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1. INTRODUCTION

This Access Plan (Access Plan) contains general information regarding the Rocky Mountain Health Maintenance Organization, Inc. (dba Rocky Mountain Health Plans or RMHP) Monument Health HMO Network (Network ID CON004) and certain policies and procedures of RMHP. The Access Plan is not, and in no event shall be, construed as a contract between RMHP and Members covered under RMHP plans; nor does it grant any rights, privileges, or benefits to any person. Rights and Responsibilities of Members covered under RMHP plans are governed by the Member Evidence of Coverage, whether such provisions are also specified or referred to in this Access Plan. Members have the right to request a copy of this or any Access Plan. Copies can be reviewed at our offices and online at https://www.rmhp.org/additional-provider-directories under RMHP Access Plans.

The Monument Health HMO Network is a clinically integrated network available to Mesa County residents and includes a tiered network of providers. Members pay less when they receive care from a Tier 1 provider, and may pay more when receiving care from a Tier 2 provider. Tier 1 includes primary care practices, local hospitals, all SCL Health providers and facilities in Denver and surrounding counties, and numerous local specialists. Tier 2 includes additional providers through the Rocky Mountain Range Network (CON003) on the Western Slope as well as in the Denver and Colorado Springs areas. Tier 2 Emergency care is always covered as a Tier 1 benefit.
RMHP Customer Service is available for Members Monday – Friday 8:00 a.m. to 5:00 p.m. at 800-346-4643 or 970-243-7050. Providers may contact RMHP by calling Customer Service Monday – Friday 8:00 a.m. to 5:00 p.m. at 800-854-4558 or 970-248-5036. Members and Providers may also email RMHP Customer Service at customer_service@rmhp.org or visit our website at https://www.rmhp.org.

2. NETWORK ADEQUACY AND CORRECTIVE ACTION PROCESSES

A. Network adequacy standards and results summary

Rocky Mountain Health Plans (RMHP) standards are defined internally, as well as by the Division of Insurance (Colorado) (DOI), Center for Medicare and Medicaid Services (CMS) and Department of Health Care Policy and Financing (Colorado) (HCPF). These standards include measuring and analyzing network adequacy in the following areas:

- Number of each type of practitioner as compared to the number of members
- Geographic and drive time distance distribution of practitioners in proximity to membership

The Monument Health HMO network is available to residents in Mesa County. Because Membership consists of residents of Mesa County, shortages of providers participating in the Monument Health HMO network outside of Mesa County may exist.

The following counties in the Monument Health HMO Network did not meet the Provider to Member ratio of 1:1000:

- Pediatrics: Garfield

The following counties did not meet the distance standards per their county designation:

- Pediatrics: Garfield

In the community listed above, RMHP contracts with all the available physicians, pharmacies, Essential Community Providers, and hospitals that meet RMHP’s credentialing and quality standards. In the counties where the provider ratios and/or distance standards are not met, there are no willing providers available to contract with. If a Member needs care and it is covered by the plan but not offered by a network provider, Members may receive preauthorization to see an out-of-network provider. RMHP will continue to monitor the areas for new providers to contract with. Additionally, telemedicine services are a benefit available to Members.

B. Process for monitoring and assuring network sufficiency

A strong and comprehensive provider network is essential to meeting the needs and preferences of health plan members. RMHP performs an annual evaluation of accessibility and availability of participating providers and RMHP’s provider networks.

Data sources to perform the evaluation includes Geo Access reports which include the following criteria:

- Provider network
- Designated county types for the geographic areas covered by the network
- Provider type
- Provider to Member ratio standards
- Maximum time and distance requirements
Additional data sources include the following Data Extraction reports:
- Claims Data Extraction telehealth and out-of-network claims reports to analyze utilization
- Preauthorization Data Extraction reports to analyze out-of-network requests

The following Member to provider ratios, access to service and wait time standards are measured and analyzed.

