Hypodermic needles, syringes or similar devices, except when they are used for administration of a covered medication when prescribed in accordance with the terms of this section.
- Therapeutic devices or appliances, including support garments and other non-medicinal supplies (regardless of intended use).
- Prescription medications dispensed in quantities that exceed the applicable limits, which are established by RMHP at its sole discretion.
- Refills that exceed the quantity prescribed by the provider or that are refilled more than one year from the date of such order.
- Prescription medications intended for the treatment of sexual dysfunction or inadequacy, regardless of origin or cause (including medications, such as Viagra®, for the treatment of erectile dysfunction).
- Prescription medications dispensed for the purpose of international travel.

For more information

- For benefit information about special foods and formulas for metabolic and nutritional needs, see the Nutrition and Food Services section. See the *Home Health Care/Home Infusion Therapy* section for benefit information about home intravenous (IV) therapy.
- If you do not get certain supplies, equipment, and appliances through an in-network pharmacy, they may be covered as medical supplies or durable medical equipment. See the *Medical Supplies and Equipment* section for benefit information about medical supplies and durable medical equipment.

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Preventive Care Services

Who should I see for preventive care services?

All Members of this plan should see a primary care provider (PCP) for preventive care services. If you need help finding a primary care provider, call RMHP Customer Service.

What preventive care services are covered?

Covered preventive services are routine PCP visits, like well-child exams and routine physicals. Annual gynecological (woman) exams are covered. Additional preventive services are also covered and include:

- Regularly scheduled childhood and adult immunizations (shots)
- Age-appropriate vision and hearing screening exams

RMHP encourages parents and providers to follow the well-child visit schedule recommended by the American Academy of Pediatrics. The table below lists the ages when a child should see a pediatric provider for well child check-ups. Schedule a well-child visit with your child’s PCP when your child is each age below.

Infancy	Early Childhood	Middle Childhood	Adolescence
Prenatal	12 Months	5 Years	11 Years
Newborn	15 Months	6 Years	12 Years
First Week	18 Months	7 Years	13 Years
1 Month	24 Months	8 Years	14 Years
2 Months	30 Months	9 Years	15 Years
4 Months	3 Years	10 Years	16 Years
6 Months	4 Years		17 Years
9 Months			18 Years

What preventive services are not covered?

The following are not covered services (exclusions):

- Immunizations required for international travel.
- Services related to routine physical or screening exams and immunizations given primarily for insurance, licensing, employment, weight reduction programs, or for any non-preventive purpose.
- Any services not medically necessary
- Services related to routine physical or screening exams and immunizations given primarily for insurance, licensing, employment, weight reduction programs, or for any non-preventive purpose.
- Any services not medically necessary. Provider Office-Based Services

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Who should I see for provider office services?

This plan covers provider office visits and office based services with RMHP participating (in-network) providers.

You do not need a referral for:

You do not need a referral to see any RMHP participating provider.

What provider office services are covered?

Benefits are provided for medical care, consultations, and second opinions to examine, diagnose, and treat an illness or injury when received in a provider's office. A provider may also provide medication management for medical conditions or mental health disorders.

Benefits are provided for office-based surgery and surgical services, which includes anesthesia and supplies. Such surgical fees include local anesthesia and normal post-operative care. For certain office-based surgical services your provider may need pre-authorization from RMHP.

Benefits are provided for diagnostic services received in a provider's office when they are required to diagnose or monitor a symptom, disease or condition. Benefits for diagnostic services done in a provider's office include, but are not limited to, the following:

- X-ray and other radiology services,
- Laboratory and pathology services, and
- Ultrasound services for non-pregnancy related conditions. For pregnancy-related ultrasounds, see the Maternity and Newborn Child Care section.

Coverage is available for the following services related to allergy tests:

- Direct skin (percutaneous and intradermal) and patch allergy tests and RAST (radioallergosorbent testing),
- Allergy medications administered by injection in a provider's office, and
- Charges for allergy serum.

Audiometric (hearing) and vision tests are also provider office services that are covered.

What provider office services are not covered?

The following services, supplies, and care are not covered (exclusions):

- Any cost related to getting your medical records or reports or the transfer of your files.
- Treatment for hair loss, even if caused by a medical condition, except for alopecia areata, which is a disease that causes loss of hair.
- Routine foot care, such as care for corns, toenails or calluses (except for Members with diabetes).

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- Treatment for sexual dysfunction.
- Infertility services.
- Genetic counseling.
- Separate reimbursement for anesthesia and post-operative care when services are provided by the same provider in the provider's office.
- Peripheral bone density scans.

For more information

- For preventive care, see the *Preventive Care Services* section.
- For family planning services, see the *Family Planning/Reproductive Health* section.
- For the treatment of alcoholism, substance abuse, or mental illness, see the *Mental Health Care* section or the *Substance Abuse Care* section.
- For information about receiving after-hours office services, call the PCP's office and request instructions; see the *Emergency and Urgent/After-Hours Care* section.
- For visits related to home health or hospice care, see the *Home Health Care/Home Infusion Therapy* section and the *Hospice Care* section.
- For coverage of inpatient hospital provider visits, see the *Inpatient Facility Services* section.
- For a service related to a dental accident, oral surgery, or temporomandibular joint (TMJ) disorder, see the *Dental-Related Services* section of this Booklet.

Substance Abuse Care for Addiction to Alcohol or Drugs

How do I get substance abuse services for addiction to alcohol or drugs?

You do not need a referral (approval in advance) from your Primary Care Provider (PCP) to get substance abuse treatment from a specialist, hospital, or other provider that is in RMHP's network. Your substance abuse service provider may need to get approval in advance from RMHP for some services. RMHP will work with you and your substance abuse provider to determine medical necessity, the appropriate treatment level and the appropriate setting for substance abuse services.

What substance abuse services are covered?

This plan covers medically necessary outpatient and inpatient substance abuse treatments. Covered outpatient services do not require a pre-authorization. If you are admitted to an inpatient substance abuse treatment facility, the provider must notify RMHP.

What substance abuse services are not covered?

The following services, supplies and care are not covered (exclusions):

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- Private room expenses.
- Vocational services (includes but is not limited to, resume writing, interview skills, work skills training, and career development).
- Psychosocial treatment (includes, but is not limited to, home and budget skills).
- Biofeedback.
- Psychoanalysis or psychotherapy that a Member may use as credit toward earning a degree or furthering the Member's education.
- Hypnotherapy.
- Religious, marital, and social counseling.
- The cost of any damages to a treatment facility caused by the Member.
- Recreational, sex, primal scream, sleep, and Z therapies.
- Self-help and weight-loss programs.
- Transactional analysis, encounter groups, and transcendental meditation.
- Sensitivity training and assertiveness training.
- Rebirthing therapy.
- Custodial care.
- Domiciliary care.
- Court or police-ordered treatment that would not otherwise be covered.
- Services not authorized by RMHP.
- Applied Behavioral Analysis (ABA) therapy is not a covered benefit.

Therapy - Outpatient Therapies (Physical, Speech, Occupational)

Where can I get outpatient therapy, including physical, speech, and occupational therapy?

All care must be received from an in-network licensed physical therapist, a licensed speech therapist or a licensed occupational therapist.

What outpatient therapies are covered?

Covered outpatient therapies include:

- Physical, occupational, and/or speech therapy are covered.
- The standard CHP+ coverage is limited to 30 visits per diagnosis per calendar year.
- The service must start within six months of the date the injury or illness occurred.
- For children ages 0 – 3, the benefit for physical, occupational, and speech therapy is unlimited

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through the Early Intervention Program. This unlimited benefit lasts through the end of the month that the child turns 3 years old.

- After the third birthday, outpatient therapy (physical, occupational, and/or speech therapy) coverage is limited to the standard CHP+ coverage of 30 visits per diagnosis per year.

The following services are a covered benefit for children ages 0 – 5 with a congenital defect or birth abnormality; the duration and number of visits are based on medical necessity:

- Learning disorders
- Stuttering
- Voice disorders
- Rhythm disorders

This benefit extends through the end of the month in which the child turns 5 years old. To be considered covered services, outpatient therapy must meet the following conditions:

- There is a documented condition or delay in recovery that can be expected to improve with therapy within 60 days of the initial referral for therapy;
- The outpatient therapy is medically necessary; and
- You could not normally be expected to improve without outpatient therapy.

Physical Therapy

Physical therapy is given to relieve pain, restore function, prevent disability following illness, injury or loss of a body part, developmental delay or prevent disability due to congenital defect or birth abnormality. Physical therapy may involve a wide variety of evaluation and treatment techniques. Examples include manual therapy, hydrotherapy and heat, and the application of physical agents and biomechanical and neuro-physiological principles and devices.

Speech Therapy

Speech therapy is for the correction of speech impairment resulting from illness, injury developmental delay or surgery. Speech therapists can also help with the medical management of swallowing disorders. Medically necessary speech therapy visits related to cleft palate or cleft lip condition are unlimited. These speech therapy visits are applied toward the maximum visits as described above but are not limited to the maximum visits.

Occupational Therapy

Occupational therapy is therapy that helps you regain independence. Examples of occupational

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therapy include: developing or relearning the skills to get dressed, brush teeth and participate in school successfully. They may give the child adaptive equipment to help with these skills.

What outpatient therapy services are not covered?

The following services, supplies, and care are not covered (exclusions):

- Formula for any medical condition that does not meet the above requirements.
- Cardiac rehabilitation programs unless following a major cardiac event.
- Maintenance therapy or care provided after you have reached your rehabilitative potential as determined by RMHP.
- Home programs for ongoing conditioning and maintenance.
- Therapies for learning disorders, stuttering, voice disorders, or rhythm disorders unless specifically listed above. Non-specific diagnoses relating to learning-related disorders.
- Therapeutic exercise equipment such as treadmills and/or weights prescribed for home use.
- Membership at health spas or fitness centers.
- Convenience items as determined by RMHP.
- The purchase of pools, whirlpools, spas, and personal hydrotherapy devices.
- Therapies and self-help programs not specifically identified above.
- Recreational, sex, primal scream, sleep and Z therapies.
- Biofeedback.
- Rebirthing therapy.
- Self-help and weight-loss programs.
- Transactional analysis, encounter groups, and transcendental meditation (TM).
- Sensitivity and assertiveness training.
- Rolfing, Pilates, myotherapy, and prolotherapy.
- Holistic medicine and other wellness programs.
- Educational programs such as behavior modification or arthritis classes, except as otherwise specifically provided for under this CHP+ Member Benefits Booklet.
- Services for sensory integration disorder.
- Occupational therapies for diversional, recreational or vocational therapies (for example, hobbies, arts and crafts).
- Acupuncture care.

