ROCKY MOUNTAIN HEALTH PLANS®

Application for RMHP Individual Medicare Plans

20

Please contact RMHP if you need information in another format.

— Please detach before completing form —

To enroll in RMHP, please provide the following information:			
Please check which plan you want to enroll in: ☐ Rocky Mountain Basic Plan (Cost)* ☐ Rocky Mountain Standard Plan (Cost)* Rocky Mountain Green Plan (Cost)* Rocky Mountain Plus Plan (Cost)* Rocky Mountain Thrifty Plan (Cost)* ***You must continue to pay your Medicare Part B Premium**			
Coverage begins on the 1st day of the month. What effective date are you applying for?	**__ __/ 0 1 / 2 0 1 9**		
Optional Supplemental Benefits:	☐ Optional UnitedHealthcare Platinum Dental Plan (additional $45.00 per month) ☐ Optional VSP Choice Vision Plan (additional $12.00 per month)		
☐ Mr. ☐ Mrs. ☐ Ms.	LAST Name:	FIRST Name:	Middle Initial:
Birth Date: __ __/__ __/__ __ __ __	Gender: ☐ M ☐ F	Phone Number: ( )	
Permanent Residence Address (P.O. Box is not allowed)			
Address:			
City:	State:	County:	Zip Code:
Mailing Address (only if different from your Permanent Residence Address)			
Address:			
City:	State:	County:	Zip Code:

Please Provide Your Medicare Insurance Information	
Please take out your red, white and blue Medicare card to complete this section. • Fill out this information as it appears on your Medicare card. – OR – • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.	**Name** (as it appears on your Medicare card): _____ **Medicare Number:** _____ **Is Entitled To:** **Effective Date:** **HOSPITAL (Part A)** _____ **MEDICAL (Part B)** _____ You must have Medicare Part B to join any of the RMHP plans listed above.

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

Please read and answer these important questions:

1. Do you have End Stage Renal Disease (ESRD)? **Yes** **No**
   If you answered "yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

2. Are you enrolled in your State Medicaid program? **Yes** **No**
   If "yes", please provide your Medicaid number: _____

3. Do you or your spouse work? **Yes** **No**
   Do you have health coverage through you or your spouse's current or former employer?
   Yes **No**

If "yes", please provide the following information:

Employer Name:_____ Insurance Carrier: _____

Policy Holder Name: _____ Policy Number: _____

Please list your Primary Care Physician (PCP) or clinic:

Clinic Name:_____

Physician Name (First and Last Name):_____

Physician or Clinic Address:_____

City: _____State: _____Zip: _____

Please tell us if you prefer to receive information in an alternate language (other than English) or an alternate format:

Alternate Language (please indicate language)

_____

Alternate Format (please indicate format): Large Print Braille Other:_____

Please indicate the types of documents you want to receive in the alternate language/format above:

- Important Letters and Notices
- Billing and Claim Information (premium invoices, explanation of benefits, etc.)
- Annual Notice of Changes/Evidence of Coverage
- Other Correspondence (marketing materials, newsletters, preventive care information, etc.)

Please contact Rocky Mountain Health Plans at 888-282-1420 if you need information in an accessible format or language other than what is listed above. Our office hours are 8am - 8pm, 7 days/week, Oct.1–March 31, and 8am - 8pm, M-F, April 1–Sept.30. TTY users should call 771.

Please Read This Important Information

If you currently have health coverage from an employer or union, joining RMHP could affect your employer or union health benefits. If you have health coverage from an employer or union, joining may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

— Please detach before completing form —

Document Delivery Preferences

CMS (Medicare) requires RMHP to provide ***every*** Member with certain required plan documents at enrollment and annually thereafter. The Evidence of Coverage (EOC) is available at **www.rmhpMedicare.org**. **TheAnnual Notice of Change (ANOC) will be sent to *every Member* by mail unless a different option is selected below:**

☐ **Option 1 – Opt In to Receive Required Documents Electronically**

To view your documents, you must have Internet access and your system must meet minimum system requirements. You will not receive paper copies.

E-mail address: _____

Option 2 - Consent to Receive One Required Document Mailing per Household (if there are multiple RMHP Members in your household)

The Members of your household can request that only one set of plan documents be sent. Each household Member must sign below.