### Commercial Network Member / Provider Ratios

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Large Metro</th>
<th>Metro</th>
<th>Micro</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>1:1000</td>
<td>1:1000</td>
<td>1:1000</td>
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<tr>
<td>Pediatrics</td>
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<td>1:1000</td>
<td>1:1000</td>
</tr>
<tr>
<td>OB/GYN</td>
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<td>1:1000</td>
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<tr>
<td>Mental Health, Behavioral Health &amp; Substance Abuse Disorder Care</td>
<td>1:1000</td>
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### Geographic Access Standards

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<tr>
<td></td>
<td>Maximum Distance (miles)</td>
<td>Maximum Distance (miles)</td>
<td>Maximum Distance (miles)</td>
<td>Maximum Distance (miles)</td>
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<tr>
<td>Gynecology, OB/GYN</td>
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<td>Pediatrics Routine/Primary Care</td>
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<td>Allergy &amp; Immunology</td>
<td>15</td>
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<td>60</td>
<td>75</td>
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<tr>
<td>Cardiothoracic Surgery</td>
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<td>75</td>
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<td>ENT/Otolaryngology</td>
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<td>Intensive Care Units (ICU)</td>
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<td>Surgical Services</td>
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<td>(Outpatient or Ambulatory Surgical Centers)</td>
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<tr>
<td>Skilled Nursing Facilities</td>
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<td>Mammography</td>
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<tr>
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<tr>
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<tr>
<td>Inpatient Psychiatric Facility</td>
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<td>45</td>
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<tr>
<td>Other Facilities</td>
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### Colorado County Designations

<table>
<thead>
<tr>
<th>County</th>
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<tbody>
<tr>
<td><strong>Large Metro</strong></td>
<td>Denver</td>
</tr>
<tr>
<td><strong>Metro</strong></td>
<td>Adams</td>
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<tr>
<td></td>
<td>Arapahoe</td>
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<tr>
<td></td>
<td>Boulder</td>
</tr>
<tr>
<td><strong>Micro</strong></td>
<td>Garfield</td>
</tr>
<tr>
<td></td>
<td>La Plata</td>
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<tr>
<td><strong>Rural</strong></td>
<td>Alamosa</td>
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<tr>
<td></td>
<td>Chaffee</td>
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<td>Clear Creek</td>
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<td></td>
<td>Delta</td>
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<td></td>
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<tr>
<td><strong>CEAC</strong></td>
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<td></td>
<td>Grand</td>
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<td>Gunnison</td>
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</tbody>
</table>

**Telehealth**

Telemedicine services are a benefit available to Members which allow health care services through telecommunications systems such as a smartphone, tablet or computer. Coverage is provided through Dr On Demand, allowing Members to connect with Board Certified doctors and therapists 24 hours a day 7 days a week. Virtual visits may be subject to Copays, Coinsurance and Deductibles applicable to the type of care provided. To learn more about Dr On Demand please visit https://doctorondemand.com/.

### C. Provider network factors

RMHP offers narrowed and tiered networks through its Monument Health HMO products. For the Monument Health HMO Network, RMHP assesses network adequacy according to defined standards based on the service area of the products offered. The Monument Health HMO Network is a clinically integrated organization with which RMHP contracts; RMHP is the payer for this group. Practices and facilities within the service area of the
products offered that have demonstrated the ability, resources, and commitment to deliver efficient, patient-centered care are invited to join the Network. Once in the Network, these practices and facilities are contracted at the Tier 1 level. RMHP in addition will; based on Network adequacy requirements, designate other providers as Tier 1. All other providers that participate in the Rocky Mountain Range HMO Network (CON003) that are located within Mesa County are designated as Tier 2 providers. In addition, in order to provide access to some more specialized services, providers in the Denver Metro and Colorado Springs area that participate in the Rocky Mountain Range HMO Network (CON003), participate as Tier 2 providers.

D. Quality assurance standards

RMHP’s Quality Improvement (QI) Program establishes a formal process for developing and implementing an effective clinical quality improvement program, promotes objective and systematic monitoring and evaluation of clinical and service related activities, and acts on opportunities for improvement. The program focuses on activities related to care quality, patient safety, physician access and availability, Member satisfaction, continuity and coordination of care, care management, pharmacy management, and Member rights and responsibilities. The QI Program also fulfills obligations to provide an ongoing review of the quality of health care services pursuant to 42 U.S.C.A. Section 300e(c)(6), Sections 10-16401(m) and 10-16-402(1)(b)(II), C.R.S., and regulations promulgated under such laws.