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Transportation - Ambulance Services

What is a covered ambulance service?

- Calls to 911 for ambulance services.
- Ambulance transports from one hospital to another hospital when the first hospital is on divert (too full to accept new patients).
- Ambulance transports from one hospital to another hospital when the first hospital is not equipped to provide the appropriate level of care you need.

What ambulance transportation services are covered?

Only emergency or medically necessary ambulance services are a covered benefit. This plan covers local transportation by a vehicle designed, equipped, and used only to transport you if you are sick and injured. The vehicle must be operated by trained personnel and licensed as an ambulance to take you from your home or the scene of an accident or medical emergency to the closest hospital with appropriate emergency facilities, or from one hospital to another for a medically necessary transport by ambulance for continuing inpatient or outpatient care.

Air Ambulance

Air ambulance is only a covered benefit when terrain, distance, or the Member's physical condition requires the services of an air ambulance. RMHP will determine on a case-by-case basis if transport by air ambulance is a covered benefit. If RMHP determines that ground ambulance could have been used, the level of benefits will be limited to those for transport by ground ambulance. You will be responsible for the remainder of the bill.

What transportation services are not covered?

The following services, supplies, and care are not covered (exclusions):

- Commercial transport (air or ground), private aviation or air taxi services.
- Transportation by private car/automobile, commercial or public transportation or wheelchair ambulance (ambu-cab).
- Ambulance transportation if you could have been transported by automobile or commercial or public transportation without endangering your health and/or safety.
- If you elect not to receive transport to an emergency facility after an ambulance has been called, then you are responsible for any charges.
- Ambulance transportation from an emergency facility to your residence.
- Non-emergent transportation services. Non-ambulance transportation such as a taxi or public transportation is not a covered benefit. This includes transportation to and from doctor office visits or to and from a pharmacy.

Questions? Rocky Mountain Health Plans is here to help.

Call us at 970-244-7960 / 855-830-1563 (TTY 711), Monday-Friday, 8:00 a.m. to 5:00 p.m.

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Vision Services

Where can I get covered vision services?

You must receive routine and specialty vision services from an in-network ophthalmologist or optometrist. Lenses, frames, and/or contacts can be purchased from an in-network or out-of-network provider, subject to benefit limits.

What vision services are covered?

The following are covered vision services:

- This plan covers age-appropriate vision screening and routine eye exam.
- One routine eye exam is covered per calendar year.
- Routine vision services do not require pre-authorization.
- This plan provides a \$50 credit per Member per calendar year towards the purchase of lenses, frames, and/or contacts. Lenses, frames, and/or contacts can be purchased from an in-network or out-of-network provider.
- This plan covers specialty vision services to an in-network provider.
- A specialty vision service is when you see a vision provider for something other than a routine exam. Your specialty vision provider may need to submit a pre-authorization request to RMHP.

What vision services are not covered?

The following vision services are not covered (exclusions):

- Vision therapy.
- Specialty services received without a pre-authorization.
- Services related to improving your eyesight with surgery, or any procedure to correct vision.

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6: General Exclusions & Limitations

This list of exclusions describes services that are not covered by this plan. The list of exclusions is not a complete list of all services, supplies, conditions or situations that are not covered services. If you have questions about covered benefits or exclusions, call RMHP Customer Service.

- These general exclusions apply to all benefits described in this CHP+ Member Benefits Booklet. In addition to these general exclusions, specific limitations, conditions, and exclusions apply to specific covered services, which may be found in the Covered Services section and elsewhere in this Booklet.

Important information about services and benefits that are not covered

- You may be billed for services that are not covered. Even if you receive a referral from a health care provider, services will not be covered if the service is an exclusion, or is not a covered benefit.
- If a service is not covered, then all services performed in conjunction with that service are not covered.
- RMHP is the final authority for determining if services and supplies are medically necessary for the purpose of payment.

This plan will not cover the following services, supplies, situations, or related expenses. This is not intended to be an all-inclusive list of non-covered services:

Acupuncture – This coverage does not cover services or supplies related to acupuncture care.

Alternative or complementary medicines – This coverage does not cover alternative or complementary medicine. Services that are considered alternative or complementary medicine include, but are not limited to, holistic medicine, homeopathy, hypnosis, aromatherapy, massage therapy, reiki therapy, herbal medicine, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergetic synchronization technique (BEST), colonics or iridology.

Adoption or surrogate expenses – This coverage does not cover expenses related to adoption or a surrogate.

Artificial conception – This coverage does not cover services related to artificial conception.

Applied Behavioral Analysis (ABA) therapy – This is not a covered benefit.

Before effective date – This coverage does not cover any service received before the Member's effective date of coverage with RMHP under this plan.

Biofeedback – This coverage does not cover services and supplies related to biofeedback.

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Chelating agents – This coverage does not cover any service, supply or treatment for which a chelating agent is used, except for providing treatment for heavy metal poisoning.

Chiropractic services – This coverage does not cover any services or supplies for care received by a chiropractor. Spinal manipulation procedures must be performed by an osteopathic doctor (DO); care provided by a chiropractor is not a covered benefit.

Chronic pain – This coverage does not cover services or supplies for the treatment of chronic pain.

Clinical research – This coverage does not cover any services or supplies provided as part of clinical research, unless allowed by RMHP's medical policy. A signed consent form for human research subjects will be considered proof that a Member is involved in a clinical research program.

Complications of non-covered services – This coverage does not cover complications arising from non-covered services and supplies. Examples of non-covered services include, but are not limited to, cosmetic surgery and procedures and services that are determined to be experimental/investigational.

Convalescent care – Except as otherwise specifically provided, this coverage does not cover convalescent care following a period of illness, an injury or surgery, unless the convalescent care is normally received for a specific condition, as determined by RMHP's medical policy. Convalescent care includes the provider's or facility's services.

Convenience/luxury/deluxe services or equipment – This coverage does not cover services and supplies used primarily for the Member's personal comfort or convenience. Such services and supplies include, but are not limited to, guest trays, beauty or barbershop services, gift shop purchases, telephone charges, televisions, admission kits, personal laundry services, and hot and/or cold packs.

This coverage does not cover supplies, equipment or appliances that are comfort, luxury or convenience items (for example, wheelchair sidecars, fashion eyeglass frames or a cryocuff unit). Equipment or appliances requested by the Member that include more features than needed for the medical condition are considered luxury, deluxe, and convenience items (for example, motorized equipment, such as electric wheelchairs or electric scooters, when manually operated equipment can be used) and are not covered.

Cosmetic services – This coverage does not cover cosmetic procedures, services, equipment or supplies provided for psychiatric or psychological reasons, to change family characteristics or to improve appearance. This coverage does not cover services required as a result of a complication or outcome of a non-covered cosmetic service. Some examples of cosmetic procedures include, but are not limited to, face lifts, Botox injections, breast augmentation, rhinoplasty, and scar revisions.

Court-ordered services – This coverage does not cover services rendered under court order, parole or probation, unless those services would otherwise be covered under this CHP+ Member Benefits Booklet.

Custodial care – This coverage does not cover care primarily for the purpose of assisting the Member in

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the activities of daily living or in meeting personal rather than medical needs, and which is not a specific treatment for an illness or injury. Custodial care cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Care can be custodial whether or not it is recommended or performed by a professional and whether or not it is performed in a facility (for example, hospital or skilled nursing facility) or at home. Examples of custodial care include, but are not limited to, the following:

- Assistance with walking, bathing or dressing.
- Transferring or positioning in bed.
- Administration of self-administered or self-injectable medicine.
- Meal preparation.
- Assistance with feeding.
- Oral hygiene.
- Routine skin and nail care.
- Suctioning.
- Toileting (assistance going to the bathroom).
- Supervision of medical equipment or its use.

Dental services – This coverage does not cover dental services except as provided in the *Dental-Related Services* section.

Discharge against medical advice – This coverage does not cover hospital or other facility services if you leave a hospital or other facility against the medical advice of the provider.

Discharge day expense – This coverage does not cover room and board charges related to a discharge day.

Discharge from facility (services received beyond the pre-authorized discharge date) – This coverage does not cover services that are provided after the discharge date indicated in the pre-authorization from RMHP. The appropriate discharge date is determined based on care guidelines.

Domiciliary care – This coverage does not cover care provided in a non-treatment institution, halfway house or school.

Double coverage – Double coverage refers to having CHP+ coverage and another insurance coverage, such as Medicaid or a commercial plan, at the same time. You cannot be eligible or covered by another insurance except for dental and Medicare while enrolled under this plan.

Elective termination of pregnancy – This coverage does not cover therapeutic or elective termination of pregnancy unless the elective termination is to save the life of the mother or if the pregnancy is the result of rape or incest.

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Experimental/investigative procedures – This coverage does not cover any treatment, procedure, drug/medication or device that RMHP has found to not meet the eligible-for-coverage criteria. If a service has not been pre-authorized, RMHP can make the determination before or after the service is rendered that the service is not considered eligible-for-coverage or is experimental/investigational. RMHP does not cover experimental/investigational treatment or procedures that are not proven to be effective, as determined by medical policy, or if no medical policy is available, as determined by appropriate medical/surgical authorities selected by RMHP.

Genetic testing/counseling – This coverage does not cover services including, but not limited to, preconception testing, paternity testing, court-ordered genetic counseling and testing, testing for inherited disorders, and discussion of family history or testing to determine the sex or physical characteristics of an unborn child. Genetic tests to evaluate risks of disorders for certain conditions may be covered based on medical policy, review, and criteria and after appropriate pre-authorization has been obtained.

Government-operated facility – This coverage does not cover services and supplies for all disabilities connected to military service that are furnished by a military medical facility operated by, for, or at the expense of federal, state, or local governments or their agencies, including a veterans administration facility, unless RMHP authorizes payment in writing before the services are performed.

Hair loss – This coverage does not cover treatment for hair loss (except for alopecia areata), including, but not limited to, medications, wigs, hairpieces, artificial hairpieces, hair or cranial prosthesis, hair transplants, or implants, even if there is a provider prescription, and a medical reason for the hair loss.

