INTRODUCTION

At Rocky Mountain Hospital and Medical Service, Inc. d/b/a Anthem Blue Cross and Blue Shield (Anthem), we work hard to help ensure that you have access to a network of providers that will meet your health care needs. This network includes doctors and other health care providers who deliver quality care and who offer convenient office hours and locations. Providers in our network are available to you for a full range of covered health care services to help you stay healthy.

Providers play an important role in helping us achieve our mission: to improve the lives of the people we serve and the health of our communities.

Our network access plan describes the process Anthem uses to develop and maintain adequate provider access, which is one of our primary responsibilities to you our member.

Customer Service

Our Customer Service representatives are available to assist you. To help them better serve you, these representatives receive specialized training in areas such as service skills, problem-solving, our benefit plans and our provider networks. Our representatives are available Monday through Friday, at the phone number listed on the back of your health plan ID card. Anthem’s website is Anthem.com.

Anthem PPO or PPO Network (Network IDs CON002 and CON004)

Anthem’s PPO network is one of the largest PPO networks in Colorado, with over 9,500 providers statewide, including more than 80 hospitals. Our network includes practitioners who provide primary care (internists, family and general practice physicians, pediatricians, along with nurse practitioners); specialists such as allergists, cardiologists, surgeons, PT/OT/ST, rehabilitation services, behavioral health, substance abuse, and autism and home health providers; facilities such as acute care hospitals and ambulatory care centers; and providers of other medical services such as rehabilitation. Emergency services are available 24 hours a day, seven days a week.

There are some PPO plans where you will be required to select a PCP for the Anthem PPO product. This change is in support of the Patient Centered Medical Home (PCMH) concept. Anthem was a participant in the multi-payer PCMH pilot for four years and the outcomes of that pilot have shown that the PCMH concepts result in both improved quality and lower costs for our members.

NETWORK ADEQUACY STANDARDS AND CORRECTIVE ACTION PROCESSES

The Anthem PPO network includes the following counts (this includes multiple practice locations): PCPs 3,750 (Family Medicine, Internal Medicine, General Practice, Pediatricians and Nurse Practitioners); Specialists 14,993 (all others not called out i.e., as cardiologists, Chiropractors, PT/OT/ST, etc.); Pediatric specialties 2,008; OB/Gyns 1,323; Behavioral Health Providers 4,926; Hospitals (including acute care, rehab, and LTACs) 113; Emergency 92 (Hospitals and Free standing ERs); Behavioral Health facilities 42; Pharmacy 844

For the following services, and in the counties indicated, we may be without a contracted provider:

- Emergency: Bent, Clear Creek, Costilla, Crowley, Custer, Dolores, Elbert, Gilpin, Hinsdale, Jackson, Mineral, Ouray, Park, Saguache, San Juan, San Miguel, and Washington
- Behavioral Health Facilities: Archuleta, Baca, Bent, Broomfield, Chaffee, Cheyenne, Clear Creek, Conejos, Costilla, Crowley, Custer, Delta, Dolores, Eagle, Elbert, Fremont, Garfield, Gilpin, Grant,

- **Hospitals:** Bent, Clear Creek, Costilla, Crowley, Custer, Dolores, Elbert, Gilpin, Hinsdale, Jackson, Mineral, Ouray, Park, Sagüache, San Juan, San Miguel, and Washington

- **Pediatricians:** Baca, Bent, Chaffee, Cheyenne, Clear Creek, Conejos, Costilla, Crowley, Custer, Dolores, Elbert, Gilpin, Hinsdale, Jackson, Kiowa, Kit Carson, Lake, Mineral, Ouray, Park, Phillips, Rio Blanco, Rio Grande, Sagüache, San Juan, San Miguel, and Washington

- **OB/GYNs:** Archuleta, Baca, Bent, Cheyenne, Clear Creek, Conejos, Costilla, Crowley, Custer, Dolores, Elbert, Gilpin, Hinsdale, Jackson, Kiowa, Kit Carson, Lake, Mineral, Otero, Ouray, Park, Rio Grande, Sagüache, San Juan, San Miguel, and Washington

- **Behavioral Health Providers:** Baca, Bent, Conejos, Crowley, Custer, Gilpin, Kiowa, Jackson, Mineral, and San Juan. Currently there are 10 counties without a Behavioral Health provider located in these counties.
  - The following Mental Health centers do provide services in these counties: Southeast Mental Health Center (Baca, Bent, Crowley, and Kiowa); Centennial Mental Health Center (Cheyenne, Elbert, Kit Carson, Phillips, and Sedgwick); San Luis Valley Mental Health Center (Conejos); West Central Mental Health Center (Custer); Jefferson Center for Mental Health (Gilpin); Mind Springs Health (Jackson); Axis Health (Mineral and San Juan). Anthem’s Behavioral Health Network is open to providers that can meet credentialing standards and are willing to contract with us.