The objective of the QI Program is to monitor, measure, and take effective actions on identified opportunities to improve the quality and safety of health care and services through the cycle of objective evaluation, intervention and reevaluation. These activities are the summation of efforts by several Departments including Quality Improvement, Care Management, Pharmacy, Provider Network Management, Customer Service, Health Promotions, Claims, Home Health, Member Administration, Marketing, Information Technologies, and effective professional peer review. Pertinent activities from all of these processes are reported and integrated into the QI Program.

E. Corrective actions process

In the event a Network need is identified, based on Membership, RMHP will contact providers in the area that meet our credentialing guidelines and are willing to negotiate in good faith within 45 days. RMHP’s goal is to add new providers within 30 days of the signed contract. New providers will be made public via the online directory. In rural areas where adequate providers are not available, RMHP will monitor the area for new providers.

F. Corrective actions summary

Rocky Mountain Health Plans will continue monitoring the areas not meeting standards for any new providers who are willing to participate with us. In the meantime, RMHP has options for those Members who have limited access to providers by utilizing either out-of-network services with prior preauthorization approval, or telehealth services provided through Dr. On Demand.

G. Obtaining a covered benefit from a nonparticipating provider

In limited circumstances, RMHP will preauthorize services for nonparticipating providers when there is not a participating provider for the covered service. In these limited cases, Members do not pay any more for these services than they would if they saw a participating provider for the same service.

H. Monitoring access process

RMHP contracts with all providers in the area that meet our credentialing guidelines, are willing to negotiate in good faith, and willing to participate with RMHP under our general and customary
contractual terms; there is no specific criteria for selection. RMHP does not use quality measures, Member experience measures, or cost-related measures to select practitioners or facilities. In establishing and maintaining our network of providers, RMHP endeavors to provide care within a reasonable travel time and distance to Members.

3. NETWORK ACCESS PLAN PROCEDURES FOR REFERRALS

A. Provider Directories

Members can utilize RMHP’s online provider directory by visiting https://www.rmhp.org, selecting “Find a Provider” and then searching by their health plan, provider or facility. Advanced search options also allows Members to search providers by location, gender, if a provider is accepting new patients, language, specialty, group affiliation and admitting privileges. The online provider directory is updated weekly. A PDF version of the directory is also available for Members to download by visiting https://www.rmhp.org/additional-provider-directories, or they can contact Customer Service to request a printed copy or a copy in other languages. The PDF/printable directories are updated within 30 calendar days of receiving new information from providers.

B. Referral Process

RMHP does not require referrals to get specialty services from any network provider that is qualified to provide benefits. We do require prior authorization (also referred to as preauthorization) for some care before the Member gets it. This section will include RMHP’s prior authorization processes in place of referral processes.

1. Referral options

Members of the Monument Health HMO Network are able to obtain consultation and treatment from in-Network specialist physicians and mid-level providers without a referral from the PCP. The Member must be eligible to receive services under a Monument Health HMO Network health plan at the time services are provided and the services that the Member receives must be covered services as specified in the Member’s Evidence of Coverage.

Certain Monument Health HMO Network plans encourage the use of certain providers through variable deductible and copayments. When RMHP does offer such variable deductible and copayments we provide adequate and clear disclosure of such variable deductible and copayments to our Members.

2. Timeliness of preauthorization requests

Members may obtain covered specialty care services from out-of-network/out-of-plan providers at the in-network benefit level, subject to obtaining RMHP’s approval by preauthorization. Such approval shall be in a timely manner relative to the Member’s condition and adequate information is submitted in the request.

3. Expedited preauthorization requests

Expedited preauthorization requests are reviewed with priority status and should only be used for medically urgent or life-threatening conditions.

