Member Benefits Booklet

Child Health Plan *Plus*

offered by Colorado Access

WHAT IS COLORADO ACCESS?

Colorado Access is a Colorado-based, nonprofit health plan. While you are enrolled in our plan, we:

- Process the claims for your provider after you get care
- Give you referrals to doctors you may need to see
- Authorize care you need
- Offer care management
- Review the services you have had (utilization review)

We have a friendly staff to help you when you have questions. You can call us at 303-751-9021, or 888-214-1101 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

Welcome!

Welcome to Child Health Plan *Plus* (CHP+) offered by Colorado Access! Enrollment in this plan is voluntary.

CHP+ offered by Colorado Access (also referred to as CHP+ HMO) is a health plan brought to you by Colorado Access. We are a nonprofit health plan in Colorado. We have been serving enrolled members in CHP+ since 1998. Our founding partners include The Children's Hospital, Colorado Community Managed Care Network, and University of Colorado Hospital/University Physicians, Inc. As a member, you can ask for information about the structure and operation of Colorado Access. You can call us at the numbers listed below. You can also go to our website at coaccess.com/about-colorado-access.

This Booklet is a guide to your CHP+ HMO benefits. Please read it carefully. Become familiar with your benefits. This includes limitations and exclusions. Please keep this Booklet in a safe place so you can find it when you need it. The more you know about your benefits, the better they work for you. You can go to our website at coaccess.com/child-health-plan-plus for more information. You can also find tips and tools on how to manage your health care. You can also request a provider directory and CHP+ HMO Member Booklet by telephone or in writing. You will get it within 10 business days.

If you get other insurance, Health First Colorado (Colorado's Medicaid Program), or move out of Colorado, you can no longer get CHP+ or CHP+ HMO.

If you have questions about your benefits, call us. We are available between the hours of 8:00 am and 5:00 pm, Monday through Friday. Our number is 303-751-9021, or 888-214-1101 (toll free). TTY users should call 720-744-5126, or 888-803-4494 (toll free). These numbers are also printed at the bottom of every page of this Booklet. You can also visit our website at coaccess.com/child-health-plan-plus.

DO YOU NEED SPECIAL HEALTH WITH THIS BOOKLET?

If you need this Booklet in large print, in Braille, on tape, or in another language, call us. If you want someone to explain something from this Booklet, call us. We will talk with you on the phone. We can also visit you in person. We are here to help. Just call us at 303-751-9021, or 888-214-1101 (toll free). TTY users should call 720-744-5126, or 888-803-4494 (toll free).

TENEMOS ESTE LIBRO DISPONIBLE EN ESPAÑOL

Si necesita información en español, llámenos al 303-751-9021. Tenemos este libro en español.

Thank you for choosing CHP+ HMO for your health care coverage. We wish you good health.

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Attention Members

What You Need to Know About CHP+ HMO

This Booklet describes your benefits and coverage. If there are large changes, we will let you know about them in writing 30 days before the change takes start. This includes changes about rights, benefits, copayments, and any other changes that you need to know as a member of this plan.

At Colorado Access, we know that each child is different. We work hard to meet every child's health care needs. We want the family or caretaker to be a part of their child's health care. That is why we make sure that the information we send you is in a format that you can understand.

You have the right to disenroll from the CHP+ HMO program at any time for any reason. You will need to contact Member Services at 800-359-1991 and let them know you want to disenroll. You can also contact the Department of Health Care Policy and Financing about your disenrollment. Their phone number is 303-866-3513 or 800-221-3943 (toll free).

You have the right to change your CHP+ HMO plan during the annual renewal period.

If you need this Booklet or any other CHP+ HMO document in another language, in large print, in Braille, or on audio tape free of charge, please call us. You can call us Monday through Friday, 8:00 am to 5:00 pm at 303-751-9021, or 888-214-1101 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

Si necesita información en español, llámenos al 303-751-9021 o 888-214-1101 (llamada gratuita).

1: Membership

This section tells you about administrative information that may be helpful while enrolled in CHP+ HMO.

ENROLLMENT PROCESS

In order to get CHP+ HMO coverage, you must:

- Follow the state of Colorado's CHP+ enrollment process and fill out the required forms (application). To learn more about this process, please visit chpplus.org.
- Live within our service area. A list of counties within our service area is online at coaccess.com/chp-service-area.

Once CHP+ determines that you are eligible, your coverage will begin on the date CHP+ receives your completed application.

ENROLLMENT FEE

Some families pay a yearly fee to be enrolled in CHP+ HMO. This enrollment fee is based on family size and income. You will get a bill from CHP+ HMO if you owe this fee before your re-enrollment date. The enrollment fees should be mailed to:

CHP+
PO Box 17548
Denver, CO 80217

RENEWAL PROCESS

You do not need to reapply for CHP+ each year. You will need to reapply if you lose your coverage under CHP+ or if you become eligible for another plan, like Health First Colorado. If you have questions about when to reapply for CHP+ coverage, please call our application assistance site at 303-755-4138 or 855-221-4138 (toll free). You may also contact us by email at appassist@coaccess.com.

ID CARDS AND NEW MEMBER INFORMATION

Your CHP+ HMO ID card shows that you are a member of CHP+ HMO. All members get a CHP+ HMO member ID card. Only the member listed can use the card to get services. Always bring your CHP+ HMO ID card when you need medical care. Have your ID card ready when you call for an appointment. You should show it to the receptionist when you sign in for your appointment. If you need a prescription, show the card to the pharmacy where it is filled. If you have not received your ID card or need a new ID card, please call us at 303-751-9021 or 888-214-1101 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

To help protect your information, follow these easy steps:

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

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

If you suspect fraud – tell us. Here's how:

You can send an email to compliance@coaccess.com or call the Colorado Access Medicaid compliance officer at 720-744-5462. To stay anonymous, you can call our compliance hotline at 877-363-3065 (toll free).

PRE-HMO PERIOD

The pre-HMO period is the length of time from your application date until you are enrolled with CHP+ HMO. During the Pre-HMO period, the CHP+ State Managed Care Network covers your services.

CHP+ HMO ENROLLMENT

Covered services before your effective date with CHP+ HMO are not covered by CHP+ HMO. These will be covered by the CHP+ State Managed Care Network.

NEWBORN ENROLLMENT

If you become pregnant, please call us at 303-751-9021, or 888-214-1101 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free). We can help you find a doctor if you need one. We also offer other services to you through our prenatal program.

PRENATAL CARE

You do not need a referral from your primary care provider (PCP) to see an in-network OB/GYN or certified nurse midwife for services related to your pregnancy. You may also see a family practice physician who provides prenatal care. Please work with your PCP to coordinate care with specialists.

It is very important that you call the state's medical assistance program at 888-367-6557 (toll free) after you have your baby. Your baby will have insurance under your CHP+ HMO coverage for the baby's first 30 days of life (or the end of the month your insurance expires) only. You will then need to apply for coverage for your newborn. We can help you with the application process. Call us at 855-

221-4138 (toll free). Most babies born to teen mothers are eligible for Health First Colorado. However, some newborns may qualify for CHP+.

CHANGING YOUR INFORMATION

If your membership information changes, like changes to your address, please call the state's medical assistance program at 800-359-1991. If you would like to change your primary care provider (PCP), call 888-367-6557 or our customer service team at 303-751-9021 or 888-214-1101 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

If your membership information changes in any way, call:

- Colorado Access at 303-751-9021 or 888-214-1101 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free)
- The state's medical assistance program at 800-359-1991
- Contact your county of residence. For individual county phone numbers, visit sites.google.com/a/state.co.us/humanservices/home/services-by-county

If you move, you have to call us within 31 days after you move. If you do not call, you may not get important notices from us, like when to renew your health care coverage. If you don't get the important notice, you still have to submit your renewal application. If you move to a place that is far from your primary care provider's (PCP's) office, you may choose a PCP who is closer to you.

OTHER HEALTH INSURANCE

If you have any other valid insurance coverage, including Health First Colorado and individual non-group and group coverage, you are not eligible for CHP+ or CHP+ HMO.

There are limited exceptions to this rule. CHP+ HMO members can have the following insurance plans and still keep their CHP+ HMO coverage:

- Medicare
- Dental
- Vision

Members with COBRA health insurance coverage can apply for the CHP+ HMO program. Once CHP+ HMO has been approved, the COBRA health insurance coverage must be canceled. Members can have the CHP+ HMO and COBRA coverage for a period of time. During that time, COBRA will be the primary insurance plan. Remember: CHP+ HMO members must get care from CHP+ HMO-participating providers in order for the care to be covered by CHP+ HMO.

If you get other coverage while you have CHP+ HMO, you must call the state's medical assistance program at 888-367-6557 and let them know you have new coverage. If you are found to have other insurance while you have CHP+ HMO, your CHP+ HMO coverage will end (be terminated). You will also be disenrolled from the CHP+ HMO program. In some cases, we will go back and end your CHP+ HMO coverage on the date that your other insurance became effective (started). This is call retroactive termination.

TERMINATION POLICY

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

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

WHEN YOUR CHP+ COVERAGE ENDS

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

CHP+ HMO benefits end on the date that your coverage ends. We will not pay for services when your coverage ends, even if CHP+ HMO preauthorized the service, unless the provider verified within two business days before each service was received.

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

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

You have the right to disenroll from the CHP+ HMO program at any time for any reason. You will need to call Member Services at 800-359-1991 to tell them of your intent to disenroll. You can also call the Department of Health Care Policy and Financing about your disenrollment. Their phone number is 303-866-3513 or 800-221-3943 (toll free).

You have the right to change your CHP+ HMO plan during annual renewal.

If you choose to disenroll or have been disenrolled from the plan and you are not happy about it, you can file a grievance. Please see the *Grievance and Appeals* section.

Summary of Covered Benefits

Service	Available Benefits	For More Information
Doctor/Physician Services		
Preventive Care	Covered in full when provided by your primary care provider (PCP). Includes immunizations (shots), checkups, and routine exams.	Page 30
Family Planning/Reproductive Health	Covered in full when provided by an in-network provider. Includes well-woman checkups.	Page 31
Maternity and Newborn Care	All prenatal and delivery visits covered in full.	Page 32
Provider Office Services	Primary care provider (PCP) visits and specialty visits covered. Standard CHP+ copays apply.	Page 34
Facility Services		
Inpatient Hospital Services	Covered in full.	Page 35
Lab, X-ray, and Diagnostic Services	Covered in full.	Page 36

Service	Available Benefits	For More Information
Skilled Nursing Facility	Covered for up to 30 calendar days per benefit year.	Page 36
Outpatient Facility Services	Covered in full.	Page 39
Emergency and Urgent Care Services		
Urgent/After-hours Care, Emergency and Travel Outside of the Country	Covered in full for a life or limb threatening emergency. Standard CHP+ copays ($0 to $20) apply.	Page 41
Ambulance Transportation Services	Covered in full for a life or limb threatening emergency	Page 45
Prescription Drugs		
Outpatient Prescription Drugs (Medications)	Covered in full if included in the formulary. Standard CHP+ copays ($0 to $10) apply.	Page 68
Over-the-Counter (OTC) Medications	Certain over-the-counter medications, including vitamins and Tylenol, are covered with a prescription from your doctor. Standard CHP+ copays ($0 to $10) apply.	Page 68
Mental Health and Substance Abuse		
Mental Health	Coverage provided for medically necessary services and may require a preauthorization.	Page 64
Substance Abuse	Coverage provided for medically necessary outpatient services and may require a preauthorization.	Page 66
Dental Services		
Dental Care provided by Delta Dental	Cleanings, exams, x-rays, fillings, and root canals. A maximum benefit of $1,000 per person per calendar year.	Page 59
Other Services		
Home Health Care and Home Infusion Therapy	Skilled services covered with preauthorization.	Page 48
Human Organ and Tissue Transplant Services	Coverage provided for limited transplants with preauthorization.	Page 51

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Service	Available Benefits	For More Information
Durable Medical Equipment	Maximum of $2,500 per calendar year. This excludes eyeglasses, contacts or hearing aids.	Page 56
Audiology Services	Coverage for age-appropriate preventive care visits.	Page 72
CHP+ HMO Enhanced Benefits		
Vision Services	Coverage for age-appropriate preventive care and specialty care visits. The standard CHP+ benefit is limited to $50 for the purchase of lenses, frames, or contacts per calendar year. **As an EXTRA BENEFIT, CHP+ HMO members get an additional $100, for a total of $150 per member per calendar year for the purchase of lenses, frames, or contacts.**	Page 72

Exclusions: If a service you need is not on the list above, it may not be covered. For more information, please call us at 303-751-9021 or 888-214-1101 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free). This is only a summary and does not guarantee coverage.

Contact Information

IMPORTANT ADDRESSES

Colorado Access Customer Service
PO Box 17580
Denver, CO 80217-0580
303-751-9021 or 888-214-1101 (toll free)

Colorado Access TTY for the Deaf or Hard of Hearing
720-744-5126 or 888-803-4494 (toll free)

Child Health Plan *Plus* (Eligibility and Enrollment)
PO Box 929
Denver, CO 80201-0929
888-367-6557

Family Healthline (Information in Health Care Programs and Resources)
303-692-2229 or 800-688-7777 (toll free)

Rocky Mountain Poison Center
800-332-3073

Delta Dental (Routine CHP+ Dental Benefits for Children)
800-610-0201

IMPORTANT WEBSITES

coaccess.com
Find information about CHP+ HMO, benefits, a provider directory, how to apply for CHP+, and other helpful resources.

coaccess.com/our-chp-plan
Find information about benefits, how to apply for CPH+, and other helpful tools.

colorado.gov/peak (also called PEAK)
Find out if you are eligible for CHP+. You can also find out about health and nutrition programs.

2: Member Rights and Responsibilities

AS A MEMBER, YOU HAVE THE RIGHT TO EXERCISE THESE RIGHTS WITHOUT FEAR OF RETALIATION:

- Get information about your health care benefits.
- Be treated fairly and with respect to your dignity and privacy.
- Not be restrained or left by yourself to make you do something you may not want to do.
- Get all of the correct benefits from CHP+ HMO.
- Get health information from your doctor in a way that you understand. This includes finding out what's going on (diagnosis), taking care of what's going on (treatment), and talking about what could happen in the future (prognosis).
- Get copies of your treatment records and service plans.
- Ask for your medical records to be changed if you think they are incorrect or incomplete.
- Get the right health care, from the right providers, at the right time, in the right setting.
- Have a talk with providers about how to take care of what's going on with your health, regardless of the cost or benefit coverage. This includes any alternative treatments that you may be able to do to yourself.
- Be a part of deciding what is best to do for your own health care.
- Get a second opinion.
- Not follow your provider's treatment plan. Your provider(s) must tell you what could happen to your health if you do so.
- Get family planning services from a licensed provider in- or out-of-network without a referral.
- Get information on how to stay well and how to help you stay and live healthy.
- Tell us about any concerns and complaints you have about the care and services you got. CHP+ HMO will look into it and will take the right action.
- File a complaint or appeal a decision with CHP+ HMO without fear of it being used against you (retaliation) (See the *Grievances and Appeals* section).
- Expect that your personal health information will be kept in a confidential manner.
- Have input about the member rights and responsibilities policies.
- Get information about CHP+ HMO, Colorado Access or other CHP+ health plans, services, providers and doctors, and the rights and responsibilities of members.
- Ask how we pay the providers and doctors that work with us. You can also ask about any incentive plans we may pay them.
- To make decisions regarding medical care and to create an advance directive that, under state law, must be respected by your provider and Colorado Access.

- Ask for information on how to be a part of the Member Advisory Board at Colorado Access by contacting the Office of Member and Family Affairs at 720-744-5610.
- Ask for information about our Quality Assessment and Performance and Healthy Living Initiatives program. You can also ask for our member satisfaction survey results.

AS A MEMBER, YOU HAVE THE RESPONSIBILITY TO:

- Use in-network providers and show your CHP+ HMO ID card.
- Stay in touch with your primary care provider (PCP) and any other doctors you see to make sure your health is taken care of.
- Be honest and give your providers all of your health information, including your health history.
- Know how to get care in non-emergency and emergency situations. You also need to know your out-of-network health care benefits, including coverage and what you have to pay (copayments).
- Tell your provider or CHP+ HMO about your concerns with the services or care you receive.
- Be considerate of the rights of other members, providers, and Colorado Access staff.
- Read and know what your CHP+ HMO Member Benefits Booklet says.
- Pay all member payment requirements on time.
- Give CHP+ HMO information about any other health care coverage and/or benefits you have or get.
- Work with your provider so he or she knows what your health care concerns are. Your provider will help you set goals and take care of your health.
- Provide Colorado Access with written notice after filing a claim or action against a third-party responsible for your illness or injury.

RIGHTS AND RESPONSIBILITIES FOR MEMBERS WITH SPECIAL HEALTH CARE NEEDS

All members have the rights and responsibilities listed above. Members with special health care needs also have some additional rights and responsibilities, which include the following:

Rights:

- To keep seeing their non-Colorado Access providers up to 60 days after they join Colorado Access.
- To keep seeing their non-Colorado Access home health or durable medical equipment (DME) provider up to 75 days after they join Colorado Access.

Responsibilities:

- To tell their medical providers, including doctors, home health, and DME providers, that they have enrolled with Colorado Access so we can work together to transfer care.