- **PCPs:** Gilpin, Jackson, Mineral, and San Juan

- **Pharmacy:** Costilla, Dolores, Hinsdale, Jackson, Mineral, Park, Sagüache, and San Juan

It is important to note that even if we do not have a contracted provider within a given county, we may have a contracted provider in an adjacent county within a reasonable travel distance and may have services available via telehealth. Please see the information below regarding Telehealth services and access mileage standards for more information. Additionally, any lack of a contracted provider in these areas can be due to one or more of several factors. In some areas of Colorado, and in some areas of specialized care, there simply are no providers or facilities (in our network or out). In other instances, the sole or few providers in that area may have refused our good faith efforts to contract or may have adopted a policy of not contracting with any health insurer. As we cannot force a provider to relocate to an area, or force a provider to enter into a contract with us or anyone else, some of these access issues cannot be corrected. In those instances, we arrange for the member to receive covered services from an out-of-network provider at the in-network level of benefits. Please see page 8, Provider Directories for how to find in-network options. Your PCP and/or your health plan can assist you in finding an in-network provider who can provide your requested services.

In those areas where we have a network need and there are providers able to deliver Covered Services, we work in good faith to try to contract with all providers that are willing to contract with us and pass credentialing.

Anthem’s quality management program uses standards, or minimum requirements, to help ensure that you have adequate access to physicians, hospitals and other health care providers.

Anthem considers many factors in order to identify, evaluate and remedy problems concerning access to care and the continuity and quality of care, including:

- The distance you must travel to see a provider receive hospital services.
- The percentage of PCPs accepting new members, i.e., those who have “open” practices.
- The number of PCPs compared to the number of members.
- The waiting time between your call for an appointment and the appointment time and date.
- The on-call or after-hours availability of providers.
- The volume of technological and specialty services available to serve your needs when you require covered technologically advanced or specialty care.
- Linguistic and cultural capability of the provider.
We monitor and help ensure compliance with these standards by reviewing reports that assess the size and
distribution of the network, evaluating member satisfaction surveys, and developing provider surveys that focus
on monitoring compliance with the standards.

We monitor compliance annually. We then design action plans to address opportunities for improvement that are
identified during the process. This may include working with providers in the Anthem network or contracting with
out-of-network providers.

- Action plans have been developed to address the following two standards that we have identified
  as currently falling below the time frame goals:
  - After-hours availability with PCPs. We monitor this standard annually in the fall with an
    after-hour survey. We have included a reminder in our provider Network Update that
    PCPs need to be available or have an on-call provider for urgent care needs after hours.
    We are also contacting the provider offices that were not compliant with a letter. We plan
    on conducting follow-up after-hours surveys with these providers to monitor improvement.
  - Initial routine appointments, 7 calendar days with Behavioral Health providers. We
    monitor this standard annually in the fall with an appointment access survey. We have
    included the appointment standards in Network Update, Provider Manual and included on
    the application to be a contracted provider. For those behavioral health providers not
    meeting this standard, we will send them a letter which will include appointment access
    standards. Providers will be surveyed in the fall for improved compliance.

We also include essential community providers (ECPs) which are providers that serve predominantly low-income,
medically underserved individuals. The following specialties are sometimes referred as ECPs: Rural Health
Clinics, Ryan White providers, family planning providers, Federal Qualified Health Centers.

**Telehealth Services:**
Consistent with Colorado law, Anthem recognizes covered services provided through the use of telehealth. In-
network providers are free, but not required, to provide appropriate covered services via telehealth. We
encourage you to talk to your providers about telehealth options. As most telehealth services are accessible from
your own home, often telehealth services can provide you with access to covered services without the need to
travel.

In addition to telehealth, Anthem plans offer coverage for online visits. LiveHealth OnLine is available 24/7 for
members to access medical services and behavioral health services. Medical services that are available: Cold,
flu, allergies, fever, sinus infections, diarrhea, pinkeye and other eye infections, skin infection or rashes.