Hypnosis – This coverage does not cover services related to hypnosis, whether for medical or anesthesia purposes.

Illegal conduct – This coverage does not cover any services required as a result of your participation in or attempt to commit a felony or to which contributing cause was the result of your being engaged in an illegal occupation.

Infant formula – This coverage does not cover infant formula unless specifically allowed as a benefit under this CHP+ Member Benefits Booklet.

Learning deficiencies – This coverage does not cover special education, counseling, therapy, rehabilitation or care for learning deficiencies, whether or not associated with intellectual/developmental disability or other disturbances.

Maintenance therapy – This coverage does not cover any treatment that does not significantly enhance or increase the Member's functioning or productivity, or care provided after the Member has reached the Member's maximum medical improvement as determined by RMHP, except as provided in the *Covered Services* section of this Booklet.

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Medical necessity – This plan only covers expenses for services and supplies that are medically necessary. Coverage of services may be denied before or after payment, unless the services were pre-authorized.

- A decision as to whether a service or supply is medically necessary is based on medical policy, and peer-reviewed medical literature as to what is approved and generally accepted medical or surgical practice.
- The fact that a provider may prescribe, order, recommend, or approve a service does not of itself make the service medically necessary.

Medical nutritional therapy – This coverage does not cover vitamins, dietary/nutritional supplements, special foods, over-the-counter infant formulas, or diets unless specifically listed as covered in this CHP+ Member Benefits Booklet.

Non-covered providers of service – This coverage does not cover services and supplies prescribed or administered by a provider or other person, supplier, or facility not specifically listed as covered in this CHP+ Member Benefits Booklet. These non-covered providers or facilities include, but are not limited to, the following:

- Health spa or health fitness centers (whether or not services are provided by a licensed or registered provider).
- School infirmary.
- Massage therapist.
- Nursing home.
- Residential institution or halfway house (a facility where the primary services are room and board and constant supervision, or a structured daily routine for a person who is impaired but whose condition does not require acute care hospitalization).
- Dental or medical services sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group.
- Services provided to the Member by the Member, by a family member or by a person who ordinarily resides in the Member's household.
- Athletic trainer.

Non-medical expenses – This coverage does not cover non-medical expense, including, but not limited to, the following:

- Adoption or surrogate expenses.
- Educational classes and supplies not provided by the Member's health care provider, unless specifically allowed as a benefit listed in this CHP+ Member Benefits Booklet.
- Vocational training services and supplies.
- Mailing and/or shipping and handling expenses.

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- Interest expenses and delinquent payment fees.
- Modifications to home, vehicle or workplace, regardless of medical condition or disability.
- Membership fees for spas, health clubs, or other such facilities, or fees for personal trainers, even if medically recommended and regardless of any therapeutic value.
- Personal convenience items such as air conditioners, humidifiers, or exercise equipment.
- Personal services such as haircuts, shampoos, guest meals, and radio or televisions.
- Voice synthesizers or other communication devices, except as specifically allowed by RMHP.

Medical orthognathic surgery – This coverage does not cover upper or lower jaw augmentation or reductions (orthognathic surgery), even if the condition is due to a genetic, congenital or acquired characteristic; except as provided in the *Dental-Related Services* section and as mandated by state law.

Orthotics – This coverage does not cover orthotic shoe inserts (except for Members with diabetes), whether functional or otherwise, regardless of the relief they provide.

Other insurance – You cannot be eligible or covered by another insurance except for dental and Medicare while enrolled with this CHP+ plan.

Over-the-counter (OTC) products – This coverage does not cover over-the-counter non-medication items and other items usually stocked in the home for general use, including, but not limited to, bandages, gauze, tape, cotton swabs, dressing, thermometers, heating pads, and petroleum jelly. This coverage does not cover laboratory test kits for home use, including but not limited to, home pregnancy tests and home HIV tests.

Over-the-counter (OTC) drugs/medications – Unless noted as covered in this CHP+ Member Benefits Booklet (see the *Prescription Medications* section) or the formulary list, this coverage does not cover non-prescription and over-the-counter medications. This includes herbal or homeopathic preparations; prescription medications with an over-the-counter bioequivalent, even if it is written as a prescription; and medications not requiring a prescription by federal law (including medications requiring a prescription by state law, but not federal law), except for injectable insulin. Some prescription medications may not be covered even if the Member receives a prescription order from a provider.

Post-termination benefits – This coverage does not cover benefits for care received after coverage is terminated, except as provided in the *Membership* section. Follow up care is not covered post-termination even if the inpatient facility admission was allowed.

Private-duty nursing service – This coverage does not cover private-duty nursing services.

Private room expenses – This coverage does not cover services related to a private room, except as provided in the *Covered Services* section.

Professional or courtesy discount – This coverage does not cover any services for which the Member's

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portion of the payment is waived due to a professional courtesy or discount.

Radiology services – This coverage does not cover Ultrafast CT scan and peripheral bone density testing.

- This coverage does not cover whole body CT scan, or routine screening.
- Ultrasounds are covered as described in this CHP+ Member Benefits Booklet. Two (2) antenatal (prenatal) ultrasounds are covered. After the second ultrasound, pre-authorization is required. This gives RMHP a chance to review the case for pending high-risk pregnancy.

Reduction mammoplasty – This coverage does not cover reduction mammoplasty unless provided in conjunction with mastectomy reconstruction and diagnosis of cancer.

Report preparations – This coverage does not cover charges for the preparation of medical reports, itemized bills, or charges for duplication of medical records from the provider when requested by the Member.

Sexual dysfunction – This coverage does not cover services, supplies or prescription medications for the treatment of sexual dysfunction or impotence.

Taxes – This coverage does not cover sales, service, or other taxes imposed by law, that apply to covered services.

Temporomandibular joint (TMJ) surgery or therapy/orthognathic surgery – This coverage does not cover services related to temporomandibular joint (TMJ) surgery, except for temporomandibular joint surgery with a medical basis.

Third-party liability (subrogation) – This coverage does not cover services and supplies that may be reimbursed by a third party. See the *Administrative Information* section for information.

Travel expenses – This coverage does not cover travel or lodging expenses for you, your family, or your provider, except as provided under the *Human Organ and Tissue Transplant Services* section.

Tubal ligation – This coverage does not cover tubal ligations.

Vasectomies – This coverage does not cover vasectomies.

Vision – This coverage does not cover any surgical, medical, or hospital service and/or supply rendered in connection with any procedure designed to correct farsightedness, nearsightedness or astigmatism.

Vision therapy – This coverage does not cover vision therapy, including but not limited to, treatments such as vision training, orthoptics, eye training, or training for eye exercises.

War-related conditions – This coverage does not cover services or supplies necessary to treat disease or injury resulting from war, civil war, insurrection, rebellion, or revolution.

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Weight loss programs – This coverage does not cover weight loss program services.

Workers' compensation – This coverage does not cover services and supplies for a work-related accident or illness. See the *Administrative Information* section for information.

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7: Administrative Information and Additional Information

This section describes administrative information that you may find helpful while enrolled in this plan.

Administrative Information

Changes to the CHP+ Member Benefits Booklet

No one other than RMHP may change this CHP+ Member Benefits Booklet. RMHP administers this CHP+ Member Benefits Booklet in strict accordance with its terms as written. Oral or written statements do not replace the terms of this booklet.

The headings used throughout this CHP+ Member Benefits Booklet are for reference only and are not to be used by themselves for interpreting the provisions of this Booklet.

Quality Improvement Plan

RMHP has a Quality Improvement plan that tells us how we are doing in providing health care and Member services. We always want to improve our quality. You can request a copy of this plan at no cost to you. If you feel you did not get the right care, you can complain. If your care was not given by the right person, at the right place, or at the right time, you can complain. There is a form at the end of this benefits booklet that you can fill out or you can call Customer Service. Your complaints help us to see what works and what we need to fix.

Notice of Privacy Practices

RMHP is committed to protecting the confidentiality of your medical information to the fullest extent of the law. In addition to the laws that govern your privacy, RMHP has its own privacy policies and procedures to help protect your information. If you would like a copy of RMHP's privacy policies and notices, visit rmhp.org/legal/notice-of-privacy-practices or call Customer Service.

Sending Notices

All Member notices are considered sent to and received by the Member when deposited in the United States mail with postage prepaid and addressed to the Member at the latest address in RMHP's membership records.

Fraud Activity

If you suspect fraud – tell us! Call RMHP Customer Service or the Colorado CHP+ program. You can also use the *Fraud Investigation Referral Form* at the end of this Benefits Booklet and mail it to:

Fraud Investigator
Rocky Mountain Health Plans
PO Box 10600
Grand Junction, CO 81502-5600

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It is against the law to knowingly provide untrue, incomplete, or misleading information to RMHP or the CHP+ program to benefit you or anyone else. This is commonly called fraud. Do not commit fraud. Penalties for fraud may include prison, money fines, and denial of insurance.

If you feel that RMHP or the CHP+ program provided you with this type of information, you can report it to the Colorado Division of Insurance within the Department of Regulatory Agencies at dora.state.co.us.

Fraud causes the cost of health care to go up. You can help decrease these costs by doing the following:

- Be wary of offers to waive copayments. This practice is usually illegal.
- Be wary of mobile health testing labs. Ask what insurance company will be charged for the test.
- Always review this RMHP CHP+ Member Benefits Booklet. If there are any differences between what is in here and what you are offered, call RMHP Customer Service.
- Be very cautious about giving any information about your CHP+ or RMHP Member ID over the phone. You will know that you are a victim of medical identity theft or fraud if you:
 - Get a bill for medical services you didn't receive
 - Are contacted by a debt collector about medical bills you don't owe
 - See medical collection notices on your credit report that you don't recognize
 - Are told by your health plan that you've reached the limit on benefits
 - You are promised free goods, such as medical equipment or gift cards, for providing your medical identification to someone.

The Colorado CHP+ program reserves the right to take back any benefit payments paid on behalf of a Member if the Member has committed fraud or material misrepresentation in applying for coverage or in receiving or filing for benefits.

Independent Contractors

RMHP has contracts with healthcare providers that allow the providers to provide treatment to Members. These providers are not able to make any promises to you for RMHP. RMHP has no control over any diagnosis, treatment, care or other service provided to a Member by any facility or professional providers. RMHP is not responsible for any claim connected with any injuries suffered by a Member while receiving care from any provider.