RIGHT AND RESPONSIBILITY FOR MEMBERS WHO ARE MORE THAN THREE MONTHS PREGNANT

Members who are more than three months pregnant have all of the rights and responsibilities listed above, but also have an additional right and responsibility as follows:

Right:

- To see their current prenatal care provider until after delivery.

Responsibility

- To tell us they are pregnant and let us know who is providing their care upon enrollment.

TRANSITION OF CARE

As a new member of CHP+ HMO, you may already get ongoing care (treatment) from a provider for a certain medical condition. Examples of ongoing care include regular visits to an asthma specialist or a behavioral health provider. To make sure that your ongoing care is not disrupted, you may need to transition your care within the above-stated time limits. Transition of care refers to any ongoing care that needs to be switched (transitioned) to a new provider who is in-network and accepts your CHP+ HMO. The switch is done so you can continue to get the care you need and to make sure it is covered and paid for.

If you need help with transition of care, set up an appointment to see your primary care provider (PCP). You can also call us to be connected to a care manager. Also, if a doctor or provider you are seeing lets us know that he or she will stop practicing or will end (terminate) the contract with CHP+ HMO, we will let you know within 15 days of that notification. We will also help you switch to a new doctor or provider.

3: About your Health Care Coverage

Learning about how your coverage works can help you make the best use of your health care benefits.

CHP+ HMO has a network of doctors, hospitals, and other health care providers that help make sure members get the health care services they need. Please work with your primary care provider (PCP) to coordinate care with specialists and to get preauthorization for services when they are needed. This will help make sure that you get the right care, at the right time, in the right place.

GETTING INFORMATION ABOUT YOUR HEALTH CARE PROVIDERS

To get information about health care providers, including physicians, nurses, specialists, and pharmacies, call the Colorado Department of Regulatory Agencies (DORA). This is the state agency that regulates providers in Colorado. They can tell you if a provider's license is active or in good standing. The Colorado Department of Regulatory Agencies (DORA) can be reached at 303-894-7800.

IN-NETWORK PROVIDERS

Make sure that your provider is in-network with your CHP+ HMO plan. If you get care from a provider who does not accept your CHP+ HMO plan, you may have to pay for the services you get.

REMEMBER

- Always show your CHP+ HMO member ID card when you get health care.
- Choose an in-network PCP.
- When you get care, always make sure your provider is in-network, except in an emergency.
- Call us if you have any questions about your coverage at 303-751-9021 or 888-214-1101 (toll free).TTY users should call 720-744-5126 or 888-803-4494 (toll free).

PRIMARY CARE PROVIDERS (PCP)

All members of CHP+ HMO must choose an in-network primary care provider (PCP). A PCP can be a family medicine doctor, an internal medicine doctor, a general practitioner, or a pediatrician. Your PCP helps you with:

- Checkups
- How to stay healthy
- Sick visits
- Taking care of any chronic conditions
- Shots
- Referrals to a specialist if you need one
- Finding out what's going on (diagnosis)
- Take care of what's going on (treatment)

Payments are only made for covered services. This is regardless of medical necessity.

It is important to work with your PCP. If it is medically necessary, your PCP may send you to get care from a specialist. You PCP will coordinate your care and get a preauthorization for those services if they are necessary.

Most services received by an in-network provider do not need a referral or preauthorization from CHP+ HMO. However, if your PCP refers you to a doctor outside of our network, they need to submit a preauthorization for those services before you go, otherwise you will be responsible for those charges. Preauthorization is necessary because services provided by out-of-network providers are not automatically covered.

If there is not an in-network specialist for a covered service, we will refer you to a provider with the skills (expertise) needed.

We encourage the use of a Medical Home. A Medical Home is more than just an office or clinic. A Medical Home is a health care team that makes sure you and your family get all of the health care and health-related services you need. This team includes your family and all of the providers your child sees.

We are obligated to make sure appropriate services and accommodations are made available to members with special health care needs. Services must be provided in a manner that promotes independent living and helps the member participate in the community.

Newborn Primary Care Provider (PCP) Assignment

Your baby will be enrolled with your PCP on his or her date of birth. If your PCP only gives care to adults, your newborn will be assigned to a PCP that gives care to children. If you would like to choose a different PCP for your newborn, call us at 303-751-9021 or 888-214-1101 (toll free) or TTY for the deaf or hard of hearing at 720-744-5126 or 888-803-4494 (toll free).

Members with special health care needs may be allowed to have direct access/standing referral to their specialist as needed for their care. Members should speak with their PCP about setting up a long-standing referral with a specialist.

Choosing or changing your PCP

You must choose an in-network PCP. There are no restrictions on who you choose as your in-network PCP. You can find a list of in-network PCPs in the provider directory. Information in the provider directory includes the names, titles, addresses, and telephone numbers for in-network providers. If you need a provider directory, or need help finding a PCP in your area, call us. You can also find a provider directory online at providers2.coaccess.com/ProviderSearch/home.jsf. Our online provider directory tool can also tell you:

- Which providers are in your area
- The language spoken, other than English, by the provider
- Which providers are accepting new patients (call the provider to make sure)

If you do not choose an in-network PCP, we will choose a PCP for you in your area. If you do not want to see the PCP we choose for you, please call us.

Once you choose an in-network PCP, call us and let us know. Please call us at 303-751-9021 or 888-214-1101 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free). You will get a new member ID card with the name of your PCP on it.

Going to see your PCP

When you need to see your PCP, call his or her office to make an appointment. The telephone number for your PCP can be found on your CHP+ HMO ID card. When you call, tell the office that you are a member of CHP+ offered by Colorado Access. The office will help you make an appointment.

Remember this important information when you schedule your appointment.

If your health concern is:	**Your appointment should be within:**
Urgent	48 hours
Non-urgent/non-emergent substance abuse or mental health services	14 calendar days
Non-urgent	30 calendar days
Non-symptomatic well care	30 calendar days

Please ask your PCP how to get:

- Medical care after normal business hours
- Medical care on weekends and holidays
- Non-emergency care within the service area for a health concern that is not life-threatening but that needs medical attention right away

In case of emergency, call 911 or go directly to the nearest emergency room.

If you cannot make your appointment, call your PCP at least 24 hours before you're supposed to be there. Talk to your PCP's office to find out if there is a cancellation policy. You should also let your PCP's office know if you are going to be late for an appointment. Your PCP may ask you to change the appointment to another day.

Referrals

Your primary care provider (PCP) gives you basic health and medical services. This includes routine and preventive care. Sometimes you might need to see a specialist or another provider Your PCP will help coordinate your care by giving you a referral. A referral from your PCP tells the specialist what type of care you need. Your PCP will make sure that all important information is given to the specialist. Once you get the referral from your PCP, you must make sure that the specialist is in-network and accepts CHP+ offered by Colorado Access. You do not need to get approval from CHP+ HMO to visit and in-network specialist.

Your PCP may tell you that you need to see a contracted specialist. This is called a referral. Your health plan does not need to approve this specialty visit.

Any visit to a non-contracted PCP or specialist will require a preauthorization. This needs to happen before the visit. If you do not get this preauthorization, you may have to pay for that visit.

You may find services on your own at any of the providers or facilities listed below:

- An emergent or urgent care facility
- An OB/GYN provider or certified nurse or midwife for obstetric or gynecologic care
- An optometrist or ophthalmologist for a routine eye exam

Mental health services – you may self-refer for mental health services. The services may require preauthorization from CHP+ HMO and may be subject to benefit limits

You need to make sure the provider or facility you choose is in-network with CHP+ HMO.

Always make sure that the services your PCP recommends are covered by CHP+ HMO. A PCP's referral does not always mean the service is covered.

4: What You Pay (Cost Sharing) – For Enrollment & Services

Cost sharing refers to how members share the cost of health care services with CHP+ HMO. It defines what we will pay for and what the member will have to pay. Members meet the cost sharing requirements by paying their copayments (as described below).

COPAYMENTS (COST SHARING)

A copayment is a dollar amount you pay in order to get a specific service, supply or prescription medication. Copayments are paid at the time of service to your provider, or when prescription medications are purchased. The standard CHP+ HMO copayments range from $0 to $50 per visit. Your copayment amount will be listed on your CHP+ HMO ID card. You are responsible for paying the copayment to your provider or pharmacy when you get services. There are no copayments for preventive visits. There are also no copayments for family planning services or prenatal care services.

CHP+ HMO copayments are based on family size and income. Copayment amounts are listed on your member ID card. The following table gives some examples of copayment amounts:

CHP+ HMO Benefit	Copayment			
	Income Level 1	**Income Level 2**	**Income Level 3**	**Income Level 4**
Emergency Care and Urgent/After-Hours Care	$3	$3	$30	$50
Emergency Transport/Ambulance Services	$0	$2	$15	$25
Hospital/Other Facility Services				
• Inpatient	$0	$2	$20	$50
• Physician	$0	$2	$5	$10
• Outpatient/Ambulatory	$0	$2	$5	$10
Routine Medical Office Visit	$0	$2	$5	$10
Laboratory and X-ray	$0	$0	$5	$10
Preventive, Covered Childhood Immunizations and Family Planning Services	$0	$0	$0	$0
Maternity Care				
• Prenatal	$0	$0	$0	$0
• Delivery & Inpatient Well Baby Care	$0	$0	$0	$0
Prescription Birth Control	$0	$0	$0	$0
Inpatient Mental Illness Care & Substance Abuse/Residential/Day Treatment	$0	$2	$20	$50
Non-Office Based Mental Health and Substance	$0	$2	$5	$10

Have questions? Need help?
We are here to help you in the language you speak! Free interpretation services are available
Call us at 303-751-9021 or 888-214-1101 (toll free)
TTY users should call 720-744-5126 or 888-803-4494 (toll free)
Email us at customer.service@coaccess.com

Abuse (there is no copay for drop-in centers, school-based, club house, or home-based services)				
Outpatient and Office-based Mental Health and Substance Abuse	$0	$2	$5	$10
Physical Therapy, Speech Therapy and Occupational Therapy	$0	$2	$5	$10
Durable Medical Equipment (DME)	$0	$0	$0	$0
Transplants	$0	$0	$0	$0
Home Health Care	$0	$0	$0	$0
Hospice Care	$0	$0	$0	$0
Prescription Medications (including covered over-the-counter medications)	$0	$1	$3 – generic $10 – brand name	$5 – generic $15 – brand name
Kidney Dialysis	$0	$0	$0	$0
Skilled Nursing Facility Care	$0	$0	$0	$0
Routine Vision Services	$0	$0	$0	$0
Specialty Vision Services – A specialty vision service is when you see a vision provider for something other than a routine exam	$0	$2	$5	$10
Audiology Services	$0	$0	$0	$0
Intractable Pain	$0	$2/office visit $2/admission	$5/office visit $20/admission	$10/office visit $50/admission
Autism Coverage	$0	$2/office visit $2/admission	$5/office visit $20/admission	$10/office visit $50/admission
Dietary Counseling/Nutritional Services	$0	$0	$0	$0
Therapies: Chemotherapy and Radiation	$0	$0	$0	$0

HOLD HARMLESS

The contracts we have with our in-network providers include a "hold harmless clause." This clause says that our members cannot be billed by the provider beyond what is paid for by CHP+ HMO in accordance with the fee schedule (the fee schedule is the amount the provider agrees to accept from CHP+ HMO for services provided to members of CHP+ HMO). If you are billed by an in-network provider, please call us at 303-751-9021 or 888-214-1101 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

WHEN YOU CAN BE BILLED FOR SERVICES

You might have to pay for services if:

- You receive non-emergency care from an out-of-state network provider and the service is not authorized
- You receive any non-covered service
- You receive services (for example, day surgery) without an authorization by CHP+ HMO
- You receive services when you are not eligible for CHP+ HMO

In-network billing procedures for covered services

When an in-network provider bills us, we will pay the provider for the appropriate charges for covered services. You are responsible for giving the in-network provider all necessary information, such as your ID card, so that the provider can submit a claim.

Remember, you are responsible for any copay amount when you get covered services.

SERVICES FROM OUT-OF-NETWORK PROVIDERS

Non-emergency services from out-of-network providers are not covered unless they are authorized by CHP+ HMO. If services for an out-of-network provider are authorized, the copayments for these authorized services are the same as copayments for covered services received from an in-network provider.

Out-of-network billing procedures for covered services

Services performed by an out-of-network provider (a provider who is not contracted to provide services for CHP+ HMO) will be covered only in an emergency as described under the *Member Benefits – Covered Services – Urgent/After-Hours Care, Emergency Care and Travel Outside of the Country* section or when preauthorized by CHP+ HMO.

In the case of emergency or urgent care, let the hospital or urgent care provider know that the claim must be sent to:

Colorado Access
PO BOX 17470
Denver, CO 80217

If the out-of-network hospital accepts payment from CHP+ HMO, then the hospital is reimbursed directly. You will not have to pay any copay amount that may apply. If the hospital will not accept payment from CHP+ HMO, then you will have to pay the hospital directly.

After you pay the hospital, you may ask us to reimburse you. You will have to submit proof that you paid for the service. An example of proof of payment is a receipt from the hospital that shows the payment or payments you made. To request a reimbursement, you will need to fill out the member reimbursement request form (available online or at the back of this Booklet) and mail it in with your receipt to:

Reimbursements
PO Box 17950
Denver, CO 80217-0580

For help with this process, please call us at 303-751-9021 or 888-214-1101 (toll free).

We will review your request. Reimbursement is not guaranteed and depends on whether the service provided is covered by CHP+ HMO.

If reimbursement is approved, we will send the reimbursement directly to you. The reimbursement you receive will be at the out-of-network rate, which may not be the full amount that you paid to the hospital.

Remember:

You may have to pay for non-emergency and non-urgent care services that you get if they are outside of the service area or from an out-of-network provider.

It is your responsibility to make sure that the provider is in-network before you get any services.

If you have any questions about a provider, or need help finding an in-network provider, call us at 303-751-9021 or 888-214-1101 (toll free). TTY users should call 720-744-6126 or 888-803-4494 (toll free).

Where providers send bills

Providers must file claims within 120 days after the date of service, or as otherwise agreed upon by CHP+ HMO and the provider. Any claims filed after this timeframe may be refused, unless the provider has a valid reason for not submitting the claim within the timeframe.

We will process claims in accordance with the timeframes required by state law for prompt payment to the extent such laws are applicable. Providers should submit claim forms to the following address:

Colorado Access
PO Box 17470
Denver, CO 80217

ANNUAL OUT-OF-POCKET LIMIT

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

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

1. Save your copayment receipts from covered medical care and covered prescription medications.
2. When you have reached your annual out-of-pocket limit, call the state's medical assistance program at 800-359-1991
3. The state's medical assistance program will ask for proof that you have reached your annual out-of-pocket limit. Send them copies of your receipts as proof.

5: Administrative Information

OVERPAYMENTS

If we make an overpayment, we may require the provider to refund the amount that was paid in error. We may collect overpayments made to a provider by subtracting them from future claim payments. We also reserve the right to take legal action to correct overpayments.

CATASTROPHIC EVENTS

In case of fire, flood, war, civil disturbance, court order, strike, an act of terrorism, or other causes beyond our control, we may be unable to process claims on a timely basis. No legal action or lawsuit may be taken against us due to delay caused by any of these events.

CHANGES TO THE CHP+ HMO MEMBER BENEFITS BOOKLET

No one other than Colorado Access may change this CHP+ HMO Member Benefits Booklet. We will administer the CHP+ HMO Member Benefits Booklet in strict accordance with its terms as written. Oral or written statements do not replace the terms of this CHP+ HMO Member Benefits Booklet.

FRAUD

As part of your responsibilities as a CHP+ HMO member, you must give truthful information related to your health care treatment. It is against the law for a member of CHP+ HMO to knowingly provide untrue, incomplete, or misleading information for the member's or another person's benefit. This is commonly called fraud. Penalties for fraud may include prison, money fines, and denial of insurance coverage. If you feel that we have provided you with this type of information, you can report it to the Colorado Division of Insurance within the Department of Regulatory Agencies at dora.state.co.us/.

The cost of investigating and filing lawsuits for fraud causes the cost of health care insurance to go up. You can help decrease these costs by doing the following:

- Be wary if your provider offers to waive your copayment. This practice is usually illegal.
- Be careful of mobile health testing labs. Ask what insurance company will be charged for the test.
- Always read and become familiar with this CHP+ HMO Member Benefits Booklet. If there are any differences between what is in the CHP+ HMO Member Benefits Booklet and the treatment you are offered, call us at 303-751-9021 or 888-214-1101 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).
- Be very cautious about giving any information about your CHP+ HMO insurance coverage over the phone to anyone.

You will know that you are a victim of medical identity theft or fraud if you:

- Get a bill for medical services you didn't receive
- Are contacted by a debt collector about medical bills you don't owe
- See medical collection notices on your credit report that you don't recognize
- Are told by your health plan that you've reached the limit on benefits
- Have been promised free goods, such as medical equipment or gift cards, for providing your medical identification to someone

If you suspect fraud by a provider, another member, or anyone else, you should contact us. You can call the Colorado Access Compliance Hotline at 877-363-3065.

You will not have to give your name or member number when you call the hotline number, unless you want to.

We reserve the right to take back any benefit payments paid on behalf of a member if the member has committed fraud or material misrepresentation in applying for coverage or in receiving or filing for benefits.