*The following are the standards we use to measure Access and Availability of our networks.*

Access is defined as the timeliness in which you are able to obtain available services.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Time Frame</th>
<th>Time Frame Goal</th>
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</thead>
<tbody>
<tr>
<td>Emergency Care – Medical, Behavioral, Substance Abuse</td>
<td>24 hours a day, 7 days a week.</td>
<td>Met 100% of the time</td>
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<tr>
<td>Urgent medical care - Medical, Behavioral, Substance Abuse</td>
<td>Within 24 hours</td>
<td>Met 100% of the time</td>
</tr>
<tr>
<td>Primary Care – Routine, Initial non-urgent symptoms</td>
<td>Within 7 calendar days</td>
<td>Met ≥ 90% of the time</td>
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<tr>
<td>Behavioral Health, Mental Health, and Substance Abuse Care – Routine, Initial non-urgent, non-emergency</td>
<td>Within 7 calendar days</td>
<td>Met ≥ 90% of the time</td>
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<tr>
<td>Prenatal Care</td>
<td>Within 7 calendar days</td>
<td>Met ≥ 90% of the time</td>
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</tbody>
</table>
Network Access Plan for Anthem, Inc. 2020

Availability is defined as the extent to which providers of the appropriate type and number are distributed geographically in our networks to meet the in-person care needs of our members.

### Network Access to Care Standards

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Availability Requirement</th>
<th>Met ≥ 90% of the time</th>
<th>Met ≥ 90% of the time</th>
<th>Met ≥ 90% of the time</th>
<th>Met ≥ 90% of the time</th>
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<tbody>
<tr>
<td>Primary Care Access to after-hours care</td>
<td>Office number answered 24/7 days a week by answering service or instruction on how to reach a physician</td>
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<td>Preventive visit/well visits</td>
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<td>Specialty Care – non-urgent</td>
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<tr>
<td>Behavioral, Mental, and Substance Abuse after-hour care</td>
<td>Office number answered 24/7 days a week by answering service or instruction on how to reach a practitioner</td>
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<tr>
<td>Behavioral, Mental and Substance Abuse routine follow-up appointment non urgent, non-emergency</td>
<td>Within 30 calendar days</td>
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<tr>
<td>Behavioral, Mental and Substance Abuse Routine Follow-up Appointment Non Urgent, Non-Emergency</td>
<td>Within 6 hours</td>
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<td>Behavioral, Mental and Substance Abuse Days to see a member after discharge from IP psychiatric hospital</td>
<td>Within 7 days</td>
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<td>Open Practices for new members (PCPs, Surveyed Specialists, Behavioral, Mental and Substance Abuse)</td>
<td>Met ≥ 65% of the time</td>
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### Network Availability Mileage Standards

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<th>Geographic Type</th>
<th>Micro Metro</th>
<th>Maximum Distance (miles)</th>
<th>Rural Metro</th>
<th>Maximum Distance (miles)</th>
<th>CEAC Metro</th>
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Network Availability Mileage Standards

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<th>Specialty</th>
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</tr>
<tr>
<td>Orthotics and Prosthetics</td>
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<td>120</td>
<td>120</td>
</tr>
<tr>
<td>Outpatient Infusion/Chemotherapy</td>
<td>10</td>
<td>30</td>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>OTHER FACILITIES</td>
<td>15</td>
<td>40</td>
<td>120</td>
<td>120</td>
</tr>
</tbody>
</table>

Member to Provider Ratios

<table>
<thead>
<tr>
<th>Provider/Facility Type</th>
<th>Large Metro</th>
<th>Metro</th>
<th>Micro</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
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<td>1:1000</td>
<td>1:1000</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>1:1000</td>
<td>1:1000</td>
<td>1:1000</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>1:1000</td>
<td>1:1000</td>
<td>1:1000</td>
</tr>
<tr>
<td>Mental health, behavioral health and substance abuse disorder Care Providers</td>
<td>1:1000</td>
<td>1:1000</td>
<td>1:1000</td>
</tr>
</tbody>
</table>

The follow table defines geographic type:

<table>
<thead>
<tr>
<th>Classification</th>
<th>Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large Metro</td>
<td>Denver</td>
</tr>
<tr>
<td>Micro</td>
<td>Eagle, Garfield, La Plata, Mesa, and Pueblo</td>
</tr>
<tr>
<td>Rural</td>
<td>Alamosa, Chaffee, Clear Creek, Delta, Elbert, Fremont, Gilpin, Lake, Logan, Montezuma, Montrose, Morgan, Otero, Pitkin, Rio Grande, Summit, and Teller</td>
</tr>
</tbody>
</table>

Network Development Strategy
In building and evaluating possible additions to its provider networks or tiers of providers within given networks, Anthem considers several criteria. We consider the service area of the products and plans utilizing the network and the nature of services covered under the products/plans. We also consider the ability of existing network providers to adequately deliver covered services, considering the relative demand and utilization of covered services.
services and the number and types of providers that can provide the covered service, either in person or via telehealth, and the relative cost we, our groups and individual consumers would bear with either including or excluding a provider.