4. Retrospective preauthorization denial

If RMHP preauthorizes care in writing, we cannot deny the benefit after the Member gets the care. This does not apply in case of fraud or abuse by the Subscriber or Member.
5. Changes to approved preauthorizations

Approved preauthorization requests for health care services that Members are eligible to receive under their health care plan are not changed unless there is evidence of fraud or abuse.

6. Variable deductibles, coinsurance and/or copays

Clear disclosure of variable deductibles and copayments/coinsurance is made available to Members in the Coverage Schedule section of their Evidence of Coverage. This section lists how much Members pay for covered health care services. Disclosure also includes benefits that are limited to a specific number of treatments, days, visits or dollar amount. Member ID cards reflect deductible and copayment/coinsurance amounts.

C. Accessing services out-of-network

Services from out-of-network providers are approved in limited circumstances. If a Member needs care and it is covered by the plan but not offered by a network provider, Members may receive preauthorization to see an out-of-network provider. Members must have written approval from RMHP before receiving care from an out-of-network provider, except for urgent services outside the RMHP service area and medical emergencies.

4. NETWORK ACCESS PLAN DISCLOSURES AND NOTICES

A. Informing members of plan’s services and features

The Annual Notice is a document that includes notices and information RMHP is required to provide Members on an annual basis. The notices that must be provided differ, according to individual and group plans, as well as by line of business. Notices include, but are not limited to, information on RMHP’s privacy policy, Member rights and responsibilities, and Notice of Women’s Health and Cancer Rights. The Annual Notices are updated as new requirements are identified.

B. Required disclosures

1. Grievance procedures

RMHP is committed to providing our Members with the best possible service and we want RMHP Members to be satisfied with the care received and the services we provide. There are several ways for Members to present questions, concerns, grievances or submit an appeal. The following is a summary of the procedures; Members should refer to their Evidence of Coverage for full details in regards to filing a grievance or appeal. This description of those procedures does not replace the terms and conditions of the Evidence of Coverage, and is intended only to serve as a summary of the procedures.

Grievance (also referred to as a complaint)

A grievance is a verbal or written statement about a concern or dissatisfaction. Members can file a grievance, or complaint, for concerns related, but not limited to, a network provider, the inability to find a network provider, waiting times at provider offices, RMHP’s customer service, etc.

Grievances may be filed by using any of the following methods:

- Email: customer_service@rmhp.org
- Phone: 800-346-4643
- Fax: 970-244-7828
- Mail:
  Rocky Mountain Health Plans
  Attn: Member Appeals Department
  PO Box 10600
  Grand Junction, CO 81502-5600
Appeals

If RMHP make a decision a Member is unsatisfied with, the decision may be appealed. An appeal is the formal process to ask us to review the situation again. Members can file an appeal for decisions concerning, but not limited to, a denied claim, a denied preauthorization request, etc.

An appeal must be submitted within 180 days from the date listed on the notice. The notice is the document that details the decision the appeal is in regards to, such as a denial letter or Explanation of Benefits. We are unable to accept appeals more than 180 days from the date on the written notice.

If a Member is appealing on behalf of someone else; or someone is submitting an appeal for a Member, a Designated Representative Form must be signed and included. The only exception is if the Member is a parent appealing a decision for their minor child.

Appeals may be filed by using any of the following methods:

- Email: customer_service@rmhp.org
- Phone: 800-346-4643
- Fax: 970-244-7828
- Mail:
  Rocky Mountain Health Plans
  Attn: Member Appeals Department
  PO Box 10600
  Grand Junction, CO 81502-5600

Standard Appeal (1st Level)

An appeal coordinator may call the Member to discuss the appeal and a letter will be sent telling the Member more about the appeal process. RMHP will review the appeal and a decision made by someone who was not involved in the initial decision. If a medical decision is required, a physician with the same or similar expertise as the requesting physician will make the decision or be consulted. An appeal decision will be issued in writing within 30 days of receiving the appeal. If the appeal is denied the Member is provided with possible additional appeal rights.