INDEPENDENT CONTRACTORS

We have contracts with health care providers that allow the providers to provide treatment to members. These providers are not able to make any promises to you for CHP+ HMO. We do not have control over any diagnosis, treatment, care or other service provided to a member by any provider. We are not responsible for any claim connected with any injuries suffered by the member while receiving care from any provider.

We may also contract with certain companies that can provide you with specialized services in certain areas such as prescription medication or substance abuse services.

NOTICE OF PRIVACY PRACTICES

We are committed to protecting the confidentiality of your medical information. In addition to the laws that govern your privacy, we have our own privacy policies and procedures to help protect your information. If you would like a copy of our privacy notice, visit coaccess.com/privacy-security-of-member-information or call us at 303-751-9021 or 888-214-1101 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

NO WITHHOLDING OF COVERAGE NECESSARY CARE

- We do not compensate, reward, or incent, financially or otherwise, associates for inappropriate restrictions of care.

- We do not promote or otherwise provide an incentive to employees or provider reviewers for withholding benefit approval for medically necessary services to which you are entitled.
- Utilization review and benefit coverage decisions are based on appropriateness of care and service and the applicable terms of this CHP+ HMO Member Benefits Booklet
- We do not design, calculate, aware, or permit financial or other incentives based on the frequency of denials of authorization for coverage, reductions, or limitations on hospital lengths of stay, medical services or charges, or telephone calls or other contacts with health care providers or members.

PHYSICAL EXAMINATIONS AND AUTOPSIES

We have the right and opportunity, at its expense, to request an examination of a person covered by CHP+ HMO when and as often as it may reasonably be required during the review of a case or claim. On the death of a member, we may request an autopsy where it is not forbidden by law.

SENDING NOTICES

All member notices are considered sent to and received by the member when deposited in the United States Postal Service mail with postage prepaid and addressed to the member at the latest address in our membership records.

TIME LIMIT ON CERTAIN DEFENSES

After one year from the beginning of your CHP+ HMO coverage, no inaccurate statements made by the member during the application process will be used to terminate the coverage or to deny a claim or a disability, unless the statement is made fraudulently. Please see the *Fraud* section for more information.

No claim for a loss incurred or a disability, as defined in the policy, commencing after one year from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or a specific description and effective on the date of loss existed before the effective date of coverage of this policy.

6: Member Benefits – Covered Services

This part of the Booklet gives you information about benefits and covered services of CHP+ HMO. Members must follow the guidelines closely.

Remember:

- CHP+ HMO covers medically necessary and preventive services and supplies.
- CHP+ HMO does not cover services listed as excluded or as exclusions in this Booklet. For more information, see the *General Exclusions & Limitations* section of this Booklet.
- CHP+ HMO covers services that are standard medical practice for the illness, injury or condition being treated, and that are legal in the United States of America.
- The fact that a provider prescribes, orders, recommends, or approves a service, treatment, or supply does not make it medically necessary or a covered service. That means it does not guarantee that CHP+ HMO will pay for it.
- If you have questions about a service or benefit, please call us at 303-751-9021 or 888-214-1101 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

All covered services are subject to other conditions and limitations of the CHP+ HMO Member Benefits Booklet.

MEMBER BENEFITS – COVERED SERVICES – PREVENTIVE CARE SERVICES

This section tells you about covered services and exclusions for preventive care.

Who should I see for preventive care services?

Go to your primary care provider (PCP) for preventive care services.

We think it is good for you to be seen by your PCP on a regular basis. We follow the well-child visit schedule put together by the American Academy of Pediatrics. Below is a chart that tells you when we think you should see your PCP for preventive care services.

Infancy	Early Childhood	Mild Childhood	Adolescence
Prenatal	12 Months	5 Years	11 Years
Newborn	15 Months	6 Years	12 Years
First Week	18 Months	7 Years	13 Years
1 Month	24 Months	8 Years	14 Years

2 Months	30 Months	9 Years	15 Years
4 Months	3 Years	10 Years	16 Years
6 months	4 years		17 Years
9 Months			18 Years

What preventive care services are covered?

Covered preventive care services are routine PCP visits like well-child exams and routine physicals.

- Regularly scheduled childhood and adult immunizations (shots)
- HPV vaccination for both male and female members
- Age-appropriate vision and hearing screening exams
- Health education given by your PCP. This may include information about preventing illness and injury. You PCP may ask you age-appropriate questions during your visit. This will help your PCP decide on topics to talk about during your health education discussion.

What preventive care services are not covered?

The following are exclusions. They are not covered preventive care services:

- Immunizations needed for international travel
- Services for routine physical or screening exams and immunizations given mainly for insurance, licensing, employment, weight loss programs, or for any non-preventive purpose
- Any services not medically necessary

MEMBER BENEFITS – COVERED SERVICES – FAMILY PLANNING/REPRODUCTIVE HEALTH

This section tells you about covered services and exclusions for family planning/reproductive health.

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

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

What family planning reproductive health services are covered?

- Prescription birth control pills are covered; see the *Member Benefits – Covered Services – Outpatient Pharmacy and Prescription Medications* section for more details. Prescription birth control does not have copays.
- Depo-Provera for birth control purposes
- Fitting of a diaphragm or cervical cap
- Surgical implantation and removal of an implantable contraceptive device
- Fitting, inserting, or removing intrauterine device (IUD)
- IUDs, diaphragms, implantable contraceptive devices, and cervical caps given in a provider's office
- Tests to diagnose a possible genetic illness/disease
- STI (sexually transmitted infection)/HIV testing and treatment

What family planning/reproductive services are not covered?

The following are exclusions. They are not covered family planning/reproductive health services:

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

MEMBER BENEFITS – COVERED SERVICES – MATERNITY AND NEWBORN CARE

The section tells you about covered services and exclusions for maternity and newborn care.

Who should I see for maternity and newborn care?

An in-network OB/GYN, certified nurse midwife or family practice physician who delivers babies. For prenatal care, you can see an in-network OB/GYN or a certified nurse midwife without a referral from your PCP.

What maternity and newborn care services are covered?

Benefits are provided for maternity and newborn care, including finding out what's going on (diagnosis), care while you are pregnant, and delivery services.

Covered services include:

- Inpatient, outpatient, and provider office services (including prenatal care, such as prescription prenatal vitamins) for vaginal delivery, cesarean section, and problems (complications) with the pregnancy
- Anesthesia services
- Routine nursery care for newborns including provider services
- For newborns, all medically necessary care and treatment of injury and sickness, which includes medically diagnosed congenital defect and birth abnormalities
- For male newborns, circumcision
- Tests to find (diagnose) possible genetic illness/disease
- Laboratory services related to prenatal care, postnatal care, or termination of a pregnancy
- Spontaneous termination of a pregnancy prior to full term
- Antenatal ultrasounds
- Post-delivery, follow-up care visits are covered in your home by a provider, nurse, or certified midwife no later than 72 hours following you and your newborn's discharge from the hospital
    - This visit includes, but is not limited to:
        - Making sure you and the newborn are checked out
        - Checking out your home support system
        - Help and training on how to breast or bottle feed
        - Any maternal or neonatal tests for the mother or newborn, including getting samples for the hereditary disease and metabolic newborn screenings usually done while in the hospital after delivery. If the mother wants, this visit may be done at the provider's office.
- We pay for services when done by an in-network certified nurse midwife or a direct-entry midwife. These are covered benefits:
    - Advising, attending, or assisting the mother during pregnancy, labor, and natural childbirth at home, and during the postpartum period in accordance with CRS 12-37-101 et. Al. seq. that includes one metabolic screening, one postpartum visit, one prescreening visit, and the actual delivery and labor.

We will pay for no less than a 48-hour hospital stay for the mother and newborn after a vaginal delivery. If the delivery is by cesarean section, we will pay for no less than a 96-hour hospital stay. If the delivery is between 8:00 p.m. and 8:00 a.m., coverage will last until 8:00 a.m. on the morning following the 48-hour or 96-hour coverage period. After talking with the mother, the provider may let the mother and newborn go home (discharge) earlier, if it is appropriate.

Please see the *Membership* section for more information about newborn coverage and enrollment.

What maternity and newborn care services are not covered?

The following are exclusions. They are not covered maternity and newborn care services. This is not a complete list.

- Counseling before you get pregnant (preconception counseling)
- A test to find out who the father is (paternity testing)
- Genetic counseling and testing (unless it is to find out if the newborn will have a disease or other health concern that is not already excluded above)
- A screen or test to find any health disorders that could be inherited from the mother or father (a talk about family history or test results to find out the sex or physical characteristics of an unborn child)
- Paying to store the umbilical blood

MEMBER BENEFITS – COVERED SERVICES – PROVIDER OFFICE SERVICES

This section tells you about covered services and exclusions for provider office services.

Who should I see for provider office services?

You must get your medical care and services in the office of an in-network provider (unless otherwise authorized).

Please work with your primary care provider (PCP) to help you coordinate your care when you need to see a specialist.

You do not need to get approval from CHP+ HMO when you get care from:

- An in-network OB/GYN or certified nurse midwife for care while you are pregnant (obstetrical) or special care for women (gynecological)
- An in-network ophthalmologist or optometrist for routine eye care

What provider office services are covered?

- Medical care, talking with a provider before you get any services (consultations), and second opinions to examine, find out what's going on (diagnose), and treat an illness or injury when you get it in a provider's office.
    - If you think you need a second opinion, you may talk to another in-network provider (consultation). You should talk with your PCP before you get a second opinion. At times, your PCP may suggest you get a second opinion. If you need help finding a provider for a second opinion or help setting up a second opinion appointment, please call us at 303-751-9021 or 888-214-1101 and a care manager can assist you.
- Your providers helping you manage your medicine (medication management).

- Surgery and surgical services done in the provider's office. This includes anesthesia and supplies. Surgical fees include local anesthesia and normal post-operative care. You may need to get a preauthorization before the surgical services are done in the provider's office. See the *Managed Care* section of this Booklet for information about preauthorization guidelines.
- Diagnostic services done in the provider's office to diagnose or monitor a symptom, disease, or condition. These include, but are not limited to, the following:
    - X-ray and other radiology services
    - Laboratory and pathology services
    - Ultrasound services for conditions other than pregnancy (for pregnancy-related ultrasounds, see the *Member Benefits – Covered Services – Maternity and Newborn Care* section).
- Allergy tests for the following services:
    - Direct skin (percutaneous and intradermal) and patch allergy tests and RAST (radioallergosorbent testing)
    - Allergy medications administered by injection in the provider's office
    - Charges for allergy serum
- Audiometric (hearing) and vision tests

What provider office services are not covered?

The following are exclusions; they are not covered provider office services:

- Any cost related to getting a copy of your medical record or to transfer your files
- Treatment for hair loss, even if caused by a medical condition, except for alopecia areata
- Routine foot care, such as care for corns, toenails, or calluses (except for members with diabetes)
- Telephone or internet consultations
- Treatment for sexual dysfunction
- Infertility services
- Genetic counseling
- Separate reimbursement for anesthesia and post-operative care when services are provided by the same provider in the provider's office
- Peripheral bone density scans

MEMBER BENEFITS – COVERED SERVICES – INPATIENT HOSPITAL SERVICES

This section tells you about covered services and exclusions for inpatient hospital services. This is care you get when in the hospital as well as the services you need to help the providers in the inpatient facility take care of you (ancillary and professional services).

Where can I get inpatient hospital services?

All acute inpatient hospital stays must be at an in-network facility. They include:

- An acute care hospital
- A long-term acute care hospital
- A rehabilitation hospital
- Other in-network inpatient hospital

What inpatient hospital services are covered?

All inpatient services are subject to preauthorization by CHP+ HMO or unscheduled admission notification guidelines. See the *Managed Care* section for information about preauthorization guidelines.

See the *Member Benefits – Covered Services* section for services, including acute medical detoxification. For accident or emergency medical care, see the *Member Benefits – Covered Surgery – Urgent/After-Hours Care, Emergency Care and Travel Outside of the Country* section. For dental services, see the *Member Benefits – Covered Services – Dental-Related Services* section.

Facility services

You may get many services while inpatient. Some of the services that will be paid for include, but are not limited to, the following:

- Charges for semi-private room (with two or more beds) and general nursing services
- Use of an operating room, recovery room, and related equipment
- Medical and surgical dressings, supplies, surgical trays, casts, and splints when supplied by the facility when inpatient
- Prescribed medications while inpatient
- A room in a special care unit once authorized by CHP+ HMO. The unit must have facilities, equipment, and supportive services for the intensive care of critically ill patients.
- Inpatient rehabilitation services
- Inpatient rehabilitation for non-acute hospital admissions are covered for medically necessary care to restore and/or improve lost functions following an injury or illness

Inpatient rehabilitation benefits are limited to 30 days per calendar year. These services must be received within six months from the date on which the illness or injury occurred.

Ancillary Services

Many providers work together to provide all of the care a patient needs. Some covered ancillary services include, but are not limited to, the following:

- Tests to find out what's going on (diagnostic) such as laboratory and x-ray tests (for example, CT scan or MRI)
- Chemotherapy and radiation therapy
- Dialysis treatment
- Respiratory therapy
- Physical, occupational, and/or speech therapy
- Charges for processing, transportation, handling, and administration of blood
- Professional services. These are the surgical and medical care provided during an inpatient admission. Some of the covered professional services include, but are not limited to, the following:
    - Provider services for the medical condition(s) during an inpatient admission
    - Surgical services, which include normal post-operative care
    - Anesthesia and anesthesia supplies and services for a covered surgery
    - Intensive medical care for constant attendance and treatment when the member's condition requires it for a prolonged period of time
    - Surgical assistant or assistant surgeons as determined by CHP+ HMO medical policy. We do not cover and pay for surgical assistants for all surgical procedures
    - Surgical services for the treatment of morbid obesity. These services are subject to meeting the criteria included in CHP+ HMO's medical policy. The hospital performing the morbid obesity surgery must be designated and approved to perform specific services for this benefit.
    - Reconstruction of a breast on which a mastectomy has been performed, and surgery and reconstruction of the other breast to produce a symmetrical appearance. Benefits are provided for physical complications for all stages of mastectomy, including lymphedemas. If a member chooses not to have surgical reconstruction after a mastectomy, we will pay for an external prosthesis.
    - Talking with another in-network provider (consultations – including second opinions)
    - Medical care by two or more providers at the same time because of multiple illnesses
    - Medical care for an eligible newborn. See the *Member Benefits – Covered Services – Maternity and Newborn Care* section.
- Long-term acute care facilities. These provide long-term critical care services to members with serious illnesses or injuries. Long-term acute care is provided for members with complex medical needs, including members with high-risk pulmonary disease with ventilator or tracheostomy needs, members who are medically unstable, members needing extensive wound care or who have post-operative surgery wounds and members with closed head or brain injuries. CHP+ HMO requires preauthorization for admission and for continued stay. See the *Managed Care* section for information about preauthorization guidelines.

- Skilled nursing facilities. These provide skilled nursing care, therapies, and protective supervision for patients who have uncontrolled, unstable, or chronic conditions. Skilled nursing care is provided under medical supervision for the non-surgical treatment of chronic conditions or care during the recovery from an acute disease or injury. Skilled nursing facility coverage does not include care for members with chronic medical needs. Skilled nursing care must be preauthorized by CHP+ HMO. Benefits are available for up to 30 calendar days per benefit year, per diagnosis, or until the member has reached the maximum medical improvement, whichever is sooner. If there is a need for you to stay longer, another preauthorization is required. See the *Managed Care* section of this Booklet for information on preauthorization guidelines.

What inpatient facility services are not covered?

We will not pay for services you get at an out-of-network hospital unless it was for an emergency or authorized by CHP+ HMO.

The following are exclusions; they are not covered inpatient facility services:

- Talking to a provider (consultation) or visit related to any non-covered service
- Inpatient provider services received on a service date that facility charges were denied
- Talking to a provider over the telephone
- Private room expenses when semi-private rooms are available, unless your medical condition requires you to be isolated to protect you from exposure to dangerous bacteria and diseases. Conditions that require isolation include, but are not limited to, severed burns and those according to public health laws.
- Admissions related to non-covered services or procedures. See the *Member Benefits – Covered Services – Dental-Related Services* section.
- Room and board and related services in a nursing home
- Custodial care facility admissions or admissions to similar institutions. Custodial care is non-medical care that can help you with your daily activities, such as preparing special diets and helping you take your medication.
- If you leave a hospital or other facility against medical advice, we will not pay any of the care you got while you were there (non-compliance care).
- Room and board charges from the facility for the day you were discharged
- Procedures that are solely cosmetic in nature
- Custodial and/or maintenance care (this is care that helps you with activities of daily living)
- Any service or care for the treatment of sexual dysfunction
- Sex change operations, preparation for a sex change operation, or complications arising from a sex change operation

- Personal comfort and convenience items, such as televisions, telephones, guest meals, personal hygiene items, and other similar services and supplies
- Surgical services for refractive keratoplasty, including radial keratotomy or Lasik, or any procedure to correct visual refractive defect
- Additional procedures not routinely performed during the course of the main surgery

It is your responsibility to follow the medical advice of your provider. If you don't, and then get injured or ill, you may need to have a surgery or another procedure. If this happens, we will not pay for it because you were not following the medical advice (non-compliant). For example, if you do not take your prescribed medicine after you have your tonsils removed (tonsillectomy), you could get an infection. To remove the infection would not be covered. You would have to pay for that procedure.