When Anthem develops a network, the following factors, among others, are considered:

- Which and how many providers work in the area
- Which providers meet Anthem’s quality and credentialing standards
- Which providers want to contract with Anthem
- How many members do we anticipate enrolling in the network
- What are the PCP referral patterns in the area, i.e., who do PCPs normally send their patients to for specialty care

With respect to developing our plans’ pharmacy networks or the tiers of providers within given networks, our pharmacy vendor may consider the above factors as well as assess our (and our groups’ and members’) need for both savings and access. The networks are designed to provide groups and members with a wide range of flexibility in pharmacy access, choice, and price. In addition, participating network pharmacies must meet rigorous credentialing and re-credentialing requirements and agree to standard contract and pricing terms. These credentialing and recredentialing policies for participating network pharmacies help ensure member safety, meet government agency requirements and help provide optimal member care services. All prospective network pharmacies are required to complete all forms and provide all required documentation during the credentialing and recredentialing process. Additionally, if and where we or our pharmacy vendor believes that there is a network inadequacy - either due to geographic constraints or lack of ability to offer a covered service - we will undertake good faith efforts to expand existing network or mail order capabilities or, as needed, contract with pharmacy providers to improve the networks’ strength and access.

**Quality Assurance Standards**

Anthem has a quality management program designed to evaluate the quality, appropriateness and outcomes of care and services. We also monitor how care and services are delivered to you. During this process, we place emphasis on identifying opportunities for improvement and problem-solving.

The program is directed by the West Region Quality Improvement Committee. We use standards developed by national organizations for developing, maintaining and reporting quality management program activities.

**When a covered service is not available from an in-network provider**

Most health care specialty services are available from providers in your Plan’s network. However, if our network does not have a provider to deliver a covered benefit, you should contact customer service to inform us of the need before the services are provided. We will work with you to find an in-network provider within a reasonable geographic distance or as appropriate arrange for you to see an in-network telehealth provider.

In such cases, if we cannot find an in-network provider, we will arrange for you to receive care from an out-of-network provider, at no additional cost to you.

In cases of emergency services at a non-contracted Colorado facility, we will process the claim at the in-network cost shares and in a manner that protects the member from balance billing of covered services.

If you do not request a network exception before the services are provided the services may be covered at the out-of-network level or denied.

**Hospital Based Providers**

Anthem continues to monitor, with the help of our participating hospital systems, member’s access to participating physician specialist services for emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services. We work diligently to ensure we know who is practicing at what facility and assessing the network adequacy of downstream, hospital-based, physicians by reviewing claims data and offer contracts to those out-of-network providers. To the extent required by applicable law, Anthem also ensures that
covered services performed by an out-of-network provider in an in-network facility, are covered at the in-network cost-share and in a manner that protects the member from balance billing of covered services.

PROCEDURES FOR REFERRALS

Provider Directories
Anthem’s provider directory lists PCPs (internists, family and general practice physicians, and pediatricians); specialty physicians (e.g., surgeons, allergists, dermatologists, cardiologists and psychiatrists); facilities (acute care hospitals, ambulatory care centers and skilled nursing facilities); and other medical specialty providers (e.g., physical therapists, home health agencies, substance abuse facilities, rehabilitation services and IV therapy laboratories).

The provider directory is available on anthem.com, Find a Doctor or by calling our Customer Service department at the phone number listed on the back of your health plan ID card. An online provider directory is available in Spanish and is located at Anthem en Espanola accessible from the home page of anthem.com. In addition to a list of providers, the directory includes information about how to use the network. Anthem’s on-line directory is updated weekly.

Referrals / Preauthorization
Your PCP is your first point of contact when care is needed. When you need specialist care, the PCP can recommend an appropriate specialty provider. With few exceptions, in our networks, no referrals are needed to access in-network specialists, including obstetricians, gynecologists or advance practice nurses, certified midwives or eye care providers.

Where a referral is required, it can be obtained for care from any provider in the network qualified to provide the covered services; however, your health benefit plan may charge a different cost-sharing requirement depending on the type of provider or place of service you request.

As with most plans, you are not required to obtain a referral from your PCP to see a physician specialist. If at any time a referral is required for medically necessary treatment to at an in-network provider a standing referral will be accepted. If your referral is approved by us it cannot be retrospectively denied after the service is performed, except for fraud or abuse. If your service requires precertification or prior authorization, and we issue such precertification or prior authorization, it cannot be retrospectively denied after the service is performed except where permitted by law. Expedited referrals are granted based on your medical condition.

However, preauthorization is required for certain services and procedures. In Colorado, in-network providers are responsible for obtaining preauthorization when it is required.

For PPO products (not EPO or HMO products), you are generally able to see in- or out-of-network providers for covered services. Under certain non-emergency circumstances, you may be able to see an out-of-network provider at the in-network cost sharing levels; such as when our network has insufficient provider specialty in your geographic region. In those instances where you seek services from an out-of-network provider to be paid using in-network cost sharing requirements, preauthorization is required. You are responsible for confirming that preauthorization is obtained when seeing an out-of-network provider or your service may be denied and you will be responsible for the full cost.