RMHP may contract with certain companies that provide specialized services, such as prescription medication and/or substance abuse services. These organizations may help RMHP by providing business services such as reviewing benefits, claims payment, or helping you with questions.

No withholding of coverage for necessary care

RMHP does not compensate, reward, or incent, financially or otherwise, associates for inappropriate restrictions of care.

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RMHP does not promote or otherwise provide an incentive to employees or provider reviewers for withholding benefit for approval for medically necessary services to which you are entitled.

Utilization review and benefit coverage decisions are based on appropriateness of care and service and the applicable terms of this CHP+ Member Benefits Booklet.

RMHP does not design, calculate, award or permit financial or other incentives based on the frequency of denials of authorization for coverage, reductions or limitations on hospital lengths of stay, medical services or charges, or telephone calls or other contacts with health care providers or Members.

You can ask Customer Service to receive information on RMHP's physician incentive plans.

Physical Examinations and Autopsies

RMHP has the right and opportunity, at its expense, to request an examination of a person covered by this plan when and as often as it may reasonably be required during the review of a case or claim. On the death of a Member, RMHP may request an autopsy where it is not forbidden by law.

Catastrophic events

In case of fire, flood, war, civil disturbance, court order, strike, an act of terrorism or other cause beyond RMHP's control, RMHP may be unable to process claims on a timely basis. No legal action or lawsuit may be taken against RMHP or the CHP+ program due to a delay caused by any of these events.

Covered Benefit Decisions

To decide if a service is a covered benefit, RMHP considers if the service is:

- Medically necessary.
- Experimental/investigational.
- Cosmetic.
- Excluded under this coverage.

To help make this decision, RMHP uses a number of tools, including:

- RMHP's adopted medical policies and practice guidelines.
- Current peer-reviewed medical literature.
- Guidelines obtained from recognized national organizations and professional associations.
- Consultations with specialists.

RMHP does not promote or otherwise provide an incentive to its employees or provider reviewers for withholding the approval of benefits for medically necessary services to which the Member is entitled.

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Medically Necessary Health Care Services

This plan only covers medically necessary services, procedures, supplies, or visits (except as otherwise provided in this CHP+ Member Benefits Booklet). Medically necessary means the services are the right services for your problem. They are the services other people with the same medical problem would receive. Just because your doctor requests a service does not make it medically necessary. To help decide if a service is medically necessary, RMHP uses:

- Medical policy,
- Medical practice guidelines,
- Professional standards, and
- Outside medical peer review.

Medical Policy

RMHP's medical policies reflect current standards of practice and evaluates medical equipment, treatment, and interventions according to an evidence-based review of scientific literature. The benefits, exclusions, and limitations of a Member's coverage take precedence over medical policy. This means that if a service is listed as excluded or not covered in this CHP+ Member Benefits Booklet, it is not covered, regardless of whether or not it meets the standards set forth by the medical policy. To make sure that medical policies are current, RMHP reviews and updates medical policies on a regular basis.

Evaluation of New Technologies

RMHP uses a systematic approach to evaluate and address new developments in medical technologies or new applications of existing technologies, including medical procedures, behavioral health procedures, pharmaceuticals, and devices for inclusion in benefit plans. The evaluation includes a review of information from appropriate government regulatory bodies, published scientific evidence, and/or input from specialists and professionals with experience in the new technology. If you would like more information regarding RMHP's approach to evaluation of new technologies, please contact Customer Service.

Appropriate Setting and Pre-Authorization

Health care services can be provided in an inpatient or outpatient setting. The appropriate setting depends on how serious the medical condition is and depends on the services necessary to manage the condition. This plan covers both inpatient and outpatient care, as long as the care is provided in the appropriate setting, pre-authorized if required, and is medically necessary.

Inpatient Admissions

Examples of inpatient settings include:

- Hospitals,

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- Skilled nursing facilities, and
- Hospice care.

Appropriate Length of Stay

RMHP works with your providers to determine the appropriate length of an inpatient stay. Some of the things used to help make this decision are medical policies and medical care guidelines. The medical care guidelines include inpatient and surgical care optimal recovery guidelines. By using these guidelines and encouraging education, you are more likely to have better outcomes.

Outpatient Procedures

Examples of outpatient settings include:

- Provider offices
- Ambulatory surgery centers
- Home health
- Home hospice settings

Outpatient services may be performed in a hospital on an outpatient basis or in a freestanding facility, such as an ambulatory surgery center.

Some procedures performed in an outpatient setting must be pre-authorized. Your health care provider is responsible for requesting pre-authorization. RMHP may ask your provider for more information to determine if the service is medically necessary.

Retrospective Claim Review

Sometimes, in order to determine if a service that is submitted on a claim is a covered service, RMHP may perform a retrospective claim review. This is when RMHP reviews charges for services that have already been provided. This is done to determine:

- If the services were preauthorized, and
- The appropriateness of services billed based on covered benefits, medical policy, and medical necessity.

RMHP may request and review your medical records to help make payment decisions. If RMHP determines that services are not covered, RMHP will not pay for the charges.

Utilization Management

Utilization management is used to determine if a service is medically necessary, delivered in the right setting and for the appropriate length of time. Care is compared to nationally recognized guidelines.

Questions? Rocky Mountain Health Plans is here to help.

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You can also email us at customer_service@rmhp.org or visit rmhp.org.

Para asistencia en español llame al 855-830-1563

Utilization review may be used to determine appropriate payment for covered services. However, the decision to obtain the service is made solely by you in conjunction with your provider, regardless of the payment/coverage decision made by RMHP. RMHP does not make covered service determinations or utilization review determinations based on the grounds of moral or religious beliefs. If you believe you are refused a covered service based on moral or religious beliefs, contact RMHP Customer Service. RMHP will assist you in finding a different provider who will provide the covered services you need.

RMHP's Utilization Management team is happy to explain our program and how services are covered. You may request information about our utilization management program to better understand how this program is used to determine the medical necessity of services. Contact RMHP Customer Service Department to learn more. If you disagree with a decision and would like to file an appeal, see instructions in the *Grievances and Appeals* section.

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8: Other Insurance, Coordination of Benefits & Subrogation

RMHP does not coordinate benefits with any other coverage except Medicare. To qualify for Colorado's CHP+ program, you must not have other insurance coverage, except the Colorado Indigent Care Program and the Health Care Program for Children with Special Needs (HCP). In other words, you can only qualify for CHP+ coverage if you do not have any other health care insurance coverage. If you are covered by any other valid coverage, including Medicaid, the Exchange, individual (private), or group coverage, you are not eligible for CHP+ and therefore not eligible to have RMHP as your CHP+ plan. There are limited exceptions to this rule - CHP+ Members can have Medicare, dental, and vision coverage and still keep their CHP+ coverage.

If you get other health insurance coverage, you must call Colorado's CHP+ Customer Service at 800-359-1991 and notify them of the new coverage. If you are found to have other insurance, your CHP+ coverage will end and you will be disenrolled from the CHP+ program. In some cases, coverage will retroactively terminate for the time period the other insurance was effective. This means that we will go back and end your coverage on the date that your other insurance became effective (started).

Other Health Insurance

COBRA

Members with COBRA health insurance coverage are eligible to apply for the Child Health Plan Plus (CHP+) program. Once the applicant is notified that he or she has been accepted to CHP+ and chooses to participate, he or she must terminate COBRA health insurance coverage. This means CHP+ Members can have dual coverage with CHP+ and their COBRA coverage for a period of time. For the period of time which the Member has both CHP+ and COBRA coverage, COBRA will be the primary insurance plan.

Coordination of Benefits

RMHP will coordinate benefits for Members who have Medicare as their primary insurance coverage, or a stand-alone dental or vision plan. In this case, RMHP shall pay as secondary. Even when CHP+ Members have other health insurance, CHP+ Members must receive care from CHP+-participating providers in order for the care to be covered (paid for) by CHP+.

Workers' Compensation

To receive benefits under workers' compensation insurance for a work-related illness or injury, you must pursue your rights under the Worker's Compensation Act or any of the employer liability laws that may apply. This includes filing an appeal with the Division of Workers Compensation. RMHP may pay claims during the appeal process if you sign an agreement to stating that you will reimburse RMHP for up to 100 percent of the benefits paid that are also paid by another source. Services and supplies resulting from work-related illness or injury are not benefits under this plan. This exclusion from coverage applies to expenses resulting from occupational accident(s) or sickness(es) covered under the following:

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- Occupational disease laws.
- Employers' liability insurance.
- Municipal, state or federal law.
- The Workers' Compensation Act.

RMHP will not pay for services related to Workers' Compensation claims because:

- You fail to file a claim within the filing period allowed by the applicable law.
- You obtain care that is not authorized by workers' compensation insurance.
- Your employer fails to carry the required workers' compensation insurance. In this case, the employer becomes liable for any of the employee's work-related illness or injury expenses.
- You fail to comply with any other provisions of the Workers' Compensation Act.

Automobile Insurance Provisions

RMHP will coordinate the benefits of the CHP+ program with the benefits of a complying automobile insurance policy. A complying automobile insurance policy is an insurance policy approved by the Colorado Division of Insurance that provides at least the minimum coverage required by law, and is subject to the Colorado Auto Accident Reparations Act or Colorado Revised Statutes §§ 10-4-601 through 10-4-633. Any state or federal law requiring similar benefits through legislation or regulation is also considered a complying policy.

How RMHP coordinates benefits with complying policies

RMHP benefits may be coordinated with complying policies. After the benefits offered by the complying policy are exhausted (run out), RMHP will pay benefits subject to the terms and conditions of this CHP+ Member Benefits Booklet. If there is more than one complying policy that offers coverage, each policy must be exhausted before RMHP is liable for any further payments.

You must fully cooperate with RMHP to make sure that the complying policy has paid all required benefits. RMHP may require you to take a physical exam in disputed cases. If there is a complying policy in effect, and you waive or fail to assert your rights to such benefits, RMHP will not pay those benefits that would have been available under a complying policy. Note the following:

- Before making any benefit payments, RMHP may require proof that the complying policy has paid all primary benefits.
- RMHP may also, but is not required to, make payments under this CHP+ Member Benefits Booklet and later coordinate with or seek reimbursement from the complying policy.
- In all cases, upon payment, RMHP is entitled to exercise its rights under this certificate and under applicable law against any and all potentially responsible parties or insurers. In that event RMHP may exercise the rights found in the Administrative Information section.