MEMBER BENEFITS – COVERED SERVICES – OUTPATIENT FACILITY SERVICES

This section tells you about covered services and exclusions for outpatient facility services.

Where can I get outpatient facility services?

All outpatient facility services must be at an in-network facility. This plan does not cover outpatient facility services at an out-of-network facility unless services are for an emergency or preauthorized by CHP+ HMO.

You can get outpatient facility services at:

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

What outpatient facility services are covered?

Some outpatient facility services require a preauthorization. See the *Managed Care* section of this Booklet for information about preauthorization guidelines.

See the *Member Benefits – Covered Services* section for covered mental health and substance abuse treatments.

See the *Member Benefits – Covered Services – Urgent/After Hours Care, Emergency Care and Travel Outside of the Country* section for information about emergency care.

For dental services covered by CHP+ HMO, see the *Member Benefits – Covered Services – Dental-Related Services* section.

Facility services – A number of health care services are provided in an outpatient facility setting. Some of the covered services include, but are not limited to, the following:

- Use of an operating room, recovery room, and related equipment
- Medical and surgical dressings, supplies, surgical trays, casts, and splints when supplied by the facility during an outpatient admission
- Drugs and medicines given during an outpatient admission

Ancillary services – Some of the covered ancillary services include, but are not limited to, the following:

- Diagnostic services such as laboratory and x-ray tests (for example, CT scan or MRI)
- Medical and surgical dressings, supplies, surgical trays, casts, and splints when supplied by an in-network provider at an outpatient facility
- Chemotherapy and radiation therapy
- Dialysis treatment
- Respiratory therapy
- Charges for processing, transportation, handling and administration of blood

Therapeutic dialysis services are covered when:

- The member is not eligible for Medicare or is covered by Medicare but does not have a Medicare supplemental insurance policy. See the *Coordination of Benefits and Subrogation* section
- Services are performed by an in-network dialysis provider

Home dialysis services require preauthorization by CHP+ HMO. Covered dialysis services include:

- Hemodialysis
- Peritoneal dialysis
- The cost of equipment rentals and supplies for in-home dialysis

Professional services – Professional services are the surgical and medical care provided during an outpatient admission. Some of the covered professional services include, but are not limited to, the following:

- Provider services for the medical condition(s) while you are in an outpatient facility
- Surgical services. The surgical fee includes normal post-operative care
- Anesthesia and anesthesia supplies and services for a covered surgery
- Surgical assistants or assistant surgeons as determined by CHP+ HMO's medical policy. CHP+ HMO does not pay for surgical assistants for all surgical procedures

- Consultation by another provider when requested by the member's provider
- Staff consultation required by facility rules are not covered

What outpatient facility services are not covered?

It is your responsibility to follow the medical advice of your provider. If you don't, and then get injured or ill, you may need to have a surgery or another procedure. If this happens, we will not pay for it because you were not following the medical advice (non-compliant). For example, if you do not take your prescribed medicine after you have your tonsils removed (tonsillectomy), you could get an infection. To remove the infection would not be covered and you would have to pay for the procedure.

The following are exclusions; they are not covered outpatient facility services:

- Procedures that are solely cosmetic in nature
- Any services or care for the treatment of sexual dysfunction
- Sex change operations, preparation for a sex change operation or complications arising from a sex change operation
- Personal comfort and convenience items such as televisions, telephones, guest meal, personal hygiene items, and other similar services and supplies
- Surgical services for refractive keratoplasty, including radial keratotomy or Lasik, or any procedure to correct visual refractive defect
- Additional procedures routinely performed during the course of the main surgery
- Peripheral bone density scans

MEMBER BENEFITS – COVERED SERVICES – URGENT/AFTER-HOURS CARE, EMERGENCY CARE AND TRAVEL OUTSIDE OF THE COUNTRY

This section tells you about covered services and exclusions for urgent/after-hours care, emergency services and travel outside of the country.

Urgent/after-hours care

Urgent care means situations that are not life-threatening but require medical attention right away so you don't get a more serious health issue. Urgent care is not considered a life or limb-threatening emergency and does not require the use of an emergency room. By choosing an urgent care center, when appropriate, instead of an emergency room, your out-of-pocket expenses may be lower.

Where can I get urgent/after-hours care?

Benefits are provided for accident or medical care received from an urgent care center or other facility, such as a provider's office. Urgent and after-hours care received within our service area is covered only when it is provided by an in-network PCP or urgent care center or urgent care provider. When you are

temporarily out of the CHP+ HMO service area, urgent/after-hours care is covered. If you are sick, please visit your PCP before you leave town. If you receive care away from home, call your doctor within 48 hours of getting care.

Emergency Care

In case of emergency, call 911 or go to the nearest hospital or medical facility.

Emergency care is a sudden and unexpected health condition that needs immediate attention. It means that if you do not get medical attention immediately, you could have a serious injury to your bodily functions, organs, or you would put your health in serious jeopardy.

Where can I get emergency care?

Medically necessary emergency care includes emergency accident care and emergency medical care received at a hospital or other facility.

We cover emergency care that is provided at in-network or out-of-network hospitals or other facilities.

If you are unable to get to an in-network hospital, go to the nearest medical facility.

You do not need a preauthorization for in-network and out-of-network emergency care.

Unless you are too injured or ill, you should call your PCP within 48 hours of getting emergency care and let him or her know.

For locations where you can get emergency care, please see our website and provider directory located at providers2.coaccess.com/ProviderSearch/home.jsf. Just type in the hospital or urgent care.

What emergency care services are covered?

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

Post-stabilization services are also covered. These are services that the provider who saw you in an emergency says you need before you can go home or go to another place for care. Post-stabilization care services are covered services that are:

- Related to an emergency medical condition;
- Provided after you are stabilized; and

- Provided to keep your condition stable, or under certain circumstances (see below), to improve or resolve your condition

The cost-sharing amount for post-stabilization services must be the same or lower for non-plan providers as for plan providers.

You do not need to get preauthorization and are not responsible for payments related to post-stabilization services.

What do I do if I am admitted to the hospital after I get emergency care?

If you get admitted into the hospital, the emergency room copayment will be waived. This means you will not have to repay it.

Tell the hospital to make sure that CHP+ offered by Colorado Access knows you got admitted. They should do this within one business day of you getting admitted. They need to let us know so we can authorize your care.

We will authorize a certain number of days based on medical necessity, as determined by our medical policy and guidelines.

If you are treated at an out-of-network hospital in an urgent situation or for an emergency, let the hospital know that the itemized bill from the hospital must be sent to:

Colorado Access
PO Box 17470
Denver, CO 80217

If the out-of-network hospital accepts payment from CHP+ HMO, the the hospital is reimbursed directly. You will be responsible for any valid copayment amount that may apply.

If the hospital will not accept payment from CHP+ HMO, then you are responsible for paying the hospital directly.

After you pay the hospital, you can ask us to reimburse you by submitting proof that you paid for the service. An example of proof of payment is a receipt from the hospital that shows the payment or payments you made. To request a reimbursement, you will need to fill out the member reimbursement request form (available online or at the back of this Booklet) and mail it in with your receipt to:

Reimbursements
Colorado Access
PO Box 17950

Denver, CO 80217-0580

For help with this process, please call us at 303-751-9021 or 888-214-1101 (toll free).

We will review your request. Reimbursement is not guaranteed and depends on if the service is covered.

If reimbursement is approved, we will send the reimbursement directly to you. The reimbursement you receive will be at the out-of-network rate, which may not be the full amount that you paid to the hospital.

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

What emergency care services are not covered?

The following are exclusions; they are not covered emergency care services:

Do not use an emergency center for non-emergency services. It is not covered.

Follow-up care, including but not limited to, removal of stitches or dressing changes, received in an emergency room or urgent care center are not considered emergency care. You should get any follow-up care from your primary care provider (PCP).

Travel Outside the Country

Health care services provided outside of the country are covered for emergency care only. If you have an emergency outside of the country, you should go to the nearest medical facility. Let them know that the itemized bill from the hospital must be sent to:

Colorado Access
PO Box 17470
Denver, CO 80217

If the hospital agrees to bill Colorado Access and accepts payment from us, then the hospital will be reimbursed directly for covered services. You will be responsible for the copayment.

If the hospital will not accept payment from Colorado Access, you should pay the hospital.

If you have to pay the hospital directly, we encourage you to pay with a credit card because the credit card company will automatically transfer the foreign currency into U.S. dollars.

We require proof of payment (for example, a receipt and documentation of the amount paid in U.S. dollars) to reimburse you directly. Please see the directions listed earlier in this section for more information.

When you return home, contact us. We may need the medical records for the services you received. You are responsible for getting these medical records and it may be necessary to provide an English translation of the medical records.

MEMBER BENEFITS – COVERED SERVICES – AMBULANCE TRANSPORTATION SERVICES

This section tell you about covered services and exclusions for ambulance transportation services.

What ambulance transportation services are covered?

- Emergent or medically necessary ambulance transportation services are offered 24/7
- 911 calls for ambulance services
- When you ride in an ambulance from one hospital to another hospital because the first hospital is too full to accept new patients (on divert)
- When you ride in an ambulance from one hospital to another hospital because the first hospital is not equipped to provide the appropriate level of care you need
- We cover local ambulance transportation by a vehicle designed, equipped, and used only to transport you if you are sick and injured
- The vehicle must be operated by trained personnel and licensed as an ambulance. It can take you from your home or the scene of an accident or medical emergency to the closest hospital. The hospital must have appropriate emergency facilities. The ambulance can also take you from one hospital to another for medically necessary continuing inpatient or outpatient care
- Air ambulance
    - Air ambulance is only a covered benefit when the land, the distance, or the member's physical condition makes it important to get care quickly. We will decide on a case-by-case basis if transport by air ambulance is a covered benefit. If we decide that ground ambulance could have been used, the level of benefits will be limited to those for transport by ground ambulance. You will have to pay for the rest of the bill

What ambulance and non-ambulance transportation services are not covered?

The following are exclusions; they are not covered ambulance transportation services:

- Commercial transport (air or ground), private aviation or air taxi services
- Transportation by private car/automobile, commercial, or public transportation or wheelchair ambulance (ambu-cab)

- Ambulance transportation if you could have been transported by automobile or commercial or public transportation without endangering your health and/or safety
- If you elect not to receive transport to an emergency facility after an ambulance has been called, then you are responsible for any charges
- Ambulance transportation from an emergency facility to your home
- Non-emergent transportation services are not covered. This means that if you take a taxi or bus (public transportation) to and from your doctor's appointment or pharmacy, you will have to pay for it

MEMBER BENEFITS – COVERED SERVICES – OUTPATIENT THERAPIES

The section tells you about covered services and exclusions for outpatient therapies. This includes physical therapy (PT), occupational therapy (OT), and speech therapy.

Where can I get outpatient therapy?

You must get all of your care from an in-network licensed physical therapist, a licensed occupational therapist, or a licensed speech therapist.

What outpatient therapies are covered?

- Physical, occupational, and/or speech therapies are covered
- The standard CHP+ benefit is limited to 30 visits per diagnosis, per calendar year. As an extra benefit for CHP+ HMO members, we cover 10 more visits, for a total of 40 visits per diagnosis, per calendar year.
- You must start getting services within six months from the date of the injury or illness
- For children ages 0-3, the benefit for physical, occupational, and speech therapy is unlimited. This unlimited benefit only lasts through the end of the month that the child turns three years old
- After the third birthday, outpatient therapy (physical, occupational, and/or speech therapy) is limited to 40 visits per diagnosis, per calendar year
- For children ages 0-5 with a congenital defect or birth abnormality, the following services are covered and will be paid for by CHP+ HMO. The length of time and number of visits will be based on medical necessity:
    - Learning disorders
    - Stuttering
    - Voice disorders
    - Rhythm disorders

This benefit lasts through the end of the month that the child turns five years old.

To be considered covered services, outpatient therapy must meet the following conditions:

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

Physical therapy

Physical therapy is given to relieve pain, restore function, prevent disability following illness, injury or loss of a body part, development delay or prevent disability due to congenital defect or birth abnormality.

Physical therapy may involve a wide variety of evaluation and treatment techniques. Examples include manual therapy, hydrotherapy and heat, and the application of physical agents and biomechanical and neuro-physiological principles and devices.

Occupational Therapy

Occupational therapy is therapy that helps you regain independence

Speech Therapy

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

What outpatient therapy services are not covered?

The following are exclusions; they are not covered outpatient therapy services:

- Formula for any medical condition that does not meet the above requirements
- Cardiac rehabilitation programs unless following a major cardiac event
- Maintenance therapy or care provided after you have reached your rehabilitative potential as determined by CHP+ HMO
- Home programs for ongoing conditioning and maintenance
- Therapies for learning disorders, stuttering, voice disorders or rhythm disorders (unless specifically listed above). Non-specific diagnoses relating to learning-related disorders

- Therapeutic exercise equipment such as treadmills and/or weights prescribed for home use
- Membership at health spas or fitness centers
- Convenience items as determined by CHP+ HMO
- The purchase of pools, whirlpools, spas, and personal hydrotherapy devices
- Therapies and self-help programs not specifically identified above
- Recreational, sex, primal scream, sleep, and Z therapies
- Biofeedback
- Rebirthing therapy
- Self-help and weight-loss programs
- Transactional analysis, encounter groups, and transcendental meditation™
- Sensitivity and assertiveness training
- Rolfing, pilates, myotherapy, and prolotherapy
- Holistic medicine and other wellness programs
- Educational programs such as behavior modification or arthritis classes, except as otherwise specifically provided for under this Member Benefits Booklet
- Services for sensory integration disorder
- Occupational therapies for diversional, recreational, or vocational therapies (for example, hobbies, arts, and crafts)
- Acupuncture care

MEMBER BENEFITS – COVERED SERVICES – HOME HEALTH CARE AND HOME INFUSION THERAPY

This section tells you about covered services and exclusions for home health care and home infusion therapy.

Who can provide home health care and home infusion therapy?

Benefits are provided for services performed by a home health agency engaged in arranging and providing nursing services, home health aide services and other therapeutic services.

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

- Home health care services are covered only when they are needed so you don't have to be put in the hospital for care.
- Prior hospitalization is not required for home health care services.
- In order for you to get home health services, you must have a written order from your provider. Your provider will work with the home health agency to set up a care plan. A registered nurse from the home health agency will coordinate the services in the care plan.

- All home health care and home infusion therapy services require a preauthorization from CHP+ HMO. CHP+ HMO has the right to review treatment plans at any time while you are getting home health care or home infusion therapy services.
- Covered home health care services include the following:
    - Professional nursing services performed by a registered nurse (RN) or a licensed practical nurse (LPN) on a defined schedule of visits
    - Certified nurse aide services if under the supervision of a registered nurse or a qualified therapist with professional nursing services
    - Physical therapy provided by a licensed physical therapist
    - Occupational therapy provided by a licensed occupational therapist or certified occupational therapy assistant
    - Respiratory and inhalation therapy services
    - Speech and hearing therapy and audiology services
    - Medical/social services
    - Medical supplies (including respiratory supplies), durable medical equipment (rental or purchase), oxygen, appliances, prostheses, and orthopedic appliances
    - Formulas for metabolic disorders, total parental nutrition, enteral nutrition and nutrition products, and formulas for gastronomy tubes are covered for documented medical needs including attainment of normal growth and development
    - Intravenous (IV) medication and other prescription medications that are not ordinarily available through a retail pharmacy
    - Nutritional counseling by a nutritionist or dietitian
    - Home infusion therapy is also known as home IV therapy or home injection therapy. Benefits for home infusions therapy include a combination of nursing, durable medical equipment, and pharmaceutical services in the home
    - Covered home infusion therapy services include, but are not limited to, the following:
        - Antibiotic therapy, hydration therapy, and chemotherapy
        - Intra-muscular, subcutaneous, and continuous subcutaneous injections

See the *Member Benefits – Covered Services – Food and Nutrition Therapy* section for information about Total Parenteral Nutrition (TPN) and enteral nutrition.

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

The following are exclusions; they are not covered home health care and home infusion therapy services:

- Custodial care

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

MEMBER BENEFITS – COVERED SERVICES – HOSPICE CARE

This section tells you about covered services and exclusion for hospice care.

Who can provide covered services?

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

What hospice services are covered?