Fast/Expedited Appeal

If a Member thinks their life or health would be in danger or they might not be able to get completely well or get back to normal unless care is received soon then a Fast/Expedited Appeal can be requested. RMHP will make a decision in 72 hours or sooner if health conditions requires us to do so. If RMHP decides the requirements for a fast appeal were not met, notification will be made within 72 hours and the appeal will be reviewed as a Standard Appeal. For situations involving urgent care or an ongoing course of treatment a Member can ask for an external expedited review while RMHP reviews the appeal internally.

Second Level Appeal or External Review Requests

If a Member does not agree with the Standard Appeal (1st Level) decision a request for a second level appeal may be available. External Reviews are also an option. More details can be found for both in the Evidence of Coverage.

Members have the right to call or write the Colorado Division of Insurance (DOI) about any complaint, dispute or disagreement at any time at:

- Phone: 800-930-3745
- Mail:
  Colorado Division of Insurance
  Department of Regulatory Affairs
2. Availability of specialty medical services

RMHP’s Monument Health HMO network consists of a broad specialty medical services network including physician specialties (such as allergists, immunologists, rheumatologists, dermatologists, gynecologists, gastroenterologists, pulmonologists, etc.), behavioral health specialists (addiction counselors, psychiatrists, marriage & family therapy, licensed clinical social workers, etc.), rehabilitative therapists (physical, occupational, speech), facilities (acute hospitals, rehabilitation facilities, surgical centers, etc.) and many other provider types including clinical labs, imaging, home health, durable medical equipment, orthotics, etc.

Members may receive covered specialty care from any network provider that accepts the Monument Health HMO network. A referral is not required; however, in most cases, the cost sharing for network specialist visits will be higher than when seeing a primary care physician. Some health care services must be preauthorized before they are received.

3. Process for providing emergent and non-emergent medical care

Urgent and Emergent, life and limb-threatening care is available, without prior authorization, for all Members 24 hours a day, 7 days a week. Additionally, Members may receive Emergency Services and Urgently-Needed Services while temporarily outside the service area. The attending emergency physician, or the provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge. RMHP will not deny payment for urgent or emergency services if the services were provided by an out-of-network provider or when instructed by a representative of RMHP to seek emergency services.

Members do not need to call a primary care physician or get preauthorization from RMHP before getting emergency care from network, non-network hospitals or emergency facilities. In an emergency Members have the following options:

- Call the local pre-hospital emergency medical service system by dialing the emergency telephone access number 9-1-1 or its local equivalent
- Call the local emergency number; or
- Go to an emergency room

If a Member has a condition that is not an emergency but still needs prompt treatment they are urged to contact their PCP first. If the PCP is not available the Monument Health HMO network includes urgent care/after hour clinics throughout the state who offer extended evening and/or weekend hours.

As a Member enrolled in the Monument Health HMO plan, designating a primary care physician is not required. RMHP knows that preventive care is key to managing health so we encourage all RMHP Members to select a primary care physician to manage their care.

4. Process for choosing and changing network providers

RMHP contracts with all providers in the area that meet our credentialing guidelines, are willing to negotiate in good faith, and willing to participate with RMHP under our general and customary contractual terms; there is no specific criteria for selection.

In establishing and maintaining our network of providers, RMHP strives to provide care within a reasonable travel time and distance to Members. To achieve this, RMHP contracts with all willing acute
care hospitals, primary care physicians, specialists and sub-specialists who meet RMHP’s credentialing and quality standards within the service area.

RMHP requires providers to contact us immediately if the following information changes in the status of their practice:

- Address and/or telephone number have changed
- Added an additional practice location and/or phone number
- If a provider is planning to leave a practice
  - RMHP requires a minimum of a 60-day advance notification from a provider who intends to terminate their contract to allow RMHP time to notify Members.
- Changes to the physician group
- Intend to open or close the practice to accepting new patients

The online provider directory is updated weekly and provider directories are updated within 30 days of receiving new information from providers. Members are notified by written communication when their primary care physician or a specialist is leaving the Monument Health HMO network.