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What happens if a Member does not have another policy?

RMHP will pay benefits for any injuries you receive while riding in or operating a motor vehicle that you own if the vehicle is not covered by an automobile-complying policy as required by law.

RMHP will also pay benefits under the terms of this plan for any injuries you sustain if you are a non-owner-operator, passenger, or pedestrian involved in a motor vehicle accident if your injuries are not covered by a complying policy. In that event, RMHP may exercise the rights found in this section.

Third-Party Liability: Subrogation

Third-party liability means that someone other than you is or may be legally responsible for your condition or injury. RMHP will not pay for any services or supplies under this plan for which a third-party is liable. However, RMHP may provide benefits under the following conditions:

- When it is established that a third-party liability does not exist.
- When you guarantee in writing to reimburse RMHP for any claims paid by RMHP on your behalf if the third-party later settles with you for any amount, or if the Member recovers any damages in court.

RMHP's rights under third-party liability

RMHP has subrogation rights when a third-party is or may be liable for the costs of any covered expenses payable to you or on your behalf under this CHP+ Member Benefits Booklet. This means that RMHP has the right, either as co-plaintiffs or by direct suit, to enforce your claim against a third-party for the benefits paid to you or on your behalf.

Member obligations under third-party liability

You have an obligation to cooperate in satisfying the RMHP CHP+ subrogation interest or to refrain from taking any action that may prejudice RMHP's rights under this plan. If RMHP must take legal action to uphold its rights and if RMHP prevails in that action, you will be required to pay RMHP's legal expenses, including attorneys' fees and court costs.

If a third-party is or may be liable (responsible) to make payments to you or on your behalf for any benefits that are available under RMHP's CHP+ plan, then the following must occur:

- You must promptly notify RMHP of your claim against the third-party.
- You and your attorney must provide for the amount of benefits paid by the CHP+ program and RMHP in any settlement with the third-party or the third-party's insurance carrier.
- If you receive money for the claim by suit, settlement or otherwise, you must fully reimburse RMHP and the CHP+ program as appropriate for the amount of benefits provided to you under this certificate. You may not exclude recovery for RMHP's health care benefits from any type of damages or settlement you recovered.

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- You must cooperate in every way necessary to RMHP enforce its subrogation rights.
- You have the responsibility to follow any process of a liable third- party payer before you receive nonemergency services.

Failure to comply with obligations in this section may result in termination of coverage from this plan.

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9: Complaints, Appeals & Grievances

You have many rights as an RMHP Colorado CHP+ Member. You have the right to complain about RMHP. You have the right to complain about your care. You, your provider or a Designated Client Representative may complain about anything you are unhappy about or have a problem with.

If you want help at any time filing an appeal or a grievance

A Designated Client Representative (DCR) is someone you choose to help you with an Appeal or a Grievance, including a provider. You must sign a form to give your DCR permission to act for you. The form must have the person's name, address, and telephone number. If your complaint is about your medical care, your DCR will have access to your medical records and specific details about your medical care.

Right to File Appeal, Grievance, and State Fair Hearing

- You have the right to “Appeal an Adverse Decision.” This means you can ask for a review of something RMHP has done. Examples of decisions you can appeal are listed in *Section A* below.
- You have the right to “File a Grievance.” This means you can complain about any matter other than a Decision (see *Section A*). Grievances are the kinds of things listed in *Section B* below.
- In addition to filing an appeal or grievance with RMHP, you may file for a State Fair Hearing, with the State of Colorado. The State Fair Hearing process is described in *Section C* below.

Section A. Appeal an Adverse Decision

RMHP may make a decision that you are not happy with. Then you or your DCR may ask for an appeal. An appeal is a review of an RMHP Adverse Decision (or decision). For example, your doctor may order you a medication or service that RMHP must okay. If it is approved, you will receive what the doctor wanted you to have. If RMHP does not approve the request, then the request by the doctor has been denied by RMHP. The decision RMHP made is to deny the request.

- Once RMHP has made a decision, you always have the right to appeal. This means you can ask RMHP to take a second look. These are examples of the kinds of decisions you may appeal:
- RMHP denies services your doctor requested for you.
- RMHP denies payment for services you received.
- RMHP shortens or ends a service we had agreed to provide you.
- RMHP does not provide services in a timely way.
- RMHP does not act within the amount of time it says it will. (This includes answering appeals, grievances and fast reviews in the number of days specified.)
- RMHP denies certain services if you live in a rural area. (This means the rights you have to use a provider, even if he or she is not in our network, when you live in a rural area.)

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There are two types of review that can happen.

Standard Review

You must call or write to appeal within 60 calendar days of the day we tell you about the decision that RMHP has made. You or your DCR can fill out the complaint form at the back of this booklet and mail it to us. If you want us to fill out the form for you, please call Customer Service. If you call us with your appeal request, we will send you a letter that you must sign and return to confirm that we understand your verbal request.

Within two working days of the day RMHP gets your appeal, RMHP will write you to tell you we got your appeal. In that letter RMHP will tell you how you may get a copy of RMHP's file about your appeal.

RMHP will also give you a chance to give us any more information about your appeal that you would like us to have. You can arrange to meet a person face to face at RMHP to listen to you about your appeal. Or you may send more information to us.

The Appeals and Grievance Coordinator will get all the facts about your case. Within 10 working days after we receive your appeal, we will send you our decision in writing. After this review, RMHP may decide to change its decision.

You may not like the decision RMHP makes about your appeal. Then you have the right to ask for a State Fair Hearing about your appeal. You can ask for the State Fair Hearing after RMHP makes a decision to continue to deny your request. You may also request a State Fair hearing if RMHP fails to make a decision or send you a decision in writing within 10 working days. You must ask for a State Fair Hearing within 120 calendar days of the date of RMHP's final decision.

Expedited (fast) Review

You can ask for an expedited or fast appeal. Fast appeals are used when RMHP's decision puts you in danger. You can ask for a fast appeal if you have a disability. We have only 72 hours to resolve the fast appeal, so you have a short amount of time to get a copy of the file RMHP has about your appeal. You will also have less time to give RMHP any more information about your appeal.

Continuing Your Benefits

For any appeal, you can still get services when you ask the plan to take a second look at a decision. The same is true when you have asked for a State Fair Hearing, (see *Section C* below). To have your benefits continue while your appeal is being reviewed, the following must occur:

- The appeal must involve termination, suspension or reduction of a previously approved course of treatment.
- The original approval must not have expired.

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- You must tell RMHP you want to keep getting your services when you send us your appeal. If a provider is helping you with your appeal, they cannot ask to have your benefits continue while your appeal is being reviewed.
- The care was ordered by a provider that works with RMHP.

If you lose your appeal you may have to pay for the care you have received. To get more information about appeals and grievances call RMHP Customer Service.

Section B. File a Grievance

You may have a problem or be unhappy with RMHP about something other than an Adverse Decision (see Section A). To complain about something other than an Adverse Decision, you may “file a grievance.” This means you send your complaint to someone who can help. Please call us if you want to complain. We can help you file a grievance.

A grievance is a verbal or written statement that says you are not happy. You will not lose your Colorado CHP+ coverage because of your complaint. You will be treated the same as any other Member. Here are some things that you can complain about:

- You are unhappy with your doctor, clinic, or any RMHP provider.
- You can't find a doctor or get in to see your doctor.
- You have a problem with RMHP Customer Service.
- You are unhappy with how your doctor took care of you.
- You feel you have been treated in a different way by RMHP or one of our providers. This could be because of your race, color, national origin, age, disability, sex, sexual orientation, or gender identity.
- You are unhappy because a provider or RMHP employee was rude to you.
- You disagree with our decision to extend the time to make a decision about your appeal.

How Grievances are Handled

You or your DCR can fill out the complaint form in this handbook and mail it to RMHP. Or, we can fill out the form for you. Call us for help. You can call or write to file your grievance at any time. In two working days, RMHP will tell you in writing that we got your

grievance. RMHP will review your grievance and send you a response within 15 working days of the day we get your grievance. RMHP may respond to your grievance sooner than two working days. If we do, then you will not get a separate letter telling you that we got your grievance.

If you do not like our response, you may contact:

Department of Health Care Policy and Financing

Questions? Rocky Mountain Health Plans is here to help.

Call us at 970-244-7960 / 855-830-1563 (TTY 711), Monday-Friday, 8:00 a.m. to 5:00 p.m.

You can also email us at customer_service@rmhp.org or visit rmhp.org.

Para asistencia en español llame al 855-830-1563

Attn: CHP+ Program Manager
1570 Grant Street
Denver, CO 80203

If your complaint is about disenrollment, you should contact: CHP+ Plan Disenrollment Grievance

Attn: CHP+ Program Manager
1570 Grant Street
Denver, CO 80203

You may also call 303-866-4623 or send an e-mail message to HCPF.MCOS@state.co.us. The Department of Health Care Policy and Financing will tell you that they got your request. They will look into your complaint and send you a response.

Section C. State Fair Hearing

A State Fair Hearing is a chance for a Colorado CHP+ Member to make a case to a judge that a denied service should have been approved, or that a denied claim should have been paid. You must wait for an answer to an appeal from RMHP before you request a State Fair Hearing.

To request a State Fair Hearing you must:

- Write a request for a hearing within 120 calendar days from the date of our decision about your appeal (see First Level Review, Section A.)
- Include your name, your address, and your State CHP+ ID number in your request for a hearing.
- Write what RMHP did or did not do that has caused you a problem with your care.
- Tell in writing what you think should be done to solve your problem. You can fax your request to 303-866-5909, or mail it to:

Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, CO 80203

If you need help, RMHP Customer Service or the Office of Administrative Courts will help you write your request for a hearing. For help with asking for a State Fair Hearing, call 303-866-2000.

Dial 711 for Relay Colorado to contact the Office of Administrative Courts if you are Deaf, hard of hearing or have a speech disability.

Your provider may file for a State Fair Hearing for you. Your provider must have your written permission to file for you.

For help from RMHP in writing and submitting a request for State Fair Hearing you may call:

- RMHP Customer Service — 970-244-7960 or 855-830-1563
- If you are Deaf, hard of hearing or have a speech disability, dial 711 for Relay Colorado or use our Live Chat on **rmhp.org**

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- Para asistencia en español — 855-830-1563

If you lose your State Fair Hearing, you may have to pay for the services you got while your appeal was pending. See *Continuing Your Benefits* above.