- We must preauthorize inpatient or home hospice services for a terminally ill member before care is received
- To be eligible for home or inpatient hospice benefits, you must have a life expectancy of six months or less, as certified by the attending provider
- Hospice care includes medical, physical, social, psychological, and spiritual services that stress palliative care for patients
- We will first approve hospice care for three months
- Benefits may continue for up to two more three-month periods, for a total of nine months. These do not have to be consecutive three-month periods
- After the three benefit periods, we will work with the provider and the hospice provider to decide if hospice care is the best care for you
- We have the right to review treatment plans while you are getting hospice care
- Coverage for hospice care is available for the following services in a member's home:
    - Hospice provider visits
    - Skilled nursing services of a registered nurse (RN) or licensed practical nurse (LPN)
    - Medical supplies and equipment supplied by the hospice provider that is used during a covered visit. If the equipment is not supplied by the hospice provider, see the *Member Benefits – Covered Services – Medical Supplies and Equipment* section.
    - Services from a licensed or certified therapist for physical, occupational, respiratory, and speech therapy
    - Medical social services provided by a qualified individual with a degree in social work, psychology, or counseling, or the documented equivalent in a combination of education,

training, and experience. Such services must be provided, at the recommendation of a provider, to assist you in coping with a specified medical condition
    - Services of a home health aide under the supervision of a registered nurse
    - Nutrition assessment, counseling, and support, such as intravenous feeding, hyperalimentation and enteral feeding
    - Benefits are also available for inpatient hospice accommodation and services
- Respite care – respite care is total care that is provided to terminally ill patients for a short period of time so that the family of the patient can have a short break
    - The patient may be placed in respite care for a period not to exceed five continuous days for every 60 days of hospice care
    - The patient may not be placed in respite care for more than two respite care stays during a hospice care benefit period (one hospice care benefit is equal to three months)
    - Mental health respite care is a covered benefit
    - All requests for respite care must come from an in-network mental health provider
    - All mental health respite care requires preauthorization and medical record review
    - Respite care is based on medical necessity and is reviewed by a CHP+ HMO behavioral health medical director

What hospice services are not covered?

The following are exclusions; they are not covered hospice services:

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

MEMBER BENEFITS – COVERED SERVICES – HUMAN ORGAN AND TISSUE TRANSPLANT SERVICES

This section tells you about covered services and exclusions for human organ and tissue transplant services.

Who can provide human organ and tissue transplant services?

Covered transplant services must be performed at designated transplant facilities.

What human organ and tissue transplant services are covered?

Coverage is available for transplant services that are medically necessary and are not experimental procedures. Benefits are provided for services directly related to the following transplants:

- Heart
- Lung (single or double) for end stage pulmonary disease only
- Heart-lung
- Kidney
- Kidney-pancreas
- Liver
- Bone marrow for a member with Hodgkin's disease, aplastic anemia, leukemia, severe combined immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II or III breast cancer or Wiskott-Aldrich syndrome
- Peripheral blood stem cell for the same procedures listed above under bone marrow
- Cornea

Services are covered based on criteria established by the medical community and by CHP+ HMO. A referral from your PCP and preauthorization from CHP+ HMO is needed before human organ and tissue transplant services. You must also follow all provisions in this benefit program.

The following guidelines must be met in order to obtain covered human organ or tissue transplant services:

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

Hospital, medical, surgical, and other services

The following hospital, surgical, medical, and other services are covered services if they are preauthorized by CHP+ HMO. See the *Managed Care* section for information on preauthorization requirements.

Hospital covered services

- Room and board for a semi-private room. If a private room is used, this benefit will only provide benefits for covered services up to the cost of the semi-private room rate unless CHP+ HMO determines that a private room is medically necessary.
- Services and supplies furnished by the hospital.
- Prescribed medication used in the hospital.
- Whole blood, administration of blood, and blood processing.
- Medical and surgical dressings and supplies.
- Care provided in a special care unit, which includes all facilities, equipment, and supportive services necessary to provide an intensive level of care for critically ill patients.
- Use of operation and treatment rooms.
- Diagnostic services, including a referral for evaluation.
- Rehabilitation and restorative physical therapy services.

Medical covered services

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

Surgical covered services

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

Other covered services

- Medically necessary immunosuppressant drugs prescribed for outpatient use in connection with a covered human organ and tissue transplant, and which are dispensed only by written prescription and approved for general use by the Food and Drug Administration.
- Transportation of the donor organ or tissue.
- Evaluation and surgical removal of the donor organ or tissue and related supplies.
- Transportation costs to and from the hospital for the recipient and for one adult. If you must temporarily relocate outside of your city of residence to receive a covered organ transplant, coverage is available for travel to the city where the transplant will be performed. Coverage is also available for the cost of reasonable lodging for you and one adult. Travel and lodging expenses for you and the accompanying adult are limited to a lifetime benefit of $10,000 per transplant under this "Human Organ Transplant" provision. The cost of lodging is limited to $100 per day. Travel expenses incurred by a donor are not applied to your lifetime travel and lodging expenses, but are applied to the maximum lifetime benefit for these transplants. Coverage is not available for travel costs associated with a pre-transplant evaluation if the travel occurs more than five days prior to the actual transplant.

As used in this section, donor refers to a person who furnishes a human organ or organ tissue for transplantation. If a donor provides a human organ or organ tissue to a transplant recipient, the following apply:

- When both the recipient and the donor are members of CHP+ HMO, each is entitled to the covered services specified in this section.
- When only the recipient is a member, both the donor and the recipient are entitled to the covered services specified in this section.
- The donor benefits are limited to those not provided or available to the donor from any other source.
- This includes, but is not limited to, other insurance coverage, grants, foundation, and government programs.
- If the donor is a member of CHP+ HMO, and the recipient is not, benefits or expenses will not be provided for the donor or recipient.
- Donor expenses are paid only after a member's initial claims for the transplant have been processed. No coverage is available to the donor after he/she has been discharged from the transplant facility.
- No benefits will be provided for procurement of a donor organ or organ tissue which is not used in a covered transplant procedure, unless the transplant is cancelled due to the member's medical condition or death and the organ cannot be transplanted to another person.

- No benefits will be provided for procurement of a donor organ or organ tissue that has been sold rather than donated.

Maximum lifetime benefit for human organ transplants

- Coverage for all covered organ transplants and all transplant-related services, including travel, lodging, and donor expenses or organ procurement is limited to a maximum lifetime benefit for major organ transplants of $1,000,000 per member.
- Amounts applied toward the maximum lifetime benefit for organ transplants include all covered charges for transplant-related services, such as hospitalizations and medical services related to the transplant and any subsequent hospitalization and medical services related to the transplant. The travel, lodging and donor expenses coverage is also applied toward the maximum lifetime benefit for organ transplant.
- A service or supply is considered transplant-related if it directly relates to a transplant covered under this CHP+ HMO Member Benefits Booklet, and is received during the transplant benefit period (up to five days before, or within one year following, the transplant).
- Exception: A pre-transplant evaluation may be received more than five days before a transplant and may be considered transplant-related (this exception does not extend to travel required to receive a transplant evaluation). Covered services received during the evaluation will be subject to the maximum lifetime benefit for organ transplants and subject to the limitation of this Human Organ Transplant benefit.
- If a member receives a covered transplant (for example, heart transplant) and later requires another transplant of the same type (for example, another heart transplant) the covered charges for the new transplant are applied to the remaining (if any) maximum lifetime benefit available per member.
- Payments under the organ transplant benefit are not applied to other specified benefit maximums.
- Expenses for covered transplant-related services in excess of the maximum lifetime benefit for organ transplants are not payable under this provision or any other portion of the CHP+ HMO Member Benefits Booklet.

What human organ and tissue transplant services are not covered?

The following are exclusions; they are not covered human organ and tissue transplant services:

- Services performed at any hospital that CHP+ HMO has not designated and approved to provide human organ and tissue transplant services for the organ or tissue being transplanted.
- Services performed if you are not a suitable transplant candidate as determined by the hospital CHP+ HMO has designated and approved to provide such services.

- Services for donor searches or donor matching, or personal living expenses related to donor searches or donor tissue matching, for the recipient or donor, or their respective family or friends.
- Any experimental or investigational transplant, treatment, procedure, facility, equipment, drug, device, service, or supply, including any associated or follow-up service or supply.
- Transplants of organs other than those listed previously in this section, including non-human organs. Services and supplies related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition that are in any way related to the artificial and/or mechanical heart or ventricular/atrial assist devices or the failure of those devices as long as any of the specified devices remain in place. This exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

MEMBER BENEFITS – COVERED SERVICES – MEDICAL SUPPLIES AND EQUIPMENT

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

Where can I get medical supplies and equipment?

The supplies, equipment, and appliances described in this section are covered benefits only if supplied by an in-network provider.

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

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

- Some supplies are subject to preauthorization requirements. See the *Managed Care* section for information about preauthorization requirements.
- Covered supplies and equipment must meet CHP+ HMO medical policy criteria.
- For more information about supplies received from a pharmacy, see the *Member Benefits – Covered Services – Outpatient Pharmacy and Prescription Medications* section.
- Durable medical equipment (DME) includes items like:
    - Crutches
    - Wheelchairs and supplies
    - Breathing equipment such as nebulizers
    - Hospital beds
    - All pumps and related supplies (other than insulin pumps)
- Durable medical equipment can be rented or purchased. This decision is up to CHP+ HMO. The rental or approved purchase of durable medical equipment, including repairs, when prescribed by a provider and required for therapeutic use (for example, wheelchair and walkers).

- Rental costs must not be more than the purchase price and will be applied to the purchase price.
- Medical equipment repair, maintenance and adjustment due to normal usage are covered if CHP+ HMO purchased the equipment or if it would have been approved. We will review other situations on a case-by-case basis.
- During the repair or maintenance of durable medical equipment, we will provide coverage for the rental of a replacement.
- Durable medical equipment used during an inpatient admission is covered as part of the inpatient hospital admission.

Prostheses and orthopedic appliance or devices – The purchase, fitting, repair and replacement, and the need for adjustments for prosthetics for arms and legs are excluded from the annual dollar amount durable medical equipment benefit limit. All other prosthetic devices, unless specifically listed in the CHP+ HMO Member Benefits Booklet are subject to the annual dollar amount durable medical equipment limit. An example of this is a neck brace.

Orthopedic appliances – Benefits for other appliances include the following:

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

Payment limit – covered services that do not apply towards the $2,000 limit:

If your primary care provider (PCP) has ordered the following medically necessary items, these items will not be subject to the maximum benefit of $2,000:

- Medical, surgical, and oxygen supplies, and orthotic shoes with the diagnosis of diabetes only.
- Medical supplies
    - Medical supplies (including casts, dressings, and splints used in lieu of casts) used during covered outpatient visits
- Disposable items received from an in-network provider and required for the treatment of an illness of injury on an inpatient or outpatient basis are covered. Benefits are provided for the following examples, but are not limited to:
    - Syringes
    - Insulin pumps and supplies
    - Needles
    - Splints
    - Other similar items that treat a medical condition

- Durable medical equipment used during a covered admission or covered outpatient visit that is owned by the facility
- Surgically implanted prosthetics or devices authorized by CHP+ HMO before you receive the device (including cochlear implants)
- Orthopedic shoes for members with a diagnosis of diabetes only
- Oxygen and oxygen supplies
    - Benefits are provided for oxygen and the rental of the equipment needed to administer oxygen (one stationary and one portable unit per member).
    - Preauthorization may be required from CHP+ HMO.
- Prosthetic and orthopedic appliances or devices
    - The purchase, fitting, repair and replacement, and the need for adjustments for prosthetics for arms and legs are excluded from the annual dollar amount durable medical equipment benefit limit. All other prosthetic devices, unless specifically listed in the CHP+ HMO Member Benefits Booklet are subject to the annual dollar amount durable medical equipment limit. An example of this is a neck brace.
    - A prosthetic device replaces all or part of a missing body part or extremity (arms and legs) to increase your ability to function.

What services are not covered?

The following are exclusions; they are not covered medical supplies and equipment services:

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

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

MEMBER BENEFITS – COVERED SERVICES – DENTAL-RELATED SERVICES

This section tells you about covered services and exclusions for dental-related services.

Routine dental coverage – Delta Dental

Dental services covered by CHP+ HMO are limited to accident-related dental services only. Delta Dental provides coverage for non-accident related dental services. Contact Delta Dental at 303-741-9300 or 800-610-0201 (toll free) for questions about dental services covered by Delta Dental for CHP+ HMO.

What dental-related services does CHP+ HMO cover?

We cover accident-related services, inpatient services for dental-related services, and cleft palate and cleft lip conditions. This Booklet provides coverage for health conditions and should not be considered as the member's dental coverage. All dental services and supplies are subject to preauthorization guidelines. See the *Managed Care* section for information about preauthorization guidelines.

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

What dental services can be performed by my PCP?

Fluoride varnish services

This section tells you about covered services and exclusions for fluoride varnish services when provided by a primary care provider (PCP) office. The fluoride varnish may also be provided by an in-network dentist. See the *Member Benefits – Covered Services – Dental-Related Services* section of this Booklet.

Where can I get covered fluoride varnish services?

You can get fluoride varnish services from an in-network PCP.

Fluoride varnish benefits – covered by your PCP

- Services provided by an in-network PCP do not require prior authorization.
- Up to two fluoride varnish treatments in a calendar year
- For children ages 0 through 4
- The fluoride varnish must be received at an in-network PCP office
- PCP must also perform a risk assessment at the time of the fluoride varnish treatment
- PCP must have received the appropriate training for the fluoride varnish treatment

Fluoride varnish benefits – not covered (exclusions)

- Children ages 5 and older
- Services obtained from an out-of-network PCP.
- Services obtained from a provider who is not a PCP.
- Fluoride varnish treatment that does not include a risk assessment performed by the PCP

Dental anesthesia – CHP+ HMO covers the following dental anesthesia services:

General anesthesia when provided in a hospital, outpatient surgical facility or other facility. The associated hospital or facility charges for dental care. In order for dental anesthesia services to be covered, you must:

- Have a physical, mental, or medically compromising condition;
- Have dental needs for which local anesthesia is not effective due to acute infection, anatomic variation, or allergy;
- Be considered extremely uncooperative, unmanageable, uncommunicative, or anxious by your provider and your dental needs must be deemed sufficiently important that dental care cannot be deferred; or
- Have sustained extensive oral, facial, and dental trauma

Inpatient admission for dental care

When medically necessary, CHP+ HMO covers inpatient facility services related to dental care, including room and board. Delta Dental covers eligible dental services.

Cleft lip and cleft palate

CHP+ HMO covers the following services in connection with cleft lip and/or cleft palate when provided by or under the direction of a provider, and are included to the extent medically necessary. Coverage is

provided only if you do not have an effective dental insurance policy or plan at the time the following services are received:

- Oral and facial surgery, surgical management, and follow-up care by plastic surgeons or oral surgeons
- Prosthetic treatment such as obturators, speech appliances, and feeding appliances
- Medically necessary orthodontic treatment
- Medically necessary prosthodontic treatment
- Habilitative speech therapy
- Otolaryngology treatment
- Audiological assessments and treatment

Medically necessary speech therapy visits related to cleft palate or cleft lip condition are unlimited. These speech therapy visits are applied toward the 30 therapy visit maximum but are not limited to the maximum visits.

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

The following dental-related services are not covered (exclusions):

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

MEMBER BENEFITS – COVERED SERVICES – FOOD AND NUTRITION THERAPY

This section tells you about covered services and exclusions for food and nutrition therapy.

Who can supply food and nutrition services?

An in-network licensed therapist or home health agency must provide the nutrition service. Covered medical foods require a prescription from your provider and you must get them through an in-network pharmacy. You will have to pay the pharmacy copay.

What food and nutrition services are covered?

We cover enteral (tube feeding) therapy and Total Parenteral Nutrition (TPN), which includes a combination of nursing, durable medical equipment, and pharmaceutical services.

The durable medical equipment and supplies related to food and nutrition services are subject to the payment limit described in the *Member Benefits – Covered Services – Medical Supplies and Equipment* section.

All services must be preauthorized. See the *Managed Care* section for information about preauthorization guidelines.

- Enteral therapy and Total Parenteral Nutrition (TPN)
    - Enteral therapy is delivery of nutrients by a tube into gastrointestinal tract.
    - Medically necessary and non-custodial nursing visits to assist with enteral nutrition are covered under the home health benefits. These services are usually provided by a home health agency. For more information, see the *Member Benefits – Covered Services – Home Health Care and Home Infusion Therapy* and the *Member Benefits – Covered Services – Hospice Care* sections.
- TPN is the delivery of nutrients through an intravenous line directly into the bloodstream
    - Medically necessary TPN received in the home is a covered benefit for the first 21 days following a hospital discharge.
    - If medically necessary, additional days may be allowed up to a maximum of 42 days per calendar year as determined to be medically necessary and when preauthorized by CHP+ HMO.
- Medical foods
    - CHP+ HMO covers medical foods for home use for metabolic disorders
    - Covered medical foods must be prescribed by your provider
    - CHP+ HMO covers medical foods that are appropriate for inherited enzymatic disorders involved in the metabolism of amino, organic, and fatty acids. Such disorders include phenylketonuria, maternal phenylketonuria, maple syrup urine disease, tryosinemia, homocystinuria, histidemia, urea cycle disorders, hyperlysinemia, glutaric acidemias, mathylmalonic academia, and propionic academia.

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

What food and nutrition services are not covered?

The following are exclusions; they are not covered food and nutrition therapy services:

- Enteral feedings, except as provided previously in this section.
- Tube feeding formula, except as provided previously in this section
- Weight-loss programs, exercise equipment, exercise classes, health club memberships, personal trainers, prescription over-the-counter medications for weight loss, or obesity treatment (except medically necessary surgical treatment or as provided previously in this section), even if the extra weight or obesity aggravates another condition
- Food, meals, formulas, and supplements, other than those listed previously in this section, even if the food, meal, formula, or supplement is the sole source of nutrition, except as provided previously in this section
- Breastfeeding education and baby formulas
- Feedings clinics

MEMBER BENEFITS – COVERED SERVICES – MENTAL HEALTH AND SUBSTANCE ABUSE CARE

This section tells you about covered services and exclusions for mental health and substance abuse care

Mental Health

How do I get mental health services?