Last Name, First Name	Member ID	Date	Signature

Attach a separate sheet if more than four Members reside at the same address.

You may change your document delivery preferences or request a paper copy, free of charge, by calling RMHP Customer Service.

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

Rocky Mountain Health Plans is a Medicare health plan and I will need to keep my Medicare Part B. I can be in only one Medicare health plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I know I may disenroll from this plan at any time by sending a written request to RMHP or by calling 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

RMHP serves a specific service area. If I move out of the area that RMHP serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a Member of RMHP, I have the right to appeal plan decisions about payment or services if I disagree.

I will read the Evidence of Coverage document from RMHP when I receive it to know which rules I must follow in order to get coverage with this Medicare health plan.

I understand that beginning on the date RMHP coverage starts, in order for RMHP to cover my medical services (except for emergency or urgently-needed services), all of my health care must be provided or arranged by RMHP. If I obtain services not provided or arranged by the plan, I will be responsible for all Medicare deductibles and coinsurance, as well as any additional charges as

prescribed by the Medicare program. I may also be liable for charges not covered by Medicare.

Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage in Canada and Mexico. Services authorized by RMHP and other services contained in my RMHP Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered.

Release of Information: By joining this Medicare health plan, I acknowledge that RMHP will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the State law where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Rocky Mountain Health Plans or by Medicare.

Signature:	**Today's Date:**

Print Name:

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number: (_____) _____

Relationship to Enrollee: _____

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID#: _____

Effective Date of Coverage: _____

IEP:_____ AEP:_____ SEP (type):_____ Not Eligible: _____

— Please detach before completing form —

RMHP
PO Box 10600
Grand Junction, CO 81502-5600

Applicant Name: _____

Medicare Claim Number: _____

Paying Your Plan Premium

You can pay your monthly plan premium by mail or Electronic Funds Transfer (EFT). You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month.

If you don't select a payment option, you will receive a bill each month.

Please select a premium payment option:

Receive a bill (mailed). Full payment is due upon receipt of invoice.

Electronic funds transfer (EFT) from your bank account each month.

Please enclose a VOIDED check or provide the following:

Account holder name (if different): _____

Account holder signature:_____

Bank routing number: _____ Bank account number: _____

Account type: | | Checking Savings

Automatic deduction from your monthly Social Security/Railroad Retirement Board benefit check.

I get monthly benefits from: Social Security RRB

(The Social Security/Railroad Retirement Board deduction may take two or more months to begin after Social Security/ Railroad Retirement Board approves the deduction. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will not include all premiums due from your enrollment effective date up to the point withholding begins. We will send you a paper bill for those months before deduction from your Social Security/ Railroad Retirement Board check starts. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your premiums. If chosen, Dental and Vision plan premiums are not deducted from Social Security of the RRB benefit check and will be billed directly to the Member.)

— Please detach before completing form —

Rocky Mountain Health Plans - H0602
2019 Medicare Star Ratings*

The Medicare Program rates all health and prescription drug plans each year, based on a plan's quality and performance. Medicare Star Ratings help you know how good a job our plan is doing. You can use these Star Ratings to compare our plan's performance to other plans. The two main types of Star Ratings are:

1. An Overall Star Rating that combines all of our plan's scores.
2. Summary Star Rating that focuses on our medical or our prescription drug services.

Some of the areas Medicare reviews for these ratings include:

- How our Members rate our plan's services and care;
- How well our doctors detect illnesses and keep Members healthy;
- How well our plan helps our Members use recommended and safe prescription medications.

For 2019, Rocky Mountain Health Plans received the following Overall Star Rating from Medicare.

3 Stars

We received the following Summary Star Rating for Rocky Mountain Health Plans's health/drug plan services:

Health Plan Services:	 3 Stars
Drug Plan Services:	Not Offered

The number of stars shows how well our plan performs.

	5 stars- Excellent
	4 stars- Above Average
	3 stars- Average
	2 stars- Below Average
	1 star- Poor

Learn more about our plan and how we are different from other plans at www.medicare.gov.

You may also contact us 7 days a week from 8:00 a.m. to 8:00 p.m. Mountain time at 888-282-1420 (toll-free) or 711 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Mountain time.