DISCLOSURES AND NOTICES

Communicating with Members
This network access plan is one way we inform you about Anthem’s provider network. We also communicate information about our provider network and the health plan’s services and features through the following: certificates of coverage, member handbook, newsletters, and the website.
Certificate
Upon enrolling in Anthem health care benefits plan, you have access to your certificate via Anthem’s website or in some cases they are available through your employer. This certificate describes the benefits available to you and how to use those benefits, along with your rights and responsibilities. It also describes Anthem’s grievance procedures, the availability of specialty medical services and Anthem’s process for preauthorizing medical care. As you enroll or renew each year, and receive your health plan ID card(s), you will receive information about how to access your certificate.

Additional copies of the certificate are available by calling our Customer Service at the phone number listed on the back of your health plan ID card.

Newsletters and Flyers
A newsletters or flyers are mailed to you at your home address at no additional cost. In addition to information designed to help you maintain and improve your health, the newsletter or flyer may include articles on benefits and provider networks.

Members Concerns (Clinical Grievance, Complaints and Appeals)
If you have a concern about access, continuity and quality of care or services received from a provider in our network you may call customer service at the phone number listed on the back or your health plan ID card.

Clinical Grievance
A clinical grievance occurs if you have an issue or concern about the quality or services you receive from a provider or facility in Anthem’s network. The quality management department strives to resolve clinical grievances fairly and quickly. We will work to clear up any confusion, settle your concerns and make sure appropriate action is taken.

To Initiate A Clinical Grievance:
A member may send a written clinical grievance to the following address:

Anthem, Inc.
Appeals Department
700 Broadway
Mail Stop CO0107-0730
Denver, CO  80273

Anthem’s quality management department will acknowledge receipt of and investigate the member’s clinical grievance. The quality management department treats each clinical grievance investigation in a strictly confidential manner.

Complaints and appeals
Anthem may have turned down your claim. We may have also denied your request to preauthorize or receive a service or a supply. If you disagree with Anthem’s decision you can:

1) Start a complaint
2) File an appeal or
3) File a grievance.

Complaints
If you want to start a complaint about Anthem’s customer service or how we processed your claim, please call customer service. A trained staff member will try to clear up any confusion about the matter. They will also try to resolve your complaint. If you prefer, you can send a written complaint to this address:

Anthem, Inc
Customer Services Department
P.O. Box 17549
If your complaint isn’t solved either by writing or calling, or if you don’t want to file a complaint, you can file an appeal. To file an appeal, write to Anthem, Attention: Grievances and Appeals Department, 700 Broadway, Denver, CO 80273. In your letter, please state plainly the reason(s) you believe payment of the claim should not have been denied. Include any documents and any other information you believe may have a bearing on our decision.

We encourage you to file your appeal within 60 calendar days from the date you receive the decision from Anthem that limits or denies coverage. We must receive appeals within 180 calendar days after your receipt of an adverse benefit determination. We determine first-level appeals (referred to as Level 1 appeals) of claim payment denials within a reasonable period of time appropriate to your medical circumstances but no later than 30 days after receipt for appeals involving utilization review. Non-utilization review appeals will be resolved within 60 days of receipt. Review the terms of your certificate, as it may give you the right to participate or appear during a Level 1 appeal. You will receive written notification of our decision. You can request an expedited Level 1 appeal if the time frame for a standard Level 1 appeal would (a) seriously jeopardize your life or health, (b) jeopardize your ability to regain maximum function, (c) create an imminent and substantial limitation of your ability to live independently, if you are disabled, or (d) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the health care service in dispute. You or your representative can ask for an expedited appeal if you had emergency services but haven’t been discharged from the facility. Expedited Level 1 appeals will be resolved as quickly as the condition requires but in no event later than 72 hours after the request has been made and if it meets expedited criteria. If you are not satisfied with our response to a Level 1 appeal, your plan may provide you with the option (but not the obligation) to file a voluntary second-level (Level 2) appeal. Please refer to your certificate for more information. If available under your plan, a Level 2 appeal must be requested in writing within 60 calendar days after you receive our Level 1 appeal decision.

For appeals involving utilization review, you may also have the right to request independent external review, where the claim decision is reviewed by an external review entity selected by the Colorado Division of Insurance. You or your representative will have the chance to submit new or additional information to the external review entity. Requests for independent external review must be made in writing within 4 months of the date of receipt of this notice or within 4 months of the date of receipt of our final internal appeal decision concerning this claim, whichever is later. If you ask for independent external review of a treatment or service we determined to be experimental or investigational, or ask for expedited independent external review, your provider may be asked to provide or certify additional information. If you request independent external review you will be required to authorize the release of medical records and health information necessary to complete the review.