You do not need a referral from your primary care provider (PCP) for mental health services. CHP+ HMO will work with you and your mental health provider to determine medical necessity, the appropriate treatment level and the appropriate setting for mental health services. Some mental health services may require preauthorization. You must call us at 303-751-9021, toll free 888-214-1101, or TTY for the deaf or hard of hearing at 720-744-5126 or toll free at 888-803-4494 to determine if the mental health services you are receiving require preauthorization. If you do not get preauthorization or if you receive services from a provider other than the provider preauthorized by CHP+ HMO, the services will not be covered. Counselors who know sign language and sign language interpreters are available. If you are receiving services from a mental health professional at the time of your enrollment, please call Customer Service to see if an authorization is required. If the mental health professional you are seeing is out-of-network, then you will need an authorization for more visits. A care manager will help you change your care to an in-network provider, if needed. CHP+ HMO must be notified about all emergency admissions, including those that occur on weekends or holidays, by the next business day.

What mental health services are covered?

Outpatient treatment – CHP+ HMO covers outpatient mental health services. Covered outpatient treatments do not require preauthorization if the provider is in-network with CHP+ HMO. Covered services include, but are not limited to:

- Individual counseling

- Family counseling
- Group counseling
- Case management services
- Medication management – CHP+ HMO covers medication management of mental health conditions by a medical provider, psychiatrist, or nurse that is legally allowed to write prescriptions (prescriptive authority)
- Day treatment – day treatment services are for specific mental health and educational needs and are sometimes part of the individual education plan (IEP). Covered day treatment services require preauthorization. Day treatment services can include, but are not limited to:
    - Individual counseling
    - Family counseling
    - Group counseling
    - Educational support services
- Case management – A CHP+ HMO case manager can help you:
    - Get the right care from doctors, providers, schools, and other programs
    - Help you find resources (such as food, clothing, and housing)

If you would like information about case management, please call Customer Service.

Emergency Services – Please see the *Member Benefits – Covered Services – Urgent/After-Hours Care, Emergency Care and Travel Outside of the Country* section for more details.

If you have a mental health emergency or crisis, go directly to the nearest emergency room or call 911.

Emergency services are available 24 hours a day, 7 days a week.

Inpatient services – CHP+ HMO covers medically necessary inpatient stays to treat mental health conditions. Covered inpatient stays do require preauthorization. Inpatient stays are a 24-hour a day mental health service provided for you in a hospital for the care of a mental illness. Covered services include:

- Provider visits received during a covered inpatient stay
- Inpatient semi-private room or ancillary services
- Group psychotherapy
- Family counseling with family members to help in your diagnosis and treatment
- Medication management

Residential treatment services – the same services covered as inpatient services are also covered for residential treatment services. Residential treatment services are services in a licensed residential

facility that can provide day services and 24-hour supervision after day program. Residential treatment services do require preauthorization and are approved only if the charges are equal to or less than partial hospitalization.

Home-based services – these are specialized mental health services that you get in your home when traditional mental health services have not been effective. Home-based covered services do require a preauthorization.

Evaluation/assessment – An evaluation (also called an assessment) is a way to find out your mental health needs and to find out the best kind of care for you. Covered services may require preauthorization. Please call Customer Service with questions about preauthorization.

Autism spectrum disorder – treatment for the diagnosis of autism spectrum disorder is a covered benefit when the treatment is medically necessary, appropriate, habilitative or rehabilitative care, such as physical therapy, occupational therapy, and speech therapy for fine and gross motor delays, and psychiatric/psychological services. See the *Member Benefits – Covered Services – Mental Health and Substance Abuse Care* section of this Booklet for details. Applied Behavioral Analysis (ABA) therapy is not a covered benefit of CHP+ HMO.

More services – if you have questions about other mental health services that are not listed, please call us at 303-751-9021, 888-214-1101 (toll free), or TTY for the deaf or hard of hearing at 720-744-5126 or 888-803-4494 (toll free).

Substance Abuse

How do I get substance abuse services?

You do not need a referral from your primary care provider (PCP) for substance abuse treatment. CHP+ HMO will work with you and your substance abuse provider to determine medical necessity, the appropriate treatment level and the appropriate setting for substance abuse services.

Some services may need to be preauthorized. You must call us at 303-751-9021, toll free at 888-214-1101, or TTY for the deaf or hard of hearing at 720-744-5126 or toll free at 888-803-4494 to find out if the substance abuse services you are getting need a preauthorization. If you do not get preauthorization or if you get services from a provider other than the provider that was preauthorized by CHP+ HMO, the services will not be covered and you will have to pay for them.

Substance abuse providers who know sign language and sign language interpreters are available.

If you are getting services from a substance abuse provider at the time of your enrollment, please call us to see if an authorization is needed. If the mental health professional you are seeing is out-of-network,

then authorization for additional visits will be needed. A care manager may assist in transitioning your treatment to an in-network provider if appropriate. CHP+ HMO must be notified about all emergency admissions, including those that occur on weekends or holidays, by the next business day.

What substance abuse services are covered?

CHP+ HMO covers medically necessary outpatient and inpatient substance abuse treatments.

- Covered outpatient services do not require a preauthorization
- Inpatient substance abuse treatments require preauthorization

What mental health and substance abuse services are not covered?

The following are exclusions; they are not covered mental health and substance abuse care services:

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

Smoking cessation programs

If you smoke and want to quit, contact your primary care provider (PCP). He or she can provide you with additional resources and/or help you create a plan to quit smoking. You can also call the Colorado Quitline at 800-QUITNOW (800-784-8669) for help to quit smoking. You must be at least 15 years old to

participate in the Quit Program. The services offered to you by the Quit Program are a benefit of CHP+ HMO. This includes information and support to help you quit smoking. When you call, give them your CHP+ HMO ID number and services will be provided to you free of charge.

MEMBER BENEFITS – COVERED SERVICES – OUTPATIENT PHARMACY AND PRESCRIPTION MEDICATION

This section tells you about covered services and exclusions for outpatient pharmacy and prescription medications.

Where can I get prescription medication?

CHP+ HMO has a nationwide network of retail pharmacies. The pharmacy network is large and includes most Colorado pharmacies. A list of in-network pharmacies is in your provider directory, which can be found online at coaccess.com/chp-member-information. You can also call us at 303-751-9021 or 888-214-1101 (toll free) or TTY for the deaf or hard of hearing at 720-744-5126 or 888-803-4494 (toll free).

To get prescription medications, go to an in-network retail pharmacy. Give the written prescription from your provider and your CHP+ HMO ID card to the pharmacist.

Do I have a prescription medication copayment?

Some members of CHP+ HMO have a prescription medication copayment. If you have a copayment, your copayment amount will be listed on your CHP+ HMO ID card. If you have a prescription medication copayment, the retail pharmacy will ask for it before they give you the medication. If you are filling more than one prescription, separate copayments are required for each covered medication or supply. If the retail price of the medication is less than your copayment amount, you will pay the retail price. The copayment will not be reduced by any discounts or rebates. CHP+ HMO does not pay for any covered medication or supply unless the negotiated rate exceeds any applicable copayment for which the member is responsible.

What prescription medications are covered?

CHP+ HMO covers a 30-day supply of a prescription medication from an in-network pharmacy. Coverage guidelines and quantity limits may apply. Please see the formulary list for more information. The formulary list is available online at coaccess.com/chp-forms-and-documents.

For these medication to be covered by CHP+ HMO, you need a prescription from your provider. Bring the prescription to an in-network retail pharmacy. For more information on getting prescription medications, please read the information located below the heading *Where can I get prescription medications* in this section.

- Oral contraceptives are limited to one pill pack (normally 28 days) per month at an in-network retail pharmacy.
- When medically necessary, a one-month vacation override is available if you are traveling out of the service area.
- For certain prescription medications, the prescribing provider may be asked to send additional information to CHP+ HMO to determine medical necessity.
- CHP+ HMO may, at its sole discretion, establish quantity limits for specific prescription medications.
- Covered services will be limited based on medical necessity, quantity limits established by CHP+ HMO, or utilization guidelines.
- CHP+ HMO covers over 200 over-the-counter medications like Tylenol and vitamins with a prescription from your doctor.
- Epi-Pens are covered with a prescription from your doctor.

Formulary list

CHP+ HMO uses a formulary list. This is a list of medications covered by CHP+ HMO. The current formulary is available at coaccess.com/chp-forms-and-documents. If you would like a paper copy, please contact us at 303-751-9021 or 888-214-1101 (toll free) or TTY for the deaf or hard of hearing at 720-744-5126 or 888-803-4494 (toll free).

The formulary list promotes and enforces the appropriate use of medications by reviewing for improper dosage, potential drug-to-drug interactions, or drug-pregnancy interaction.

If your provider prescribes a medication that is not on the formulary list, the medication requires preauthorization.

The formulary list is subject to review and may be changed. Inclusion of a medication or related items on the formulary list is not a guarantee of coverage.

Prescription medication preauthorization

Certain prescription medication or the prescribed quantity of a particular medication may require preauthorization. A list of the prescription medications that require preauthorization can be found on the formulary list. If you need a prescription medication that requires preauthorization, the provider that prescribed the medication should contact CHP+ HMO. If preauthorization is denied, you can appeal the decision by following the instructions in the *Grievances and Appeals* section.

If your doctor does not get preauthorization, and you try to fill the prescription, the in-network retails pharmacist will let you know that the medication requires preauthorization. You will need to contact the

provider that prescribed the medication and ask them to send information to CHP+ HMO. If you need help, please call us.

Inpatient pharmacy benefits

CHP+ HMO covers medications provided during a covered inpatient stay when the medications are billed by a hospital or other facility. See the *Member Benefits – Covered Services – Inpatient Hospital Services* section for information about inpatient care.

Other benefits

For benefit information about special foods and formulas for metabolic and nutritional needs, see the *Member Benefits – Covered Services – Food and Nutrition Therapy* section. See the *Member Benefits – Covered Services – Home Health Care and Home Infusion Therapy* section for benefit information about home intravenous (IV) therapy.

If you do not get certain supplies, equipment, and appliances through an in-network pharmacy, they may be covered as medical supplies or durable medical equipment. See the *Member Benefits – Covered Services – Medical Supplies and Equipment* section for benefit information about medical supplies and durable medical equipment.

What do I do if I pay for medication that is covered by CHP+ HMO?

If you do not have your ID card when you go to an in-network pharmacy, or you fill a prescription at an out-of-network pharmacy, you may be charged for the full cost of the prescription medication.

If you pay the full charge for a covered prescription medication, please follow these steps:

Ask the pharmacist for an itemized receipt that shows that you paid for the covered prescription medication. Please include your name and address.

Mail the itemized receipt along with a written request for reimbursement to:

Colorado Access
Reimbursements
PO Box 17950
Denver, CO 80217-0950

We will review your request for reimbursement and the itemized receipt. If the medication that you paid for is not on the formulary list or requires preauthorization, we may request information from the provider that prescribed the medication to review the medical need of the medication.

If your request is approved, you will be reimbursed based on the charge for the covered medication, minus any applicable copayment. Prescription medications dispensed in excess of a 30-day supply are not reimbursable.

What prescription medications are not covered?

The following are exclusions; they are not covered outpatient pharmacy and prescription medication services:

- Prescription medications and supplies received from an out-of-network pharmacy.
- Unless specifically noted above or in the CHP+ HMO formulary list, non-prescription and over-the-counter medications are not covered. This includes herbal or homeopathic preparations; prescription medications with an over-the-counter bioequivalent, even if it is written as a prescription; and medications not requiring a prescription by federal law (including medications requiring a prescription by state law, but not federal law), except for injectable insulin. Some prescription medications may not be covered even if the member receives a prescription order from a provider.
- Medications prescribed for weight control or appetite suppression.
- Medications or preparations used for cosmetic purposes to promote or prevent hair growth, or medicated cosmetics including, but not limited to, Rogaine®, Vaniqa®, and Tretinoin (sold under such brand names as Retin-A®).
- Any medication, product or technology within six months of the Food and Drug Administration (FDA) approval. CHP+ HMO may, at its sole discretion, waive this exclusion in whole or in part for a specific new FDA-approved medication product or technology.
- Any medications used to treat infertility.
- Standard CHP+ HMO benefits do not cover special formulas, food or food supplements (unless for metabolic disorders); see the *Member Benefits – Covered Services – Food and Nutrition Therapy* section for benefit information.
- Delivery charges for prescriptions.
- Charges for the administration of any medication, unless it is dispensed in the provider's office or though home health services.
- Medications provided as samples to the provider.
- Antibacterial soap/detergent, toothpaste/gel, shampoo, or mouthwash/rinse.
- Hypodermic needles, syringes or similar devices, except when they are used for administration of a covered medication when prescribed in accordance with the terms of this section.
- Therapeutic devices or appliances, including support garments and other non-medicinal supplies (regardless of intended use).

- Prescription medications dispensed in quantities that exceed the applicable limits, which are established by CHP+ HMO at its sole discretion.
- Refills that exceed the quantity prescribed by the provider or that are refilled more than one year from the date of such order.
- Prescription medications intended for the treatment of sexual dysfunction or inadequacy, regardless of origin or cause (including medications, such as Viagra®, for the treatment of erectile dysfunction).
- Prescription medications dispensed for the purpose of international travel.

MEMBER BENEFITS – COVERED SERVICES – AUDIOLOGY SERVICES

This section tells you about covered audiology services.

Where can I get audiology services?

You must get audiology services from an in-network audiologist or hearing center.

What audiology services are covered?

The following audiology services are covered:

- Age-appropriate hearing screenings for preventive care.
- Newborn hearing screening and follow-up for a failed screen.
- One hearing aid every five years. Additional hearing aids can be provided if medically necessary, including:
    - A new hearing aid when alteration to the existing hearing aid cannot adequately meet your needs.
    - Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

MEMBER BENEFITS – COVERED SERVICES – VISION SERVICES

This section tells you about covered services and exclusions for vision services.

Where can I get covered vision services?

You must get routine and specialty visions services (office visits for routine eye exams) from an in-network ophthalmologist or optometrist. Routine eye exams are not covered if you go to an out-of-network provider.

Lenses, frames, and/or contacts can be purchased from an in-network or out-of-network provider, subject to benefit limits.

What vision services are covered?

- Routine vision services do not require preauthorization.
- Age-appropriate vision screenings and routine eye exams.
- One routine eye exam is covered per calendar year.
- The CHP+ HMO benefit provides a $150 credit per member, per calendar year towards the purchase of lenses, frames, and/or contacts. Lenses, frames, and/or contacts can be purchased from an in-network or out-of-network provider.
- Specialty vision services to contracted providers. A specialty vision service is when you see a vision provider for something other than a routine exam.
- Some specialty vision treatments may require a preauthorization.

What vision services are not covered?

The following are exclusions; they are not covered vision services:

- Vision therapy
- Specialty vision treatment services received without a preauthorization, if an authorization is required.
- Services related to refractive keratoplasty, radial keratotomy, or any procedure designed to correct vision.

7: General Exclusions & Limitations

This list of exclusions describes services that are not covered by CHP+ HMO. This is not a complete list of all services, supplies, conditions, or situations that are not covered services. If you have questions about covered benefits or exclusions, please call us at 303-751-9021 or 888-214-1101 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

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

REMEMBER:

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

We will not cover the following services, supplies, situation, or related expenses: (This is not intended to be an inclusive list of all non-covered services)

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

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

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

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

Applied Behavioral Analysis (ABA Therapy) – This coverage does not cover applied behavioral analysis therapy services.

Before effective date – This coverage does not cover any service received before the member's effective date of coverage with CHP+ HMO.

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

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

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

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

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

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

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

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

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

Cosmetic services – This coverage does not cover cosmetic procedures, services, equipment or supplies provided for psychiatric or psychological reasons, to change family characteristics or to improve appearance.

This coverage does not cover services required as a result of a complication or outcome of a non-covered cosmetic service.

Some examples of cosmetic procedures include, but are not limited to, face lifts, botox injections, breast augmentation, rhinoplasty, and scar revisions.

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

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

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

Dental services – Dental services are provided by Delta Dental unless specifically listed in the *Member Benefits – Covered Services – Dental-Related Services* section.

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

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

Discharge from facility (services received beyond the preauthorized discharge date) – This coverage does not cover services that are provided after discharge date indicated in the preauthorization from CHP+ HMO. The appropriate discharge date is determined based on managed care guidelines.

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

Double coverage – Double coverage refers to having both CHP+ HMO and another insurance coverage, such as Health First Colorado or a commercial plan, at the same time. You cannot be eligible or covered by another insurance except for dental and Medicare while enrolled with CHP+ HMO.

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

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

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

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

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

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

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

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

Learning deficiencies – This plan does not cover special education, counseling, therapy, rehabilitation or care for learning deficiencies, whether or not associated with retardation or other disturbance.

Maintenance therapy – This coverage does not cover any treatment that does not significantly enhance or increase your ability to function or how productive you are, or care provided after you reach your maximum medical improvement as determined by CHP+ HMO, except as provided in the *Member Benefits – Covered Services* section of this Booklet.