- You have certain rights under Colorado rules covering State Fair Hearing:
- You have the right to represent yourself at the hearing.
- You have the right to choose someone to be your representative at the hearing.
- You have the right to present information or evidence to the administrative judge during the hearing.
- You have the right to read or examine all RMHP documents related to the appeal before and during the hearing.

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10: Glossary

This section defines words and terms used throughout this CHP+ Member Benefits Booklet. You should refer to this section to find out exactly how a word or term is used, for the purposes of this Booklet.

Accidental injuries – unintentional internal or external injuries, examples of accidental injuries are strains, animal bites, burns, contusions, and abrasions (cuts) that result in trauma to the body. Accidental injuries are different from illness-related conditions (being sick) and do not include disease or infection.

Acupuncture services – treatment of a disease or condition by inserting special needles along specific nerve pathways for therapeutic purposes. The placement of the needles varies with the disease or condition being treated.

Acute care – care provided in an office, urgent care setting, emergency room or hospital for a medical illness, accident, or injury. Acute care may be emergency, urgent or non-urgent, but is not primarily preventive in nature.

Admission – the period of time between the date a patient enters a facility as an inpatient and the date he or she is discharged as an inpatient.

Adverse decision – includes any of the following:

The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit.

- The reduction, suspension or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner (as determined by the State).
- The failure of RMHP to act within the timeframe required for the standard resolution of grievances and appeals.
- For a resident in a rural area with only one health plan, the denial of an enrollee's request to exercise his or her right to obtain services outside the network.
- The denial of an enrollee's request to dispute financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities

After-hours care – office services requested after a provider's normal or published office hours or services requested on weekends and holidays.

Alcoholism and substance abuse – conditions defined by usage that continue despite occupational,

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Audiology services – the testing for hearing disorders through identification and evaluation of hearing loss.

Authorization – approval of benefits for a covered procedure or service. See also Pre-authorization.

Billed charges – the dollar amount a provider bills for services or supplies before any applicable in-network provider discounts or adjustments.

Birth abnormality – a condition that is recognizable at birth, such as a fractured arm.

Calendar year – a period of a year that begins January 1st and ends on December 31st.

Care management – this is a way that RMHP helps Members with serious illnesses or injuries. Care management is used when illnesses or injuries are so complex that individualized coordination of care is helpful. Sometimes care management is also called case management.

Care manager/case manager – a professional (for example, nurse, doctor or social worker) who works with Members, providers and RMHP to coordinate services deemed medically necessary for the Member.

Chemical dependency – dependence on either alcohol and/or other substances; for example, drugs. See also Substance abuse.

Chemotherapy – medication therapy administered as treatment for malignant conditions and diseases of certain body systems.

CHP+ Member Benefits Booklet – this document explains the benefits, limitations, exclusions, terms, and conditions of a CHP+ Member's health coverage. This document also serves as a contract between RMHP and its Members.

RMHP participating provider – also known as an in-network provider. This is a professional health care provider or facility (for example, a provider, hospital or home health agency) that contracts with RMHP to provide services to RMHP Members. In-network providers agree to bill RMHP directly for services provided and to accept the payment amount (provided in accordance with the provisions of the contract) and a Member's copayment as payment in full for covered services. RMHP pays the in-network provider directly. RMHP may add, change or delete specific providers at its discretion or recommend a specific provider for specialized care as medically necessary for the Member.

RMHP service area – the geographic area where enrollment in RMHP CHP+ is available.

Chiropractic services – a system of therapy in which disease is considered the result of abnormal function of the nervous system. This method of treatment usually involves manipulation of the spinal column and specific adjustment of body structures.

Chronic pain – ongoing pain that lasts more than six months that is due to non-life threatening causes and has not responded to current available treatment methods. Chronic pain can continue for the remainder of a person's life.

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Cold therapy – the application of cold to decrease swelling, pain or muscle spasm.

Complaint – an expression of dissatisfaction with RMHP or the practices of an in-network provider, whether medical or non-medical in nature. This is sometimes also called a grievance.

Congenital defect – a condition or anomaly existing at or dating from birth, such as a cleft palate or a clubfoot. Disorders of growth and development over time are not considered congenital.

Consultation – a visit between a provider and a patient to determine what medical examinations or procedures, if any, are appropriate and needed.

Copayment – a dollar amount you pay in order to receive a specific service, supply, or prescription medication. A copayment is a predetermined fixed amount paid at the time the service is rendered. The copayment amount is printed on each Member's ID card.

Cosmetic services – services or surgery performed on a physical characteristic to improve an individual's appearance.

Cost sharing – the general term used for out-of-pocket expenses paid by a Member. A copayment is a type of cost sharing.

Covered services – services, supplies or treatments that are:

- Medically necessary or otherwise specifically included as a benefit under this CHP+ Member Benefits Booklet.
- Within the scope of the license of the provider performing the service.
- Rendered while coverage under this CHP+ Member Benefits Booklet is in force.
- Not experimental/investigational or otherwise excluded or limited by the CHP+ Member Benefits Booklet, or by any amendment made to the Booklet or rider added to the Booklet.
- Authorized in advance by RMHP if such pre-authorization is required.

Cryocuff – a specially designed pad that has a pump. The pump circulates fluid through the pad. The fluid provides continuous cold or heat therapy to a specific area.

Custodial care – care provided primarily to meet the personal needs of the patient. This includes help in walking, bathing or dressing. It also includes, but is not limited to, preparing food or special diets, feeding, administration of medicine that is usually self-administered or any other care that does not require continuing services of specialized medical personnel.

Dental services – services performed for treatment of conditions related to the teeth or structures supporting the teeth.

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Detoxification – acute treatment for withdrawal from the physical effects of alcohol or another substance.

Diagnostic services – tests or services ordered by a provider to determine the cause of illness.

Dialysis – the treatment of acute or chronic kidney ailment. During dialysis, impurities are removed from the body with dialysis equipment.

Discharge planning – the evaluation of a patient’s medical needs and arrangement of appropriate care after discharge from a facility.

Durable medical equipment (DME) - any equipment that can withstand repeated use, is made to serve a medical condition, is useless to a person who is not ill or injured, and is appropriate for use in the home.

Effective date – the date that CHP+ coverage with RMHP begins.

Elective surgery – a procedure that does not have to be performed on an emergency basis and can be reasonably delayed. Such surgery may still be considered medically necessary.

Emergency – the sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s health in serious jeopardy.

Experimental or investigative procedures or services –

- a. Any drug/medication, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis, evaluation or treatment of a disease, injury, illness or other health condition that RMHP determines, in its sole discretion, to be experimental or investigational. RMHP will deem any drug/medication, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply to be experimental or investigational if it determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought.

The drug/medication, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply:

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA) or any other state or federal regulatory agency, and such final approval has not been granted.
- The FDA has advised against the specific use.
- Is provided as part of a clinical research protocol or clinical trial, or is provided in any other manner that is intended to evaluate the safety, toxicity or efficacy of the drug/medication, biologic device, diagnostic product, equipment, procedure, treatment, service or supply; or is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function.

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- Is provided pursuant to informed consent documents that describe the drug/medication, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply as experimental or investigational, or otherwise indicate that the safety, toxicity or efficacy of the drug/medication, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is under evaluation.
- b. Any service not deemed experimental or investigational based on the criteria in subsection (a) may still be deemed to be experimental or investigational by RMHP. In determining if a service is experimental or investigational, RMHP will consider the information described in subsection (c) and assess all of the following:
- Whether the scientific evidence is conclusory concerning the effect of the service on health outcomes.
 - Whether the evidence demonstrates that the service improves the net health outcomes of the total population for whom the service might be proposed as any established alternatives.
 - Whether the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
- c. The information RMHP considers or evaluates to determine if a drug/medication, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is experimental or investigational under subsections (a) and (b) may include one or more items from the following list, which is not all-inclusive:
- Randomized, controlled, clinical trials published in an authoritative, peer-reviewed United States medical or scientific journal.
 - Evaluations of national medical associations, consensus panels, and other technology evaluation bodies.
 - Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate or investigate the use of the drug/medication, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.
 - Documents of an IRB or other similar body performing substantially the same function.
 - Consent documentation(s) used by the treating providers, other medical professionals or facilities, or by other treating providers, other medical professionals or facilities studying substantially the same drug/medication, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.
 - The written protocol(s) used by the treating providers, other medical professionals or facilities or by other treating providers, other medical professionals or facilities studying substantially the same drug/medication, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.

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- The opinions of consulting providers and other experts in the field.
- d. RMHP has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug/medication, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is experimental or investigational.

Explanation of benefits – also known as an EOB. An EOB is a printed form sent by an insurance company to a Member after a claim has been filed and a decision has been made about the claim. The EOB includes such information as the date of service, name of provider, amount covered and patient balance.

Formulary list – a list of prescription medications approved for use by RMHP for CHP+ Members. This list is subject to periodic review and modification.

Formulas – authorized formulas for metabolic disorders, Total Parenteral Nutrition, enteral nutrition and nutrition products, and formulas for gastrostomy tubes are covered for documented medical needs including attainment of normal growth and development.

Generic drug – the chemical equivalent of a brand name prescription medication. By law, brand name and generic medications must meet the same standards for safety, purity, strength and quality.

Grievance – an oral or written expression of dissatisfaction about any matter other than an adverse decision. Grievances may include the quality of care or services provided, the practices of an in-network provider, whether medical or non-medical in nature. A grievance also includes a Member's right to dispute an extension of time proposed by RMHP to make an authorization decision. A grievance is sometimes also called a complaint.

Healthy living initiative – projects to promote healthier lifestyles and help our Members to avoid preventable diseases.

Hemodialysis – the treatment of an acute or chronic kidney ailment during which impurities are removed from the blood with dialysis equipment.

Holistic medicine – various preventive and healing techniques that are based on the influence of the external environment and the various ways different body tissues affect each other along with the body's natural healing powers.

Home health agency – an agency certified by the Colorado Department of Public Health and Environment as meeting the provisions of Title XVIII of the federal Social Security Act, as amended, for home health agencies. A home health agency primarily arranges and provides nursing services, home

Home health services – this is also called home health care. These are professional nursing services, certified nurse aide services, medical supplies, equipment and appliances suitable for use in the home, and physical therapy, occupational therapy, speech pathology, and audiology services provided by a certified home health agency to eligible Members, who are under a plan of care, in their place of residence.