Independent external review is normally available only after completing a Level 1 appeal. But if we fail to handle the appeal according to applicable Colorado insurance law and regulations regulating appeals, you will be eligible to request independent external review. You can also ask for expedited independent external review at the same time you request an expedited Level 1 appeal. Once the case is assigned to the external review entity, a decision will be provided within 72 hours for expedited review (45 calendar days for standard independent external review).

You have the right to designate a representative (e.g. your physician or any one of your choosing, including an attorney) to file any level of appeal with us on your behalf. This designation must be given to us in writing. For claim amounts not covered because the charges are for services we determine are not medically necessary or are experimental/investigational, or because the charges exceed our allowed amount, a copy of the guidelines, criteria and/or explanation of the clinical reasons for the denial are available free of charge by calling customer service at the phone number on the back of your health plan ID card. For claim amounts not covered because of a contract or plan exclusion, you have the right to appeal the applicability of the exclusion by providing evidence from a medical professional that there is a reasonable medical basis that the exclusion does not apply. Please refer to your certificate for detailed information about the entire appeals process.

Members covered under health benefit plans sponsored by their employers and subject to the Employee Retirement Income Act of 1974 (ERISA) must file a Level 1 appeal concerning an adverse benefit determination.
before exercising their right to bring a civil action under section 502(a) of ERISA. All other available appeal levels will be considered voluntary.

Grievances
You may send a written grievance to:

Anthem, Inc.
Appeals Department
700 Broadway
Mail Stop CO0107-0730
Denver, CO  80273

Anthem’s Member Grievances Department will acknowledge that we’ve received your grievance. They’ll also investigate it. We treat every grievance confidentially.

Division of Insurance inquiries
If you have a question about health care coverage in Colorado, please call the Division of Insurance at (303) 894-7490. Representatives will speak with you Monday through Friday, from 8:00 a.m. to 5:00 p.m. You can also write to:

The Division of Insurance
Attention ICARE Section
1560 Broadway, Suite 850
Denver, Colorado 80202.

Specialty Services:
Anthem’s comprehensive specialty network includes physician specialists (surgeons, allergists, dermatologists, cardiologists, etc.); other specialists (mental and behavioral health providers, physical therapists, occupational therapists, speech therapists, home health agencies, etc.); facilities (acute care hospitals, ambulatory care centers, hospices, etc.); and providers of other specialty care, including rehabilitation services.

Specialist recommendations within a medical management group
When a member’s PCP is part of a medical management group and you ask your PCP for a specialist recommendation, the PCP will typically refer you to a specialist within the same highly aligned network or medical management group. If preauthorization is required but not obtained for care received from an out-of-network provider, you will be financially responsible for those services.

Specialist recommendations through independent PCPs
If your PCP is not affiliated with a highly aligned network or medical management group, your PCP will make recommendations to any specialty provider within the network. Whether you seek specialty care on your own or receive a recommendation from your PCP, it is important to stay within the network to receive coverage.

Hospital services
You can access hospital services at a network hospital. Whether you seek hospital care on your own or receive a recommendation from your PCP or specialist, it is important to stay within the network to receive coverage through your benefit plan. To obtain additional information, you may go to anthem.com, or call Customer Service, at the phone number listed on the back of your health plan ID card. However, some services such as Inpatient hospital services require preauthorization. In Colorado, your network provider is responsible for obtaining pre-authorization.

Behavioral health and substance abuse services
A referral from your PCP is not required. A comprehensive directory that lists providers and facilities in the network is available at anthem.com or by calling our customer service department at the phone number listed on the back of your health plan ID card. However, some services such as Inpatient behavioral health and chemical
dependency services require preauthorization. In Colorado, your network provider is responsible for obtaining pre-
authorization.

**Pharmacy Services:**
Depending on the benefits of your plan, you can receive pharmacy services from an inpatient provider, outpatient
provider, retail pharmacy, specialty pharmacy or mail-order pharmacy. If your plan requires that you obtain your
prescription drug from a specialty pharmacy, mail order pharmacy or designated pharmacy provider, the drug will
be shipped to your home or provider by our network provider.

**Vision Services:**
To receive an annual routine eye exam and/or obtain any prescription eyewear covered under your health plan,
you will need to visit an eye care provider in the Blue View Vision network. To locate a Blue View Vision provider,
go to anthem.com and select Find a Doctor. Choose Vision when selecting the type of care, and choose Blue View
Vision when selecting a plan/network. Routine vision coverage is for routine eye care only. If you need medical
treatment for your eyes, you will need to visit a participating eye care doctor from your medical network.