Current Members please call 888-282-1420 (toll-free) or 711 (TTY).

*Star Ratings are based on 5 Stars. Star Ratings are assessed each year and may change from one year to the next.

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Notice of Privacy Practices (Aviso de prácticas de privacidad*)

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

You may ask for an additional paper copy of this privacy notice at any time. *Para recibir esta noticia en español llame al 800-346-4643. 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.

In this notice, the words "us" "our" and "we" mean Rocky Mountain Health Plans or RMHP. These plans are underwritten by Rocky Mountain Health Maintenance Organization (RMHMO).

Q. Why is this notice provided?

A. Rocky Mountain Health Plans respects the privacy of your personal health information, also called PHI. By law, we have to make sure that your PHI is kept private. We must also give you this notice of our legal duties, your rights, and our privacy practices about your PHI. We must tell you about how and when we may use, share, or discuss your PHI with others.

Q. What is PHI?

A. PHI includes information that we have about your past, present, or future health or medical condition that could be used to identify you. This includes such things as health care treatment, or payment for health care you have received.

Q. How and when can you use, give out, or tell others about my PHI?

A. RMHP can use or give out your PHI:

- To help make sure your medical bills sent to us for payment are handled the right way.
- To help your doctors or other health care providers manage your health care, such as if you're in a wellness program or if you are a home health patient.
- To send you a reminder if you have a doctor's visit.
- To give you information about other health care treatments, services, and programs you may be interested in, such as a weight-loss program.
- To tell an employer that helps pay for your health benefits of your enrollment with RMHP. Any PHI we might give to your employer group plan sponsor cannot be used for employment or benefit decisions.
- With other people who are with you at the time we discuss your PHI. For example, when you allow others to be in the room when a home health nurse visits your home or if your spouse is with you on the phone when you call us. In these cases, we may talk about your PHI with both of you.
- If you are injured or unconscious we may share PHI with your family or friends to help make sure you get the care you need and talk about how the care will be paid for.

Please Note: We will not use your PHI that is genetic information for any underwriting purpose.

Q. Are there state or federal laws that may call for RMHP to share your PHI?

A. Yes, there are also state and federal laws that may call for us to give your PHI to others. For example, we may give out your PHI:

- To state and federal agencies that regulate us, such as the U.S. Department of Health and Human Services and the Colorado Division of Insurance.
- For public health activities. This may include reporting disease outbreaks.
- To public health agencies if we think there is a serious health or safety threat.
- For government health oversight activities, such as fraud investigations.
- To a court or administrative agency, such as to obey a court order.
- For law enforcement purposes, such as to find a suspect.
- To a government authority when there is abuse, neglect, or violence in the home.
- To a coroner, medical examiner, or funeral director to

aid in deciding cause of death.

- For getting, saving, or transplanting organs, eyes, or tissue, and also in limited ways for research activities.
- For special government functions, such as for national safety.
- For job-related injuries because of state worker compensation laws.

If none of the above reasons apply, we must ask you to tell us in writing that we may use or give out your PHI before we do it.

Q. Are there other reasons you can use, share, or tell others about my PHI?

A. No, except for the situations listed above, we will not use or disclose your PHI for any other reason unless we have your written permission. If you tell us in writing that we may use or give out your PHI and change your mind, you may take back your written permission at any time. But you cannot take back your written permission if we already acted when we had your permission. Most uses and disclosures of psychotherapy notes, and uses and disclosures of PHI for marketing reasons or that are tied to a "sale" of PHI can only happen with your written permission.

Q. What are my rights with respect to my PHI?

A. **You have the right** to ask that we limit how we use and give out your PHI. You also have the right to ask us to limit how much PHI we give to someone who is involved in your care or helping pay for your care. Please note that we do not have to agree to the request.

You have the right to ask that we talk with or write to you in a different way or at a different place to protect you from danger. For example, you may ask us to send your PHI to your work address instead of your home address.

You have the right to see and ask for a copy of your PHI. You can ask to have your PHI given to you in a particular way or form, such as paper or electronic format. We will try to meet your request if it is not too difficult to provide it in that format. You may also ask that we tell you in writing about the PHI we have about you. We will respond to you within 30 days after we get your written request. If we deny your request, we will write back to you with the reasons. We will also explain your right to have our denial reviewed. We may charge you a reasonable fee based on the copy costs for labor and supplies to meet your request or for writing a description of PHI if that is what you asked for.

