How to File a Grievance, an Organization/Coverage Determination or an Appeal

This is a summary of our grievance, coverage determination (including exceptions) and appeals processes.

Below we summarize how to ask for coverage decisions, make appeals or make a complaint if you are having trouble getting the medical care or prescription drugs you think are covered by our plan. This includes asking us to make exceptions to the rules or extra restrictions on your prescription drug coverage, and asking us to continue covering hospital care and certain types of medical services if you think your coverage is ending too soon.

For step-by-step guidance please refer to the Evidence of Coverage for your plan in the chapter titled *What to do if you have a problem or complaint (coverage decisions, appeals, complaints).*

How to make a Complaint or Grievance

The complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times, customer service or other concerns that are not about benefits or coverage. Please refer to your Evidence of Coverage chapter titled *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)* for step-by-step instructions.

To make a complaint, usually calling Customer Service is the first step. If there is anything else you need to do, Customer Service will let you know.

If you do not wish to call, or you called and were not satisfied, you can put your complaint in writing and send it to us.

If you want to complain to us regarding any of the issues described above, you must call or send us a letter within 60 days after you had the problem you want to complain about.

We look into your complaint and give you our answer. If possible, we will answer you right away. Most complaints are answered in 30 days. If we need more information and the delay is in your best interest, we may take up to 14 more calendar days (44 calendar days total) to answer your complaint.

If we do not agree with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer.

If your complaint is about the quality of care you received, you can make your complaint to our plan, to Medicare,or you can make your complaint directly to the Quality Improvement Organization. If you wish, you can make your complaint to all three organizations. Information on how to contact Medicare and the Quality Improvement Organization is located in the chart below.

ROCKY MOUNTAIN HEALTH PLANS®

How to ask for a Coverage Decision

A coverage decision is any decision we make about your benefits and coverage, or about the amount we will pay for your medical services or drugs.

If you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you. You can call, write, or fax a request for us to provide coverage for the medical care you want. You, your doctor, or your representative can do this. When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard decision means we will give you an answer within 14 days after we receive your request. If your health requires it, ask us to give you a "fast decision" we will answer within 72 hours. There are requirements that must be met to qualify for a "fast decision. For example, you can get a fast decision only if you are asking for coverage for medical care you have not yet received.

You may ask for a coverage decision for your Part D drugs. For example, you may ask us whether a drug is covered for you and whether you need to get approval from us before we will cover it for you. You might also need to ask us to pay for a drug you already bought.

A request for an "exception" is also a type of coverage decision. If a drug is not covered in the way you would like it to be covered, you can ask us to make an exception, e.g.,

- Ask us to cover a drug that is not on the drug list (formulary);
- Ask us to waive a restriction on our coverage of a drug, such as limits on the amount you can get;
- Ask to pay a lower cost-sharing amount for a covered drug.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request.

When we give your our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast decision means we will answer within 24 hours.

Making an appeal about medical coverage

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. When we have completed the review, we give you our decision.

To start an appeal you, your doctor, or your representative must contact us. Make your standard appeal in writing by submitting a signed request. You may also ask for an appeal by calling us. Contact information can be found in the chart below.

You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this

deadline and have a good reason for missing it, we may give you more time to make your appeal. If your health requires a quick response, you must call and ask for a "Fast appeal."

Our plan considers your appeal, and we give you our answer. When we are using the "fast deadlines", we must give you our answer within 72 hours after we receive your appeal. If our answer is yes to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal. When we are using the standard deadlines, we must give you our answer within 30 days after we receive your appeal. If our answer is yes to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 30 days.

If our plan says no to your appeal for medical coverage, we are required to automatically send your appeal to the "Independent Review Organization". The Independent Review Organization is an independent organization that is chosen by Medicare. Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The Independent Review Organization will tell you its decision in writing and explain the reasons for it. If your appeal is turned down and your case meets the requirements, you choose whether you want to take your appeal further. There are three additional levels in the appeals process. Please refer to your Evidence of Coverage in the chapter *What to do if you have a problem or complaint (coverage decisions, appeals, complaints*) for step-by-step instructions.

Making an appeal about drug coverage (for plans with Part D prescription drug coverage)

If our plan says no to your coverage request, you have the right to request an appeal, and ask us to reconsider and possibly change our decision.

To start your appeal, you or your representative or your doctor or other prescriber must contact us. You may make your appeal by submitting a written request or you may ask for an appeal by calling us at the phone number listed in the chart below.

You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing, we may give you more time to make your appeal. If we are using the fast deadlines, we must give you an answer within 72 hours after we receive your appeal. We will give you our answer sooner if your health requires it. If we are using the standard deadlines, we must give you our answer within 7 (seven) calendar days after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If our answer is yes to all or part of what you requested, we must provide coverage no later than 7 (seven) calendar days after we receive your appeal.

If we deny any part of your appeal, you or your appointed representative have the right to ask the Independent Review Organization to review your case. The written notice we send you will include instructions on how to make this appeal and how to reach the review organization. If we do not give you our decision within the required appeal time frame, we must immediately forward the complete case file to the independent organization for review. Please refer to your Evidence of Coverage in the chapter *What to do if you have a problem or complaint (coverage decisions, appeals, complaints*) for step-by-step instructions on how to make a Level 2 Appeal.

Rocky Mountain Health Plans Medicare Members	
CALL	888-282-1420 (TTY dial 711) Calls to this number are free. Call 8:00 a.m. to 8:00 p.m., Mountain Time, (from Oct.1-Feb.14, 7 days/week; from Feb. 15-Sept. 30, M-F)
TTY	Dial 711 for Relay Colorado This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX Complaints for Medical Care or Part D Prescription Drug Coverage	970-263-5590
FAX Coverage Decisions (pre-authorization) for Medical Care	877-201-7302
FAX Appeal for Medical Care or Part D Prescription Drug Coverage	970-244-7828
FAX Coverage Decisions about your Part D Prescription Drug Coverage	970-248-5034
WRITE For Coverage Decisions or Complaints for Medical Care or Part D Prescription Drug Coverage	Rocky Mountain Health Plans Customer Service P.O. Box 10600 Grand Junction, CO 81502-5600
WRITE For Appeals for Medical Care or Part D Prescription Drug Coverage	Rocky Mountain Health Plans Member Appeals P.O. Box 10600 Grand Junction, CO 81502-5600
CALL or WRITE To Complain to the Quality Improvement Organization about the Quality of Care You Received	Colorado Foundation for Medical Care 23 Inverness Way East, Suite 100 Englewood, CO 80112-5708 800-727-7086
CALL or VISIT THE WEBSITE To Complain to Medicare about the Quality of Care You Received	1-800-MEDICARE Or https://www.medicare.gov/MedicareComplaintForm/home.aspx

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

This information is available for free in other languages. Please call our Customer Service number at 888-282-1420 (TTY dial 711). Hours are 8am - 8pm, 7 days/week, Oct. 1–Feb.14, and 8am - 8pm, M-F, Feb.15–Sept.30.

Esta información está disponible gratuitamente en otros idiomas. Por favor llame a la línea de Atención a Clientes, al 888-282-1420 (TTY marque 711). Horario de 8am - 8pm, 7 días a la semana, del 1 de octubre al 14 de febrero; y de 8am - 8pm, de lunes a viernes, del 15 de febrero al 30 de septiembre.