**Dental Services:**
To receive your dental services which are covered under your health plan, you will need to visit a dental provider
in the Dental Prime network. To locate a Dental Prime provider, go to anthem.com and select Find a Doctor.
Choose Dental when selecting the type of care, and choose Dental Prime when selecting a plan/network. Please
refer to your health plan certificate for your covered dental services. Please go to this link to where the Dental
Access Plans are located [www.anthem.com/co/networkaccess](http://www.anthem.com/co/networkaccess).

**Transplant Centers of Excellence**
Depending on the benefits of your plan, you may be able to receive in-network transplant services from our
Centers of Excellence. In that event, and in the event the in-network transplant provider is not within a reasonable
travel distance from you, we will provide or reimburse for transportation as explained in your benefit booklet.

**Out-of-network providers**
Providers who are not in our provider network are out-of-network providers. If you see an out-of-network provider
for non-emergency services the services may be covered at the out-of-network benefit level (if any) or the
services may be denied, depending on the terms of your Plan. When you see an out-of-network provider, you
generally will be responsible for the entire amount of the provider’s charges. Out-of-network providers may bill you
directly for these charges and may require payment in full.

**Selecting and Changing PCPs**
When selecting a PCP from our networks, you have several options. You may choose a physician you know, one
located close to your home or office, or one that is in the same highly aligned network or medical management
group as your specialist provider. For children, you can choose an in-network pediatrician. We encourage you to
get to know your PCP to establish a common understanding of your health care needs and goals. If your plan
requires you to select a PCP and you fail to do so, we may assign a PCP to you. To change your PCP, call
Customer Service at the phone number listed on the back of your health plan ID card or go on-line through the
member secured access at [anthem.com](http://anthem.com).

Your PCP is available to provide advice to you about your health care concerns. **However, in a life- or
limb-threatening situation that requires immediate medical care to prevent death or serious impairment of
health, YOU SHOULD CALL 911 OR IMMEDIATELY GO TO THE NEAREST EMERGENCY FACILITY.** You
should then contact your PCP as soon as possible. The PCP will then be aware of your condition and can
coordinate follow-up care.

**Programs to Improve Member Health Care Needs and Health Outcomes**
The quality management program uses a structured process to evaluate and improve the program, including:

1. Enhanced Personal Healthcare payment innovation program
2. Participation in the NCQA Accreditation process
3. Participation in the URAC Accreditation process
4. Care Management and Disease Management - identification and management of High Risk and Chronic Conditions

We have procedures and tools to address the needs, including access and accessibility of services, of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical or mental disabilities; and to identify the potential needs of special populations. In addition, we analyze the specific health care needs of our members. By reviewing claims data, surveys and member demographic data (chronic diseases, cultural backgrounds, etc.), we identify certain populations, such as members who have diabetes, heart disease, or lung disease, and provide programs and self-management support to improve the health of those members.

In addition to the above, we have other methods for assessing the health care needs of covered persons, for tracking and assessing clinical outcomes from network services, for assessing needs on an on-going basis, for assessing the needs of diverse populations, and for evaluating consumer satisfaction with services provided. For example, within the Enhanced Personal Health Care for patient-centered primary care, the participating physicians are supported and encouraged to perform care coordination activities for their at risk patients. Proper care coordination should allow for seamless transitions across the health care continuum in an effort to improve outcomes and reduce errors.

Care coordination is a patient and family-centered, assessment-driven, team-based activity designed to meet the needs of patients and their families or care givers. Care coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs in order to achieve optimal health and wellness outcomes.

We also review specific populations to help ensure that our network includes an adequate number of providers, including specialists, to serve those populations.

Anthem places a priority on preventing illness and delivering the appropriate care in the appropriate setting. For example, women who do not receive their annual cervical cancer screening are identified by claims records and are reminded of the importance of the screening via phone or mail.

Members with physical and mental disabilities (needs)
The provider directory indicates provider locations that are accessible if you have a disability. Arrangements will be made for you if you require other assistance, such as special communication tools. Anthem customer service representatives are available to assist you if you have special needs.

Non-English speaking members
Providers who speak languages in addition to English are identified in Anthem’s provider directory. If you do not speak English, or have limited English skills, you can call our customer service department and we will communicate with you through a language line vendor. The customer service representative connects you with a translator from the vendor via teleconference to complete the service call. This allows us to accommodate 140 different languages.

Some materials are available in Spanish and are furnished on request. We continually strive to identify the unique needs of our members and address those needs through our provider networks and through company initiatives.

We also have a website for Spanish speaking members at the following link: https://es.anthem.com/cp/web/abcbs/inicio.