You have the right to get a list of times we have given out your PHI during the six years before your request. Please note we are not required to give you a list of every time we gave out your PHI.

We do not have to tell you the times we gave out your PHI:

- Before April 14, 2003.
- For treatment, payment, and health care operation purposes.
- To you or others, if we have your written permission.
- To persons involved in your care or payment for care.
- For national safety reasons, or in special situations required by law enforcement or health oversight agencies.

We will act on your request within 60 days. Your first list will be free. We will give you one free list every 12 months if you ask for it. If you ask for another list within 12 months of getting your free list, we may charge you a fee.

You have the right to ask us to change your PHI or add missing information if you think there is a mistake in your PHI. We will respond within 60 days of getting your written request. If we deny your request, we will tell you the reasons in writing. Our written denial will also explain your right to file a written statement of disagreement. You can ask us to attach your request, our denial, and your statement of disagreement to your PHI anytime we give it out in the future.

Q. If I want to use these rights, do I have to make a written request?

A. Yes. All requests must be made in writing. You do not have to use any special form, but you can get a request form by calling our Customer Service at 970-243-7050 or 800-346-4643. Send in your request to: Rocky Mountain Health Plans, PO Box 10600, Grand Junction, CO 81502-5600.

Q. How may I complain about RMHP's privacy practices?

A. Send your written complaint to RMHP Customer Service, Attn: Privacy, PO Box 10600, Grand Junction, CO 81502-5600. You also may complain to the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint about our privacy practices or for using any of the rights described in this notice.

Q. What other steps do we take to protect your PHI?

A. We limit access to your PHI to those who need it in order to help us provide products or services to you.

Other policies, such as limiting access to facilities, only discussing PHI in secure areas, keeping fax machines in secure areas, requiring passwords for computer access, and checking your identity before we discuss your PHI also help to protect your information. If there is a breach of your unsecured PHI, you have the right to be notified of the breach and we will provide notice to you in writing.

Q. How will I know if my rights described in this notice change?

A We follow the terms of the notice that is now in effect. This notice is effective as of September 23, 2013. We reserve the right to change the terms of this notice and our privacy policies at any time. Then the new notice will apply to all your PHI. If we change this notice, we will put the new notice on our website and mail a copy of the new notice to our subscribers with the next regular annual mailing after the new notice takes effect.

Q. Who should I contact to get more information or to get a copy of this notice?

A. You can do this in one of three ways:

- Visit our website: www.rmhp.org.
- Write to us: Rocky Mountain Health Plans, PO Box 10600, Grand Junction, CO 81502-5600.
- Call Rocky Mountain Customer Service: 970-243-7050 or 800-346-4643.

RMHP is a Medicare-approved Cost plan. Enrollment in RMHP depends on contract renewal. Please call our Customer Service at 888-282-1420 (TTY dial 711). Hours are 8 a.m. to 8 p.m., 7 days/week, October 1-March 31, and 8 a.m. to 8 p.m., Monday through Friday, April 1-September 30.

Notice of Nondiscrimination

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

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

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

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

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

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

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Multi-Language Insert

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-346-4643 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-346-4643 (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 1-800-346-4643 (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 1-800-346-4643 (TTY: 711)。
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-346-4643 (TTY: 711)번으로 전화해 주십시오.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-346-4643 (телетайп: 711).
Amharic	ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-346-4643 (መስማት ለተሳናቸው: 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-346-4643 (رقم هاتف الصم والبكم: 117).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-346-4643 (TTY: 711).
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-346-4643 (ATS : 711).
Nepali	ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-346-4643 (टिटिवाइ: 711) ।
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-346-4643 (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。1-800-346-4643（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 1-800-346-4643 (TTY: 711).
Persian	**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-346-4643 (117:YTT) تماس بگیرید.
Ibo/Igbo	Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-800-346-4643 (TTY: 711).
Kru-Bassa	Dè ɖɛ nià kɛ dyéɖé gbo: Ɔ jŭ ké m̀ [Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀] jŭ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Đá 1-800-346-4643 (TTY: 711)
Yoruba	AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-800-346-4643 (TTY: 711).