Medical necessity – This coverage does not cover expenses for services and supplies that are not medically necessary. Coverage of services may be denied before or after payment, unless the services were preauthorized.

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

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

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

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

- Health spa or health fitness centers (whether or not services are provided by a licensed or registered provider)

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

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

- Adoption or surrogate expenses
- Educational classes and supplies not provided by the member's health care provider, unless specifically allowed as a benefit listed in this Booklet
- Vocational training services and supplies
- Mailing and/or shipping and handling expenses
- Interest expenses and delinquent payment fees
- Modifications to home, vehicle or workplace, regardless of medical condition or disability
- Membership fees for spas, health clubs, or other such facilities, or fees for personal trainers, even if medically recommended and regardless of any therapeutic value
- Personal convenience items such as air conditioners, humidifiers or exercise equipment
- Personal services such as haircuts, shampoos, guest meals, and radios or televisions
- Voice synthesizers or other communication devices, except as specifically allowed by CHP+ HMO

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

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

Over-the-counter (OTC) drugs/medications – Unless noted as covered in this Booklet (see the *Member Benefits – Covered Services – Outpatient Pharmacy and Prescription Medications* section) or the formulary list, this coverage does not cover non-prescription and over-the-counter medications. This includes herbal or homeopathic preparations; prescription medications with an over-the-counter

bioequivalent, even if it is written as a prescription, and medications not requiring a prescription by federal (including medications requiring a prescription by state law, but no federal law), except for injectable insulin. Some prescription medication may not be covered even if the member receives a prescription order from a provider.

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

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

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

Professional or courtesy discount – This coverage does not cover any services when the member's portion of the payment is waived due to a professional courtesy or discount.

Radiology services – This coverage does not cover Ultrafast CT scan and peripheral bone density testing. This coverage does not cover whole body CT scan for non-medical routine screening.

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

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

Sex-change operations – This coverage does not cover services or supplies related to sex-change operations, reversals of such procedures, and complications of such procedures or services received before any such operation.

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

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

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

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

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

Tubal ligation – This coverage does not cover tubal ligations.

Vasectomies – This coverage does not cover vasectomies.

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

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

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

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

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

Have questions? Need help?
We are here to help you in the language you speak! Free interpretation services are available
Call us at 303-751-9021 or 888-214-1101 (toll free)
TTY users should call 720-744-5126 or 888-803-4494 (toll free)
Email us at customer.service@coaccess.com

8: Managed Care

This section explains managed care. To make sure you are getting the right health care for your needs, we use some managed care tools or processes. This includes:

- Preauthorization for health care services
- Concurrent hospital review
- Care management and disease management
- Advance Medical Directives

PREAUTHORIZATION FOR HEALTH CARE SERVICES

This section will also help you understand what you need to do to get the right care.

For some services, you need to get a preauthorization from us before you can get the service. This includes some procedures, testing to find out what is going on (diagnostic tests), durable medical equipment, home health services, and medication. When you have to stay at the hospital (get admitted), except in emergency situations, you need to get a preauthorization. Please see the *Member Benefits – Covered Services* section of this Booklet for more information.

The provider who wants you to get more services or thinks you need to stay at the hospital is responsible for getting the preauthorization.

We look at every preauthorization request. We need to make sure the service or supply is:

- A covered benefit
- Medically necessary (it is right for you, in the right place, and in a medically-appropriate setting)

The preauthorization process may set limits on your coverage. For example, we may say that only a certain number of visits will be covered (paid for). If your provider feels that you need more visits, he or she can ask for more by doing another preauthorization request. Coverage is limited to the benefits that are listed in this Booklet.

A preauthorization does not mean a services or supply will be covered (paid for). Fraud or abuse may cause a claim to be denied. This means we will not pay for it. Also, when a claim is received, we use this Booklet as a tool to see if it is covered (paid for). If we get a claim for a service that is not covered, the claim may not be paid (denied). The claim may also be denied if the service on the claim is different than the service that was preauthorized.

If you have any questions about preauthorization, please call us at 303-751-9021 or 888-214-1101 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

Adverse Service Determinations (Denial of Services)

An adverse service determination (denial) means that we did not approve the preauthorization request. CHP+ HMO will send you and your provider a letter for all adverse service determinations. You can appeal the decision by following the process in the *Grievance and Appeals* section of this Booklet.

Covered Benefit Decisions

To decide if a service is a covered benefit, we look at:

- If the service is right for you (medically necessary);
- If the service is experimental or still being investigated;
- If the service is cosmetic, and
- If the service is excluded under this coverage.

To help make this decision, we use a number of tools, including:

- Our medical policies and practice guidelines;
- Current medical information;
- Guidelines from well-known national organizations and professional groups, and
- Meetings with specialists

We do not promote or give any incentive to our employees or provider reviewers for denying medically necessary services that our members need and are entitled to.

MEDICALLY NECESSARY HEALTH CARE SERVICES

We only cover medically necessary services, procedures, supplies, or visits (except as otherwise provided in this Booklet). To help decide if a service is medically necessary, we use:

- Medical policies
- Medical practice guidelines
- Professional standards
- Outside medical peer reviews

Medical Policies

We made our medical policies after studying recent standards of care and scientific information. The benefits, exclusions, and limitations of a member's coverage take priority over the medical policy. This means that if a service is listed as excluded or not covered in this Booklet, it will not be paid for (not covered), regardless of whether or not it meets the standards set forth by the medical policy.

To make sure that our medical policies are current, we review and update them on a regular basis.

Experimental/Investigational and/or Cosmetic Procedures

We will not pay for any services, procedures, surgeries or supplies that we consider experimental/investigational and/or cosmetic. Since these services are not covered, we will not pay for complications that are the result of any service, procedure, surgery, or supply that we consider experimental/investigational and/or cosmetic.

Excluded Services

Excluded services are the services listed as not covered, or excluded, in this Booklet. See the *General Exclusions and Limitations* section.

APPROPRIATE SETTING

Health care services can be provided in an inpatient or outpatient setting. The appropriate setting depends on how serious the medical condition is and on the services needed to take care of the condition.

We cover both inpatient and outpatient care, as long as the care is provided in the appropriate setting, preauthorized, if required, and is medically necessary.

Scheduled Inpatient Admissions

Examples of inpatient settings include:

- Hospitals
- Skilled nursing facilities
- Hospice care

All inpatient stays require a preauthorization. Your provider must contact us to ask for the authorization before scheduling inpatient admissions. A preauthorization is good only for a specific place and during specific dates. You can only get the approved service at the specific place and during the specific dates listed in the preauthorization. If you do not get the service during the specific dates, or if you need more services, your provider must contact us again to ask for another authorization. We will review the request. If the request is approved, all covered services will be paid for. We may ask for more information to make sure the service is a medical necessity. Some of the things used to help make this decision are medical policies and medical care guidelines. The medical care guidelines include inpatient and surgical care optimal recovery guidelines. By using these guidelines and encouraging education, you are more likely to have better outcomes.

Inpatient stay charges are covered when authorized by CHP+ HMO, otherwise you may have to pay for all charges linked to your inpatient stay.

We work with your providers to decide how long an inpatient stay should be. We will authorize a certain number of days for the inpatient stay. If your provider requests more days, we will review that request. We may also review your stay while you are in the hospital if it goes over the number of days authorized.

If we find that more time in the hospital is not medically necessary, we will let the hospital and provider know the day you should go home (recommended date of discharge). The hospital will let you know about our decision in a timely manner. If you decide to stay in the hospital after they let you know, we will not pay for the services you get after the date we think you should go home (recommended date of discharge). You will have to pay for all charges after the recommended date of discharge. We will send you, your provider, and the hospital a written letter (notification) about our decision. If you do not agree with the decision, you can appeal by following the procedures in the *Grievance and Appeals* section.

Emergency (Unscheduled) Admissions

It is your responsibility to make sure that we know about an emergency admission, unless you are unable to do so, within one business day of being admitted. An example of an emergency admission is when a member is admitted to the hospital after an accident or serious illness. Once we know, we will help you manage your hospital benefits. We will also help you plan during hospitalization and after you are let go (discharged). If you do not make sure that we know of an emergency admission, your claims may not be paid or your coverage may be denied.

Outpatient Procedures

Examples of outpatient settings include:

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

Outpatient services may be performed in a hospital on an outpatient basis or in another facility, like an ambulatory surgery center.

Some procedures performed in an outpatient setting must be preauthorized. Your health care provider must call and ask for a preauthorization. If a preauthorization is required for a procedure, your provider must contact us to ask for the authorization before scheduling the procedure. We may ask your provider for more information to decide if the service is medically necessary.

A preauthorization is good only for a specific place and during specific dates. You can only get the approved service at the specific place and during the specific dates listed in the preauthorization. If you

do not get the service during the specific dates, or if you need more services, your provider must contact us again to ask for another authorization.

Concurrent Hospital Review

While you are in the hospital, we will review your medical care to make sure you are getting the right care and services. This is called concurrent review.

RETROSPECTIVE CLAIM REVIEW

When claims are sent to us, in order to decide if the service is covered, we may do a retrospective claim review. A retrospective claim review is when we review charges for services that have already been given to you. We do this to find out:

- If the services were preauthorized, and
- If the claim was correct (covered benefit, complies with medical policy, and is medically necessary)

We may look at your medical records to help make payment decisions. If we decide that services are not covered, we will not pay for the charges.

ONGOING CARE NEEDS

Ongoing care is coordinated through services like utilization management, care management, and disease management.

UTILIZATIONS MANAGEMENT

We made our utilization management program after studying nationally recognized guidelines. Utilization management is used to decide if you are getting the right care, at the right time, in the right place. Utilization review may be used to decide how much we will pay for a covered service. However, the decision to get the service is made by you and your provider. We do not make covered service determinations or utilization review determinations based on the grounds of moral or religious beliefs. If you are refused a covered service based on moral or religious beliefs, please contact our customer service department. They will assist you in finding a different provider who will provide the covered services you need.

To better understand how the utilization management program decides if a service is medically necessary, please call us at 303-751-9021 or 888-214-1101 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free). If you disagree with a decision and would like to file an appeal, please see instructions in the *Grievances and Appeals* section.

CARE MANAGEMENT AND DISEASE MANAGEMENT

Our care management and disease management teams are made up of health care professionals called health coaches, care managers or transition coordinators. Our team has knowledge about many different health and disease conditions.

Care management is a way that we help members with serious illnesses or injuries. A serious illness or injury can be very hard to heal with. Having a point person to work with often makes things a lot easier to manage. In a case like this, a care manager may work with the member to coordinator or facilitate medical care. The care management program works to find patients who could benefit from care management as early as possible. The care manager works to create a care plan for the member. They will also help put the care plan into action and make sure it's working. They make sure the member is getting the right care, at the right time, in the right place. They also help make sure your providers are talking to each other.

Care management is designed for each individual member in the program. In some cases, we may, at our sole discretion, provide benefits for care that is not listed as covered services. We may also extend covered services beyond the contractual benefit limits of this coverage. These decisions will be made on a case-by-case basis. If we decide to extend the benefit or approve care not listed as a covered service, it does not mean that we are obligated to provide the same benefits again to that member or to any other member. We can (reserve the right to), at any time, alter or cease providing extended benefits or approving care not listed as a covered service. In such cases, we will let the member know in writing. Also, the member may never have contact with the assigned case manager. However, care coordination can still be conducted on behalf of the member.

Getting Involved in Care Management

There are many ways for members to get in the care management program.

- We can identify members and contact them
- Provider may refer their CHP+ HMO patients
- You can contact us at 303-751-9021 or 888-214-1101 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

ADVANCE MEDICAL DIRECTIVES

Advance medical directives say what kind of medical care you want if you get too sick or hurt to talk or think clearly. Advance medical directives:

- Protect your right to make medical decisions and choices about your health care
- Help family members make decision if you cannot

Help your doctor by telling them your wishes.

There are three kinds of advance medical directive:

Living Will

A living will tells your doctor whether to use artificial life support if you become "terminally ill" (deathly sick). Copies of living will forms are at health care facilities, doctors' offices, or office supply stores. You can also get them from the Guardianship Alliance of Colorado by calling 303-228-5382.

Medical Durable Power of Attorney

A "medical durable power of attorney" is a person you choose to make health care choices for you if you cannot speak for yourself.

Cardiopulmonary Resuscitation (CPR) Directive

CPR is performed to get someone's heart and/or breathing started again. If you have a CPR directive, medical staff will not try to get your heart or breathing started.

You will get more information on advance medical directives if you are admitted to a hospital. You are not required to have one. If you decide to have or change an advance medical directive, it is important to talk to you doctor, family, and other people about your choices. Give copies of your advance medical directive to your doctor, family members, and health care proxy, if you have one.

What happens if your advance medical directive isn't followed?

You can file a grievance with CHP+ HMO by calling 720-744-5134 or 877-276-5184 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free). Please see the *Grievances and Appeals* section for more information.

Call the Colorado Department of Public Health and Environment at 303-692-2980. Or write to:

Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South
Denver, CO 80246-1530

If you would like to learn more about the state applicable laws concerning advance medical directives, go to our website at coaccess.com/advance-directives.

9: Coordination of Benefits & Subrogation

We will not coordinate benefits with any other coverage except Medicare, dental, vision, or COBRA coverage. Qualifying for CHP+ HMO is contingent upon the absence of other insurance coverage excluding the Colorado Indigent Care Program and Health Care Program for Children with Special Needs (HCP). If you are covered by any other valid coverage, including Health First Colorado and individual non-group coverage, you are not eligible for CHP+ HMO.

If you get other coverage, you must call the state's medical assistance program at 800-359-1991, or contact us at 303-751-9021 or 888-214-1101 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free). If you are found to have other insurance, CHP+ HMO coverage will be terminated (ended). In some cases, coverage will retroactively terminate for the time period the other insurance was effective. This means that we will go back and end your coverage on the date that your other insurance became effective (started). You may be responsible to pay for any medical services you had during that time. The exceptions to this rule are Medicare, dental, vision, and COBRA.

COORDINATION OF BENEFITS

We will coordinate benefits for CHP+ HMO members who have Medicare as their primary insurance coverage, or a stand-alone dental, vision, or COBRA plan. In this case, we shall pay as secondary.

WORKERS' COMPENSATION

To receive benefits under workers' compensation insurance for a work-related illness or injury, you must pursue your rights under the Workers' Compensation Act or any of the employer liability laws that may apply. This includes filing an appeal with the Division of Workers' Compensation. We may pay claims during the appeal process if you sign an agreement stating that you will reimburse us for up to 100% of the benefits paid that are also paid by another source.

Services and supplies resulting from work-related illness or injury are not benefits under this Booklet.

This exclusion from coverage applies to expenses resulting from occupational accident(s) or sickness(es) covered under the following:

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

We will not pay for services related to worker's compensation claims because:

- You fail to file a claim within the filing period allowed by the applicable law

- You obtain care that is not authorized by workers' compensation insurance
- Your employer fails to carry the required worker's compensation insurance. In this case, the employer becomes liable for any of the employee's work-related illness or injury expenses
- You fail to comply with any other provisions of the Worker's Compensation Act

AUTOMOBILE INSURANCE PROVISIONS

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

HOW CHP+ HMO COORDINATES BENEFITS WITH COMPLYING POLICIES

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

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

Note: Before making any benefit payments, we may require proof that the complying policy has paid all primary benefits.

We may also, but are not required to, make payments under this Booklet and later coordinate with or seek reimbursement from the complying policy. In all cases, upon payment, we are entitled to exercise our rights under this plan and under applicable law against any and all potentially responsible parties or insurers. In that event, we may exercise the rights found in the *Administrative Information* section.

If you do not have another policy

We will pay benefits for any injuries you receive while riding in or operating a motor vehicle that you own if the vehicle is not covered by an automobile complying policy as required by law. We will also pay benefits under the terms of this Booklet for any injuries you sustain if you are a non-owner operator, passenger, or pedestrian involved in a motor vehicle accident, if your injuries are not covered by a complying policy. In that event, we may exercise the rights found in the next section, *Coordination of Benefits & Subrogation*.

THIRD-PARTY LIABILITY: SUBROGATION

Third-party liability means that someone other than you is or may be legally responsible for your condition or injury. We will not pay for any services or supplies under this Booklet for which a third-party is liable.

However, we may provide benefits under the following conditions:

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

CHP+ HMO's rights under third-party liability

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

Member obligations under third-party liability

You have an obligation to cooperate in satisfying our subrogation interest or to refrain from taking any action that may prejudice our rights under this Booklet. If we must take legal action to uphold our rights, and if we prevail in that action, you will be required to pay our legal expenses, including attorneys' fees and court costs.

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

- You must promptly notify us, in writing, of your claim against the third party.
- You and your attorney must provide for the amount of benefits paid by CHP+ HMO in any settlement with the third-party of the third-party's insurance carrier.
- If you receive money for the claim by suit, settlement, or otherwise, you must fully reimburse us for the amount of benefits provided to you under this certificate. You may not exclude recovery for CHP+ HMO's health care benefits from any type of damages or settlement you recovered.
- You must cooperate in every way necessary to help us enforce our subrogation rights.
- You have the responsibility to follow any process of a liable third-party payer prior to receiving non-emergency services.

Note: Failure to comply with obligations in this section may result in termination of coverage under this Booklet.

10: Grievances and Appeals

Please let us know if you are not happy with us, our providers, your services, or any decisions that are made about your treatment.