5. Needs of special populations

RMHP performs an annual assessment to ensure the organization is meeting cultural, ethnic and linguistic needs of our Members. In addition to collecting data that identifies the race, ethnicity, and primary language needs of our Members, RMHP performs a number of activities to further support Member needs. Some of the services include, but are not limited to:

- Identifying network providers in provider directories who speak languages other than English, including American Sign Language
  - When a bilingual provider is not accessible, interpretation services are made available
- Translate Member materials in to any language
  - Some common materials are already available in Spanish
- RMHP contracts with a language services vendor to provide translation services for non-English speaking Members
- RMHP values diversity and encourages all network providers to be aware and sensitive to the cultural differences within our Membership by participating in various cultural competency programs and/or trainings
- RMHP Customer Service and Care Management staff training on diversity, cultural competency, special needs of Members and health disparities

6. Special population needs

For Members with complex medical and social needs, RMHP case managers work with people to coordinate the health care and other community services that our Members need, when they need them, and for the best value. Members may complete a Transition of Care Form at enrollment. This form helps identify Members who have special needs to develop complex or chronic health conditions. RMHP staff, PCPs, or other providers may refer to Members for case and disease management. As health needs are realized, the case managers streamline care to aid a Member’s condition. The Member’s progress toward recovery or resuming life activities is assessed.

7. Determining health care needs

RMHP has a variety of mechanisms in place to assess and track our Member’s needs, including case management services, individual health appraisals, Care Management (CM), and quality improvement activities.
The CM team conducts concurrent and retroactive reviews of utilization data to discover which Members use what services and why. From this information, we evaluate how services provided by contracted providers match our Member’s needs.

The Quality Improvement Committee evaluates a number of activities to assess Member needs including HEDIS and CAHPS performance, Member feedback from surveys focused on clinical programs and satisfaction with providers, Member appeals and grievances, and provider feedback. Opportunities for improvement are identified and quality improvement initiatives are developed to improve the quality of care and service for our Members.

5. PLANS FOR COORDINATION AND CONTINUITY OF CARE

A. Coordination and continuity of care to specialty providers

RMHP offers formal Case Management Programs in the following areas:

- **Oncology Case Management**: A specially trained nurse provides support and coordinates services that help Members understand treatment plans.
- **Special Needs Case Management**: Nurse Case Managers help Members manage the health care system by improving continuity of and promote communication.
- **Catastrophic Case Management**: Nurse Case Managers work with providers and Members during a catastrophic health event to develop comprehensive and coordinated approach to the Members care.
- **High-Risk OB Case Management**: Qualified RNs assist Members with coordination of care to make sure the Member receives support, education and resources to minimize risk during pregnancy and the postpartum period.
- **Transplant Case Management**: Program focused on educating and helping Members become active and responsible in managing their own health care.

B. Ancillary services

RMHP supports and encourages primary care physicians to coordinate the Members care. Requests for assistance are directed to RMHPs Case Management staff, who consider services that may be provided by ancillary providers, including social services or other community resources.

For new Members who are currently involved in active treatment, RMHP may consider approving the continued use of non-participating providers. RMHPs Care Management Department maintains a process for facilitating coordination of care for new Members. Services from non-participating providers must be evaluated and approved before treatment is continued and services are received by the Member. RMHPs Care Management staff will contact the non-participating provider and obtain a treatment plan and agreement from the nonparticipating provider not to balance bill the Member.

C. Discharge planning

Discharge Planning is initiated by the attending physician, hospital staff, and/or Care Manager Coordination staff upon the patient’s admission. This process is performed through the identification of patient / family needs, distribution of community resource information, and recommendation to the attending physician of specific resources available to meet the patient / family needs. A physician’s order is required for discharge.

D. Changing primary care providers

Members should follow these guidelines when selecting or changing to a new primary care physician (PCP):

- Each covered family member may pick a different PCP
• If a Member is new to a PCP’s office, be sure to call the office to ensure they are accepting new RMHP Monument Health HMO patients
• If a Member is changing to a new PCP have medical records transferred to the new PCP’s office

When RMHP receives notification from a primary care physician, written communication is sent to the Member notifying them their primary care physician is terming with RMHP. Members are encouraged to find another primary care physician and to contact Customer Service with any questions, concerns or to provide assistance with finding a new primary care physician.