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Hospice agency – an agency licensed by the Colorado Department of Public Health and Environment to provide hospice care in Colorado. A hospice is a centrally administered program of palliative (care that controls pain and relieves symptoms), supportive and interdisciplinary team services providing physical, psychological, spiritual, and sociological care for terminally ill individuals and their families, within a continuum of inpatient care, home health care and follow-up bereavement services available 24 hours a day, 7 days a week.

Hospice care – an alternative way of caring for terminally ill individuals that stresses palliative care. Hospice care focuses on the patient/family as the unit of care. Supportive services are offered to the family before and after the death of the patient. Hospice care addresses physical, social, psychological, and spiritual needs of the patient and the patient's family.

Hospital – a health institution offering facilities, beds, and continuous services 24 hours a day and that meets all licensing and certification requirements of local and state regulatory agencies.

ID card – the card RMHP gives Members with information such as the Member's name, and ID number, and copayment amount (if applicable). This is also known as the RMHP CHP+ Member ID card.

Implantable birth control device – device inserted underneath the skin that prevents pregnancy.

In-network provider – a provider that is contracted with RMHP.

Inpatient medical rehabilitation – care that includes a minimum of three hours of therapy, for example, speech therapy, respiratory therapy, occupational therapy, and/or physical therapy, and often some weekend therapy. Inpatient medical rehabilitation is generally provided in a rehabilitation section of a hospital or at a freestanding facility. Some skilled nursing facilities have rehabilitation beds.

Intractable pain – a pain state in which the cause of the pain cannot be removed and which in the generally accepted course of medical practice no relief or cure of the cause of the pain is possible, or none has been found after reasonable efforts, including but not limited to, evaluation by the attending provider and one or more providers specializing in the treatment of the area, system or organ of the body perceived as the source of the pain.

IUD – stands for intra-uterine device, a birth control device inserted into the uterus to prevent pregnancy.

Keratoconus – cone-shaped protrusion of the cornea.

Laboratory and pathology services – testing procedures required for the diagnosis or treatment of a condition. Generally, these services involve the analysis of a specimen of tissue or other material that has been removed from the body.

Long-term acute care facility – an institution that provides an array of long-term crucial care services to patients with serious illnesses or injuries. Long-term acute care is provided for patients with complex

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medical needs. These include patients with high risk pulmonary conditions who have ventilator or tracheotomy needs or who are medically unstable, patients with extensive wound care needs or post-operative surgery wound care needs, and patients with low-level, closed-head injuries. Long-term acute care facilities do not provide care for low-intensity patient needs.

Maternity services – services required by a patient for the diagnosis and care of a pregnancy, complications of pregnancy, and for delivery. Delivery series include:

- Normal vaginal delivery;
- Cesarean section delivery;
- Spontaneous termination of pregnancy before full term; and
- Therapeutic or elective termination of pregnancy provided the termination is to save the life of the mother or the pregnancy is the result of rape or incest.

Maximum medical improvement – a determination at RMHP's sole discretion that no further medical care can reasonably be expected to measurably improve a patient's condition. Maximum medical improvement shall be determined without regard to whether continued care is necessary to prevent deterioration of the condition or is otherwise life sustaining.

Maximum benefit – there is no lifetime maximum benefit under RMHP's CHP+ program; however, certain covered services have maximum benefit limits per admission, per calendar year, per diagnosis, or as specifically defined in this CHP+ Member Benefits Booklet.

Medical care – non-surgical health care services provided for the prevention, diagnosis, and treatment of illness, injury, and other general conditions.

Medically necessary – an intervention that is or will be provided for the diagnosis, evaluation, and treatment of a condition, illness, disease or injury and that RMHP solely determines to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the condition, illness, disease or injury.
- Obtained from a licensed, certified or registered provider.
- Provided in accordance with applicable medical and/or professional standards.
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes.
- The most appropriate supply, setting or level of service that can safely be provided to the patient and which cannot be omitted, and is consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained as an outpatient).
- Cost-effective compared to alternative interventions, including no intervention (cost effective does not mean lowest cost).

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- Not experimental/investigational.
- Not primarily for the convenience of the patient, the patient's family or the provider.
- Not otherwise subject to an exclusion under this CHP+ Member Benefits Booklet.
- The fact that a provider may prescribe, order, recommend or approve care, treatment, services or supplies does not itself make such care, treatment, services or supplies medically necessary.

Medical supplies – items (except prescription medications) required for the treatment of an illness or injury.

Member – any person who is enrolled for coverage with CHP+ with RMHP as his/her CHP+ health plan.

Mental health condition – non-biologically based mental conditions that have a psychiatric diagnosis or that require specific psychotherapeutic treatment, regardless of the underlying condition (for example, depression secondary to diabetes or primary depression). RMHP defines mental health conditions based on the American Psychiatric Association's guidelines.

Myotherapy – the physical diagnosis, treatment, and pain management of conditions that cause pain in muscles and bones.

Nephritis – infection or inflammation of the kidney.

Nephrosis – condition in which there are degenerative changes in the kidneys without the occurrence of inflammation.

Nutrition assessment/counseling – medical nutrition therapy provided by a qualified nutrition professional such as a registered dietitian without training in pediatric nutrition. Services provided by a registered dietitian may require pre-authorization from RMHP. Medical nutrition therapy includes nutrition assessment, support, and counseling to determine a treatment plan to increase nutritional intake to promote adequate growth, healing and improved health.

Occupational therapy – the use of educational and rehabilitative techniques to improve a patient's functional ability to live independently. Occupational therapy requires that a properly accredited occupational therapist (OT) or certified occupational therapy assistant (COTA) perform such therapy.

OMT – stands for Osteopathic Manipulative Therapy, a hands-on modality of evaluation, diagnosis, and treatment using palpation of the body's tissues and musculoskeletal system with a variety of therapeutic techniques involving fascia, muscles, and joints to help resolve both acute and chronic musculoskeletal injuries.

Organ transplants – a surgical process that involves the removal of an organ from one person and placement of the organ into another person. Transplant can also mean removal of body substances, such as stem cells or bone marrow, for the purpose of treatment and re-implanting the removed organ or tissue

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into the same person. Organ transplant benefits provided to Members of the Colorado CHP+ program may be subject to a lifetime maximum benefit.

Orthopedic appliance – a rigid or semi-rigid support used to eliminate, restrict or support motion in a part of the body that is diseased, injured, weak or malformed.

Orthotic – a support or brace for weak or ineffective joints or muscles.

Out-of-network provider – an appropriately licensed health care provider that has not contracted with RMHP. Services provided by an out-of-network provider may not be covered unless a pre-authorization is obtained. A Member may be financially responsible for services performed by an out-of-network provider unless stated otherwise in this CHP+ Member Benefits Booklet, or the services are approved (authorized) by RMHP.

Out-of-area services – covered services provided to an RMHP CHP+ Member when he or she is outside the service area.

Out-of-pocket annual maximum – the total amount (cost sharing) a Member may be responsible for during a specified period as described in the CHP+ Member Benefits Booklet. The out-of-pocket annual maximum is designed to protect Members from catastrophic health care expenses. For each Member's calendar year benefit period, after the out-of-pocket annual maximum is reached, for most services, payment will be made at 100% of the allowable charge for the remainder of that calendar year.

Outpatient medical care – non-surgical services provided in a provider's office, the outpatient department of a hospital or other facility, or the patient's home.

Overweight/obesity – weight for height at greater than the 95th percentile or Body Mass Index (BMI) greater than the 95th percentile. Obesity in children has long-term consequences that become major health issues later in life. Treatment plans are standard pediatric weight management programs medically supervised by medical professional seldom using surgical or pharmacological interventions due to the long-term side effects of these treatments.

Palliative care – care that controls pain and relieves symptoms, but does not cure.

Paraprofessional – a trained colleague who assists a professional person, such as a radiology technician.

PCP – stands for Primary Care Provider. It is the appropriately licensed and credentialed provider who has contracted with RMHP to supervise, coordinate, and provide initial and basic care to Members, refer patients to other providers including specialists, and maintain continuity of patient care.

Physical therapy – the use of physical agents to treat a disability resulting from disease or injury. Physical agents used include heat, cold, electrical currents, ultrasound, ultraviolet radiation, massage, and therapeutic exercise. A provider or registered physical therapist must perform physical therapy.

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Physician – a doctor of medicine or osteopathy who is licensed to practice medicine under the laws of the state or jurisdiction where the services are provided.

Pharmacy – an establishment licensed to dispense prescription medications and other medications through a licensed pharmacist upon an authorized health care professional's order. A pharmacy may be an RMHP in-network or an out-of-network provider. An in-network pharmacy is contracted with RMHP to provide covered medications to Members under the terms and conditions of this CHP+ Member Benefits Booklet. An out-of-network pharmacy is not contracted with RMHP.

Prescription drugs and medications

- **Brand-name prescription drug:** The initial version of a medication developed by a pharmaceutical manufacturer or a version marketed under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted an exclusive patent to manufacture and market a new medication for a certain number of years. After the patent expires and Food and Drug Administration (FDA) requirements are met, any manufacturer may produce the medication and sell the medication under its own brand name or under the medication's chemical (generic) name.
- **Formulary list:** A list of pharmaceutical products developed in consultation with providers and pharmacists and approved for their quality and cost-effectiveness.
- **Generic prescription drug:** Medications determined by the FDA to be bio-equivalent to brand-name medications and that are not manufactured or marketed under a registered trade name or trademark. A generic medication's active ingredients duplicate those of a brand-name medication. Generic medications must meet the same FDA specifications as brand-name medications for safety, purity, and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the counterpart brand-name medication. On average, generic medications cost about half as much as the counterpart brand name medication.
- **Legend drug:** A medicinal substance, dispensed for outpatient use, which under the federal Food, Drug and Cosmetic Act is required to bear on its original packing label, "Caution: Federal law prohibits dispensing without a prescription." Compounded medications that contain at least one such medicinal substance are considered to be prescription legend drugs. Insulin is considered a prescription legend drug under this CHP+ Member Benefits Booklet.

Preventive care – comprehensive care that emphasizes prevention, early detection and early treatment of conditions through routine physical exams, immunizations, and health education.