Membership Surveys
Anthem conducts several member surveys. These surveys help us understand how you feel about various aspects of your health care benefits plan, such as the waiting time for appointments, your satisfaction with the care received and the number of providers in our network.

The surveys are used to identify opportunities for improvement. We then build action plans around these opportunities.
Health Assessment
Depending on your coverage, you can do a Health Assessment which is a helpful resource to understand your health risks and help provide you with actionable steps you can take on improving your health. The Health Assessment is an on-line tool you can access on Anthem.com in the Health and Wellness section by logging on to your secured account.

COORDINATION AND CONTINUITY OF CARE

Transition of care
When benefits end while you still need care, we assist with the transition by offering to educate you about alternatives for continuing care and, as appropriate, how to obtain continuing care. Our nurse case manager completes this process.

Coordination and Continuity of care
We ensure that the coordination and continuity of your care continues with your referral to specialty providers, when using ancillary services, including social services and other community resources and to ensure you have appropriate discharge planning.

If your provider leaves the Plan network or when you join Anthem, you may have to change providers. We provide coverage for continuing care under a non-network provider under certain circumstances and for a limited amount of time. Continuing care may be allowed when:

- A participating like specialist is not available in the specified access area
- Medical treatment was in process prior to the effective date with the health plan and services are covered by the benefit contract and are medically necessary; for example:
  - A pregnant member who is in the second or third trimester of pregnancy, through the postpartum timeframe.
  - Elective surgeries approved by the prior carrier’s preauthorization process, if the surgery was previously scheduled and if we determine that it is a covered benefit and in accordance with the Anthem Medical Policies, Clinical Guidelines and pharmacy benefit guidelines.
  - The member was advised by us that the provider was in the network and the member has undertaken substantial steps in the furtherance of that treatment, such that transitioning the member to an in-network provider is not medically appropriate at that point in time.
- Ongoing treatment for an acute episode or certain chronic conditions for a specific period of time
- Life threatening conditions and terminal illnesses for a specific period of time
- Member has a physical or mental condition that is verified by a physician and which determines that the member's condition substantially limits their ability to travel and would threaten their safety and welfare. In these situations, once medically stable and deemed safe to transition, Anthem, the primary care physician, the specialist and along with you work together. We try to complete treatment with the existing providers or transfer care to providers in Anthem’s network.
- Anthem also cooperates with other health plans when a member or provider leaves Anthem or should Anthem ever cease operations or become insolvent. If a provider leaves Anthem's network or if we discontinue your plan or otherwise cease operations, we will contact you as required by law. In that letter, we will explain your options for selecting another provider or another health plan as appropriate. When you change from Anthem to another health plan, we may be able to provide the successor health plan with relevant care management information. However, when an Anthem individual member terminates their eligibility, the Anthem benefits end, unless the law requires otherwise.

Discharge Planning:
Discharge planning begins at the time of admission notification (day 1) or with identification of post-discharge needs during precertification or continued stay review.
It is the responsibility of the Anthem Care Coordination Nurse to:

- Facilitate coordination of ongoing care (lower level of inpatient care or in the home, supporting continuity between levels of care and efficient use of resources
- Provide a proactive approach based on the member’s specific needs
- Evaluate discharge planning needs to assess needs and coordination of care planning
- Coordinate discharge plan and referrals with the facility nurse/discharge planner
- Confirm benefits
- If required contact receiving facility if member is being transferred

Notice of Provider Changes/Terminations

When a PCP’s contract terminates, we send a letter to you letting you know that your PCP is no longer contracted in our network and ask that you select a new PCP. After you select a new PCP, we will issue you a new health plan ID card with updated information.

When a specialist’s contract terminates, we will send a letter to you letting you know that the specialist that you have had care in the past 12 months is no longer in our network, we work with the specialist to identify Anthem members in the specialist’s care. We then help those members transition to another provider in a timely manner.

When the provider initiates the termination, the provider agrees to continue ongoing treatment of Anthem members until active treatment is completed within a reasonable timeframe or until continued care can be arranged.

Note: In the unlikely event that Anthem ceases to operate, you are protected from responsibility for unpaid network provider claims. Our provider contracts contain a “hold harmless” clause, which prevents the provider from attempting to collect from you any amount which Anthem owes and has failed to pay. Should Anthem cease operations, we will cooperate fully with state regulators to communicate with members as needed to explain continuity of care options and to ease the transition to a new health insurance carrier, including notifying you of ceased operations and options for transferring to other carriers or providers in a timely manner.

The Anthem network access plan is designed to assist our members in understanding their benefits and how to access the providers and hospitals available to them through Anthem’s health care benefits plans. If you have any questions about your plan or the information in this document, please call Customer Service at the phone number listed on the back of your health plan ID card.