E. Contract termination continuity of care proposed plan

In the event of provider termination, RMHP provides continuity of care for Members who are in an active course of treatment according to 10-16-704(9) (j) C.R.S. RMHP shall provide written notice within (30) calendar days of the termination to Members who have been undergoing treatment or have been seen at least once in the last twelve months by the provider being removed.

Such notifications will describe continuity of care and will inform the Member of disenrollment procedures. If the contract termination involves a PCP, all Members who are patients of that PCP will be notified and will be instructed on how to choose a new PCP. Case Management will assist Members in selecting a new PCP upon request. Appropriately trained Case Management staff are available to assist the Member/family and or guardian with the transition to a new provider.

RMHPs Care Management Department maintains a process for facilitating continuity and coordination of care in the following circumstances: a practitioner’s contract is discontinued, a Member joins the health plan, benefit coverage ends and additional services are required.

F. “Hold harmless” provisions

All RMHP provider contracts contain a provision that in no event, including but not limited to nonpayment by RMHP or RMHPs insolvency or any breach of the provider contract, shall a provider bill, charge or collect a deposit from or seek compensation, remuneration from or have any recourse against any covered Member for covered services.

If RMHP becomes insolvent or unable to continue operations for any reason, all Members will be given written within fifteen days of such an event. RMHP participating providers will continue to provide benefits to covered persons through the date of termination of RMHPs contract with the State to provide services, and will continue care for Members confined in an inpatient facility until their discharge. RMHP providers cannot seek reimbursement from RMHP Members for covered services received during this period, except for any applicable copayments, coinsurance, or deductibles.
Commercial Tagline for Notices

English
There is important information about your coverage or application with Rocky Mountain Health Plans (RMHP) in this notice. Review it carefully. Look for address you may need to take and deadlines. You have the right to get information in your language at no cost. Call 800-346-4643 for assistance.

Spanish
Hay información importante sobre su cobertura o solicitud de Rocky Mountain Health Plans (RMHP) en este aviso. Revíslo cuidadosamente. Tome las acciones necesarias y considere las técnicas de negociación. Ud. tiene el derecho a obtener esta información en su idioma sin ningún cargo. Llame al 800-346-4643 para obtener asistencia.

Arabic
لقد تم إعداد هذا النص لنشره على مستوى اللغة العربية أو اللغة الإنجليزية، تuspend على النشاط الأساسي للموضوع. RMHP يقدم هذه المنطقة، تقدم RMHP خطوات تحسين السهولة في الإبلاغ عن القضايا المرتبطة، تแสนي عقلية النشاط المحتمل، يتم معالجة النشاط في RMHP في وقت متساوي مع RMHP.

German

French

Japanese
この通知に含まれるロッキー・マウンテン・ヘルス・プランズ(RMHP)の補償範囲と申請に関する重要な情報が含まれていますので、よくお読みください。行動のあらゆる手続き及び細部についてご参照ください。お客様には、関連情報をお手許しの個別オプションがあります。800-346-4643までご連絡いただきサポートを提供いたします。

Korean
이 안내문은 로키 마운틴 헬스 플랜즈(RMHP)의 보험 및 특정 요구사항에 대한 중요한 정보를 포함하고 있습니다. 신속한 검토를 구립니다. 절차와 확장 및 확장에 유의해 주세요. 고객님의 안정을 위해 필요한 정보를 무료로 받으실 수 있습니다. 서비스 관련 문의는 800-346-4643으로 신청하시기 바랍니다.

Nepali
यो सुचिको विवरण नै निर्देशण भएको हुन्छको र यो सुचिको विवरण RMHP भएको हुन्छको र सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुचिको विवरण सुচि
Notice of Nondiscrimination

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

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

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

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

If you believe that RMHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: the RMHP EEO Officer at 800-346-4643, 970-244-7760, ext. 7683, or TTY 970-248-5019, 800-704-6370, Relay 711; para asistencia en español llame al 800-346-4643, or eecoficer@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](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf), or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).


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