Pre-authorization – a process during which requests for procedures, services or certain prescription medications are reviewed prior to being rendered, for approval of benefits, length of stay, appropriate location, and medical necessity. For prescription medications, the designated RMHP pharmacy and therapeutics committee defines the medications and criteria for coverage, including the need for pre-authorization for certain medications.

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Private-duty nursing services – services that require the training, judgment and technical skills of an actively practicing registered nurse (RN) or licensed practical nurse (LPN). Such services must be prescribed by the attending provider for the continuous medical treatment of the condition.

Prosthesis – a device that replaces all or part of a missing body part.

Provider – a person or facility that is recognized by RMHP as a health care provider and fits one or more of the following descriptions:

- **Professional provider** – A provider who is licensed or otherwise authorized by the state or jurisdiction where services are provided to perform designated health care services. For benefits to be payable, services of a provider must be within the scope of the authority granted by the license and covered by this Booklet. Such services are subject to review by a medical authority appointed by RMHP. Other professional providers include, among others, certified nurse- midwives, dentists, optometrists, and certified registered nurse anesthetists. Services of such a provider must be among those covered by this Booklet and are subject to review by a medical authority appointed by RMHP.
- **Facility provider** – an inpatient and outpatient facility provider, as defined below:
 - Inpatient facility provider is a hospital, substance abuse treatment center, residential facility, hospice facility, skilled nursing facility or other facility that RMHP recognizes as a health care provider. These facility providers may be referred to collectively as a facility provider or separately as a substance abuse treatment center provider.
 - Outpatient facility provider is a dialysis center, home health agency or other facility provider such as an ambulatory surgery center (but not a hospital, substance abuse treatment center or hospice facility, skilled nursing facility or residential treatment center) recognized by RMHP and licensed or certified to perform designated health care services by the state or jurisdiction where services are provided. Services of such a provider must be among those covered by this certificate and are subject to review by a medical authority appointed by RMHP.

Radiation therapy – X-ray, radon, cobalt, betatron, telocobalt, radioactive isotope, and similar treatments for malignant diseases and other medical conditions.

Reconstructive breast surgery – a surgical procedure performed following a mastectomy on one or both breasts to re-establish symmetry between the two breasts. The term includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty or mastoplasty.

Reconstructive surgery – surgery that restores or improves bodily function to the level experienced before the event that necessitated the surgery or in the case of a congenital defect, to a level considered normal. Reconstructive surgery may have a coincidental cosmetic effect.

Reproductive health services – services include pap smears, pelvic and breast exams, STI/HIV testing and treatment, health education, counseling, and a variety of contraceptive options, including abstinence (family planning).

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Resident – an individual who maintains legal domicile within the state of Colorado and who is presumed, for purposes of this agreement, to be a primary resident of the state, as evidenced by any three of the following:

- Payment of Colorado income tax.
- Employment in Colorado, other than that normally provided on a temporary basis to students.
- Ownership or residential real estate property in Colorado.
- State identification card or driver's license.
- Acceptance of future employment in the state of Colorado.
- Vehicle registered in Colorado.
- Voter registration in Colorado.
- Phone bill or utility bill from Colorado.

Room expenses – expenses that include the cost of the room, general nursing services and meal services for the patient.

Routine care – services for conditions not requiring immediate attention and that can usually be received in the PCP's office, or services that are usually done periodically within a specific time frame (for example, immunizations and physical exams).

Second opinion – a visit to another professional provider (following a first visit with a different provider) for review of the first provider's opinion of proposed surgery or treatment.

Skilled nursing care facility – an institution that provides skilled nursing care (for example, therapies and protective supervision) for patients with uncontrolled, unstable or chronic conditions. Skilled nursing care is provided under medical supervision to carry out non-surgical treatment of chronic diseases or convalescent stages of acute diseases or injuries. Skilled nursing facilities do not provide care for patients with high intensity medical needs, or for patients who are medically unstable.

Special care units – special areas of a hospital with highly skilled personnel and special equipment to provide acute care, with constant treatment and observation.

Specialist – a professional, usually a provider, devoted to a specific disease, condition or body part (for example, an orthopedist is someone who specializes in the treatment of bones and muscles).

Speech therapy (also called speech pathology) – services used for the diagnosis and treatment of speech and language disorders. A licensed and accredited speech/language pathologist must perform speech therapy.

Sub-acute medical care – medical care that requires less care than a hospital but often more care than

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a skilled nursing facility. Sub-acute medical care may be in the form of transitional care when a patient's condition is improving but the patient is not ready for a skilled nursing facility or home health care.

Sub-acute rehabilitation – care that includes a minimum of one hour of therapy when a patient cannot tolerate or does not require three hours of therapy a day. Sub-acute rehabilitation is generally provided in a skilled nursing facility.

Substance abuse – the use of alcohol and/or other substances that leads to negative effects on a person's physical or mental health.

Substance abuse treatment center – a detoxification and/or rehabilitation facility licensed by the state to treat alcoholism and/or drug abuse.

Surgery – Any variety of technical procedures for treatment or diagnosis of anatomical disease or injury, including but not limited to, cutting, microsurgery (use of scopes), laser procedures, grafting, suturing, castings, treatment of fractures and dislocations, electrical, chemical or medical destruction of tissue, endoscopic examinations, anesthetic epidural procedures, and other invasive procedures. Covered surgical services also include usual and related anesthesia and pre- and post-operative care, including recasting.

Surgical assistant – an assistant to the primary surgeon who provides required surgical services during a covered surgical procedure. RMHP, at its sole discretion, determines which surgeries do or do not require a surgical assistant.

Ultrasound – a radiology imaging technique that uses high frequency sound waves to obtain a visual image of internal body organs or the fetus in a pregnant woman.

Urgent care – care provided for individuals who require immediate medical attention but whose condition is not life threatening (non-emergency).

Utilization management – is the evaluation of the appropriateness, medical need and efficiency of health care services procedures and facilities according to established criteria or guidelines and under the provisions of this plan's benefits.

Utilization review – a set of formal techniques using standardized criteria designed to monitor the use, or evaluate the clinical necessity, appropriateness, efficacy or efficiency, of health care services, procedures or settings. Techniques include ambulatory review, prospective review, second opinion, certification, concurrent review, care management discharge planning, and/or retrospective review. Utilization review also includes review to determine coverage. This is based on whether a procedure or treatment is considered experimental/investigational in a given circumstance (except if it is specifically excluded under this CHP+ Member Benefits Booklet), and review of a Member's medical circumstances, when such a review is necessary to determine if an exclusion applies in a given situation.

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Well-child visit – a provider visit that includes the following components: an age-appropriate physical exam, history, anticipatory guidance, and education (for example, examining family functioning and dynamics, injury prevention counseling, discussing dietary issues, reviewing age-appropriate behaviors, etc.), and assessment of growth and development. For older children, a well-child visit also includes safety and health education counseling.

X-ray and radiology services – services including the use of radiology, nuclear medicine, and ultrasound equipment to obtain a visual image of internal body organs and structures, and the interpretation of these images.

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Fraud Investigation Referral Form



Member, Provider, or Health Care Facility Information

First Name:	Last Name:
Street 1:	Street 2:
City:	State:
Zip Code:	Telephone Number:
Patient First Name:	Patient Last Name:
Member Number:	Provider Number:
Claim Number:	

Suspected Fraudulent or Abusive Activity

What are they doing?

Reporting Entity (leave blank for anonymous referrals)

First Name:	Last Name:	Phone #:
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Complete and send to:

Fraud Investigator
Rocky Mountain Health Plans
PO Box 10600
Grand Junction, CO 81502-5600

Member Complaint and Appeal Form



Complaint/Appeal is for:

Member Name: _____

Address: _____

City State Zip: _____

Telephone: _____

Member ID number: _____

Person submitting this form: _____

Relationship to Member: _____

Tell us the problem (please describe in detail):

Mail to:

Rocky Mountain Health Plans
Member Concerns Coordinator
P.O. Box 10600
Grand Junction, CO 81502-5600

You can send us a complaint at any time. You must send us an appeal within 60 calendar days of the letter/notice that told you that RMHP would not cover or pay for a service.

Call Customer Service at 970-244-7960 or 855-830-1563 if you have any questions or need help. We can give you information about complaints and appeals. If you want help filling out the form, please call Customer Service. We will help you.

- If you are deaf, hard of hearing, or have a speech disability, dial 711 for Relay Colorado or use our Live Chat on rmhp.org.
- Para asistencia en español llame al 855-830-1563.
- For callers who speak languages other than English or Spanish, RMHP uses Language Line Solutions.

Member Signature: _____ Date: _____

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-282-8801 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-282-8801 (TTY: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-282-8801 (TTY: 711).
Chinese	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 1-888-282-8801 (TTY: 711)。
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-282-8801 (TTY: 711)번으로 전화해 주십시오.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-282-8801 (телетайп: 711).
Amharic	ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-888-282-8801 (መስማት ለተሳናቸው: 711)።
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-282-888-1 (رقم هاتف الصم والبكم: 117).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-282-8801 (TTY: 711).

French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-282-8801 (ATS : 711).
Nepali	ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-282-8801 (टिटिवाइ: 711) ।
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-282-8801 (TTY: 711).
Japanese	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。1-888-282-8801 (TTY:711) まで、お電話にてご連絡ください。
Cushite – Oromo	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-282-8801 (TTY: 711).
Persian	رایگان، امداد، خدمات زبانی از گلدیس، زبان شما اگر توجیه 1088-282-888-1 تماس. همد تند دسد ترس در شما به (117:YTT).
Ibo/Igbo	Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-888-282-8801 (TTY: 711).
Kru-Bassa	Dè dɛ nià kɛ dyédé gbo: ɔ jũ ké m̄ [Bàsòò-wùdù-po-nyò] jũ ní, nií, à wuɖu kà kò dò po-poò bɛ̀in m̄ gbo kpáa. Đá 1-888-282-8801 (TTY:711)
Yoruba	AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-888-282-8801 (TTY: 711).

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- 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 1-888-282-8801, or TTY: 711.

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Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Para asistencia en español llame al 1-888-282-8801 o eeoofficer@rmhp.org

Call RMHP at 1-888-282-8801, or TTY: 711, if you want this document or any other RMHP document in other formats - like large print, electronically, or other accessible format. RMHP provides free auxiliary aids and services to people with disabilities to communicate effectively with us.