- You have the right to express a concern about anything you are not happy with.
- You also have a right to appeal. This means you can ask for a review of a CHP+ HMO action or decision about what services you get.

Call our grievances and appeals department at 303-751-9021 or 888-214-1101 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

WHAT IS A DESIGNATED CLIENT REPRESENTATIVE?

A designated client representative is someone you choose to talk for you when you have a concern or appeal about your services. It could be a provider, an advocate, a lawyer, a family member, or any other person you trust.

If you decide to designate someone as your grievance and appeal representative, you must do so in writing. Please include the name, address, and phone number of your grievance and appeal representative. This is so we can contact him or her during the investigation or appeal process. This person will not see your medical records or get information about your situation unless you also sign a form to release medical information to him or her. You may also sign an authorization and let us know that you have designated someone as your grievance and appeal representative at the same time.

GRIEVANCES

If you are not happy with something other than a service decision, you can file a grievance. A grievance can be about anything other than a decision by CHP+ HMO to deny, limit, or change a service that you or your provider requested. This is your right. You do not need to worry that you will be treated badly for making a grievance. We want to make sure that you are treated fairly and receive the best service possible. This is one way you can stand up for yourself and your rights. It also helps us make our services better for you and others. To better assist you, there is a CHP+ HMO Member Grievance Form located in the back of this Booklet.

Examples of grievances might include:

- The receptionist was rude to you.
- Your provider would not let you look at your mental health records.
- Your service plan does not have the things that you wanted to work on.
- You could not get an appointment when you needed one.

Who to contact to file a grievance:

- You or your representative can call the Colorado Access Grievances and Appeals department
- You can fill out the CHP+ HMO Member Grievance Form at the end of this Booklet and send it to us
- You can write us a letter. Call us if you want help writing your grievance.
- Other people can help you or your representative with a grievance, including:
    - Your provider. He or she can assist you on your behalf with any denial of services.
    - The Department of Health Care Policy and Financing at 303-866-3513 or 800-221-3943 (toll free).

How to file a grievance with CHP+ HMO

You or your representative can call or write to the Colorado Access Grievances and Appeals Department. You should do this within 30 calendar days from when the problem happened. To better assist you, there is a member grievance form at the end of this Booklet. Send this form to:

Colorado Access
Grievances and Appeals Department
PO Box 17950
Denver, CO 80217-0950
Phone: 303-751-9021 or 888-214-1101 (toll free)

Be sure to include your name, state identification (ID) number, address, and phone number.

What happens when I file a grievance?

- After we get your phone call or letter, we will send you a letter within two business days. The letter will say we got your grievance.
- We will review your grievance. We may talk with you or your representative, talk to the people involved in the situation, and look at your medical records.
- Someone who was not involved in the situation that you are concerned about, and who has the right experience, will review your grievance.
- Within 15 business days after we get your letter, we will send you a letter saying what we found and how we fixed it. Or, we will let you know that we need more time. You will get a letter from us after we finish the review.
- We will work with you or your representative to try to find a solution that works best for you. Sometimes we may not be able to fix a problem.

How to contact the Department of Health Care Policy and Financing

If you are unhappy with our review, you or your representative can contact the Colorado Department of Health Care Policy and Financing. They will do another review. Their decision about you concern is final. You or your representative can call or write the Department of Health Care Policy and Financing and let them know that you have filed a grievance.

Department of Health Care Policy and Financing
CHP+ MCO Contract Manager
1570 Grant St.
Denver, Colorado 80203
Phone: 303-866-3586

Let them know that you are a CHP+ offered by Colorado Access member. Tell them what the problem is. Tell them how you want it fixed.

The Department of Health Care Policy and Financing will review your grievance. They will work with you to find a solution. You will get a letter from the Department of Health Care Policy and Financing. This letter will explain the results of the review. This decision is final.

APPEALS

An appeal is when you try to change a decision, called and "action," that we make about your services. You have this right. If we take an action, you and your provider will get a letter that tells you why. This letter also will explain how to appeal if you want to.

You can appeal any of the following actions:

- When we deny or limit a type or level of service you requested.
- When we reduce, suspend, or stop a service that was previously approved.
- When we deny payment for any part of a service.
- When we do not provide or authorize (approve) services in a timely manner.
- When we do not act within timelines required by the state to provide notifications to you.
- If you live in a rural area and we deny your request to seek care outside of our network.

If you or your representative asks for an appeal, we will review the decision. Your provider may file an appeal for you or help you with your appeal as your representative. For you grievance and appeal representative to get your medical records for an appeal, you or your personal representative must give written permission to your provider.

You will not lose your benefits if you file an appeal. If you are getting services that have already been approved by us, you may be able to keep getting those services while you appeal, if all of these requirements are met:

- Your appeal has been sent to us within the required timeframes by you or your provider.
- An in-network provider has asked that you get the services.
- The time period that the approval (authorization) of the services has not ended.
- You specifically request that the services continue.

You may have to pay for services that you get during the appeal if you lose the appeal. If you win the appeal, you will not have to pay. Please let us know when you ask for an appeal if you want to keep getting your services.

If you continue to get the approved services, they will continue for a certain time period. The services will continue until:

- You withdraw your appeal.
- A total of 10 days pass after we mail the original notice to you that we are denying your appeal. If you request a state fair hearing within those 10 days, your benefits will continue until the hearing is finished.
- The state fair hearing office decides that your appeal is denied.
- The authorization for the services ends.

Example of decisions that you could appeal include:

- You are told you are being discharged from the hospital and don't feel ready to go.
- Denial of continued services, such as physical therapy, that you feel are still needed.

How to ask for an appeal (another review) of a decision or action:

If the appeal is about a new request for services, you or your representative must request an appeal within 30 calendar days from the date on the letter saying what action we took or plan to take. You or your representative can call the Colorado Access Grievance and Appeals department to start your appeal. The phone number is 303-751-9021 or 888-214-1101 (toll free). Tell them you are a CHP+ offered by Colorado Access member. Tell them you want to appeal a decision or action. If you call to start your appeal, you or your representative must send us a letter after the phone call unless he or she requests expedited resolution. The letter must be signed by you or your representative. We can help you with the letter, if you need help. The letter must be sent to:

Colorado Access
Grievance and Appeals Department

PO Box 17950
Denver, CO 80217-0950
Phone: 303-751-9021 or 888-214-1101 (toll free)

You or your representative can request a "rush" or expedited appeal if you are in the hospital, or feel that waiting for a regular appeal would threaten your life or health. See the *Expedited Appeals* section for more information about expedited appeals.

If you are getting services that have already been approved by us, you may be able to keep getting those services while you appeal. You may have to pay for those services that you get during the appeal if you lose the appeal. If you win the appeal, you will not have to pay. Please let us know when you ask for an appeal if you want to keep getting services.

Continuation of benefits

If you appeal an action to lower, change, or stop an authorized service, you must file your appeal on time. On time means within 10 days of receiving a notice of action. If you want to continue receiving previously approved benefits while going through the appeals process, you will have to file within 10 business days after receiving the notice of action.

What happens with an appeal

After we receive your phone call or letter, you will get a letter within two business days. This letter will tell you that we got your request for an appeal. You or your representative can tell us in person or in writing why you think we should change our decision or action. You or your representative can also give us any information or records that you think would help your appeal. You or your representative can ask questions, and ask for the criteria or information we used to make our decision. You or your representative can look at our records that have to do with your appeal. If the decision or action you are appealing is about a denial or change of services, a doctor will review your medical records and other information. This doctor will not be the same doctor who made the first decision.

We will make a decision and notify you within 10 business days from the day we get your request, unless it is expedited (rushed). We will send you a letter that tells you the decision and the reason for the decision.

If we need more information from your doctor, we will send you a letter to let you know we are extending our review for no more than 14 calendar days.

EXPEDITED ("RUSH") APPEALS

If you feel that waiting for an appeal would seriously affect your life or mental health, you may need a fast decision from us. You or your representative can ask for an expedited (rush) appeal. For a rush

appeal, a decision would be made within three business days, instead of 10 business days for a regular appeal.

We will make our decision on an expedited appeal within three business days. This means that you or your representative have a short amount of time to look at our records, and a short amount of time to give us information. You can give us information in person or in writing. During this time, your services will stay the same.

If your request for a rush appeal is denied, we will call you as soon as possible to let you know. We will also send you a letter within two calendar days. Then we will review your appeal the regular way. You will get a letter that tells you the decision of the appeal and the reason.

If you are not happy with the outcome of the expedited appeal, or any appeal, you have the right to request a state fair hearing.

HOW TO REQUEST A STATE FAIR HEARING

A state fair hearing means that a state administrative law judge (ALJ) will review our decision or action. You can ask for a state fair hearing:

- Instead of using our appeal process;
- At any time during your appeal with us; or
- If you are not happy with our decision about your appeal

A request for a state fair hearing must be in writing.

You will not lose your CHP+ HMO benefits if you express a concern, file a grievance, an appeal, or request a state fair hearing. It is the law.

- If your request is about a treatment that has not been approved before, you or your representative must make the request within 30 calendar days from the date on the letter that tells you the action that we have taken, or plan to take.
- If you request the state fair hearing before a decision regarding your appeal has been made, then you shall be allowed to make the request within 30 calendar days from the date of the notice of action that lead to the appeal.
- If your request is about treatment that has been approved before and you would like to continue this treatment while awaiting a state fair hearing, you or your representative must make the request within 10 calendar days from the date on the letter that tells you the action that we have taken, or plan to take, or before the effective date of the termination or change in services, whichever is later.

- If you or your representative want to ask for a state fair hearing, you or your representative may call or write to:

  Office of Administrative Courts
  1525 Sherman St., 4th Floor
  Denver, CO 80203
  Phone: 303-866-2000
  Fax: 303-866-5909

The Office of Administrative Courts will send you a letter that explains the process and will set a date for your hearing.

You can talk for yourself at a state fair hearing, or you can have a representative talk for you. A representative can be a lawyer, a relative, an advocate, or someone else. The judge will review our decision or action. Then the judge will make a decision. The decision of the judge is final.

We encourage you to file with the administrative law judge (ALJ) at the same time that you file your appeal with us. This will keep you within the calendar day deadline, and protect your right to an ALJ hearing. The ALJ contact information is provided above. You must make your request for an ALJ hearing in writing and you must sign your request.

If you are getting services that have already been approved by us, you may be able to keep getting those services while you are waiting for the judge's decision. But, if you lose at the state fair hearing, you may have to pay for services that you get while you are appealing. If you win, you will not have to pay. If you win the state fair hearing and you were not getting services while waiting on the decision, we will promptly approve those services for you.

If you want help with any part of the appeal process, please contact us. We can help you with any questions you have or help you file an appeal. Call us at 303-751-9021 or 888-214-1101. TTY users should call 720-744-5126 or 888-803-4494 (toll free).

11: Glossary

This section defines words and terms used throughout this Booklet. You should refer to this section to find out exactly how a word or term is used in this Booklet.

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

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

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

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

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

Alcoholism and substance abuse – conditions defined by patterns of usage that continue despite occupational, social, or physical problems. Abuse means an unusually excessive use of alcohol or other substances. These conditions may also be recognized by severe withdrawal symptoms if the use of alcohol or other substances is stopped.

Alternative/complementary care – therapeutic practices of healing or treating disease that are not currently considered an integral part of conventional medical practice. Therapies are termed complementary when used in addition to conventional treatments and as alternative when used instead of conventional treatments. Alternative medicine includes, but is not limited to, eastern medicines such as Chinese or Ayurvedic, herbal treatments, vitamin therapy, homeopathic medicine, naturopathy, faith healing, and other non-traditional remedies for treating diseases or conditions.

Ambulance – a specially designed and equipped vehicle used only for transporting the sick and injured. It must have customary safety and lifesaving equipment such as first aid supplies and oxygen equipment. The vehicle must be operated by trained personnel and licensed as an ambulance.

Ancillary services – services and supplies (in addition to room expenses) that hospitals and other facilities bill for. Such services include, but are not limited to, the following:

- Use of an operating room, recovery room, emergency room, treatment room, and related equipment; intensive and coronary care units.
- Drugs/medication and medicines, biologics (medicines made from living organisms and their products) and pharmaceuticals.
- Medical supplies (dressings and supplies, sterile trays, casts, and splints used instead of a cast).
- Durable medical equipment owned by the facility and used during a covered admission.
- Diagnostic and therapeutic services.
- Blood processing and transportation and blood handling costs and administration.
- Anesthesia – there are two types of anesthesia:
    - General anesthesia, also known as total body anesthesia, causes the patient to become unconscious or put to sleep for a period of time.
    - Regional or local anesthesia causes loss of feelings or numbness in a specific area without causing loss of consciousness and is usually injected with a local anesthetic drugs such as lidocaine. Anesthesia must be administered by a provider or certified registered nurse anesthetist (CRNA).

Annual enrollment fee – some families pay an annual fee to be enrolled in CHP+ HMO. This enrollment fee is based on family size and income. You will receive a bill from us if you owe an annual fee before your reenrollment date.

Appeal – a process for reconsideration of our decision regarding a member's claim or preauthorization.

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

Authorization – approval of benefits for a covered procedure or service. See also Preauthorization.

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

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

Calendar year – a year-long period that begins in January and ends in December.

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

Care manager/case manager – a professional (for example, a nurse, a doctor, or a social worker) who works with members, providers, and CHP+ HMO to coordinate services deemed medically necessary for the member.

Chemical dependency – dependence on either alcohol and/or other substances such as drugs. See also Substance Abuse.

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

CHP+ HMO Member Benefits Booklet – this document explains the benefits, limitations, exclusions, terms, and conditions of a CHP+ HMO member's health coverage. This document also serves as a contract between us and our members.

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

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

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

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

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

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

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

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

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

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

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

Covered services – services, supplies, or treatments that are:

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

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

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

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

Detoxification – acute treatment for withdrawal from the physical effects of alcohol or other substances.

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

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

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

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

Effective date – the date coverage with CHP+ HMO begins.

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

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

Experimental or investigative procedures or services –

a. Any drug/medication, biologic device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which we determine, in our sole discretion, to be experimental or investigational.

   We will deem any drug/medication, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be experimental or investigational if we determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The drug/medication, biologic, device, diagnostic, product, equipment, procedures, treatment, service, or supply:

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

- Is provided pursuant to informed consent documents that describe the drug/medication, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as experimental or investigational, or otherwise indicate that the safety, toxicity, or efficacy of the drug/medication, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

b. Any service not deemed experimental or investigational based on the criteria in Subsection A may still be deemed to be experimental or investigational by CHP+ HMO. In determining if a service is experimental or investigational, we will consider the information described in Subsection C and assess all of the following:
   - Whether the scientific evidence is conclusory concerning the effect of the service on health outcomes.
   - Whether the evidence demonstrates that the service improves the net health outcomes of the total population for whom the service might be proposed as any established alternatives.
   - Whether the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

c. The information we consider or evaluate to determine if a drug/medication, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is experimental or investigational under Subsection A and B may include one or more items from the following list, which is not all-inclusive:
   - Randomized, controlled, clinical trials published in an authoritative, peer-reviewed United States medical or scientific journal.
   - Evaluations of national medical associations, consensus panels and other technology evaluation bodies.
   - Documents issued by and/or filed with the FDA or other federal, state, or local agency with the authority to approve, regulate, or investigate the use of the drug/medication, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply.
   - Documents of an IRB or other similar body performing substantially the same function
   - Consent documentation(s) used by the treating providers, other medical professionals or facilities, or by other treating providers, other medical professionals or facilities studying substantially the same drug/medication, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply.
   - The opinions of consulting providers and other experts in the field.

d. We have the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug/medication, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is experimental or investigational.

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

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

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

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

Grievance – an oral or written expression of dissatisfaction with CHP+ HMO's services or the practices of an in-network provider, whether medical or non-medical in nature. This is sometimes also called a complaint.

Healthy living initiatives – these are projects to promote healthier lifestyles and help our members avoid preventable diseases.

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

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

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

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

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

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

ID card – the card we give members of CHP+ HMO with information such as the member's name, ID number, PCP, and copayment amount (if applicable). This is also known as the CHP+ HMO member ID card.

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

In-network provider – a provider that is contracted with us to provide services to our members.

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

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

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

Keratoconus – cone-shaped protrusion of the cornea.

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

Long-term acute care facility – an institution that provides an array of long-term crucial care services to patients with serious illnesses or injuries. Long-term acute care is provided for patients with complex medical needs. These include patients with high-risk pulmonary conditions who have ventilator or tracheotomy needs or who are medically unstable, patients with extensive wound care needs or post-

operative surgery wound care needs, and patients with low-level, closed-head injuries. Long-term acute care facilities do not provide care for low-intensity patient needs.

Managed care – a system of health care delivery. The goals of managed care are to provide members with access to quality, cost-effective health care while optimizing utilization and cost of services, and to measure provider and coverage performance.

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

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

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

Maximum benefit – there is no lifetime maximum benefit under CHP+ HMO. However, certain covered services have maximum benefit limits per admission, per calendar year, per diagnosis, or as specifically defined in this Booklet.

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

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

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the condition, illness, disease, or injury.
- Obtained from a licensed, certified, or registered provider.
- Provided in accordance with applicable medical and/or professional standards.
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes.
- The most appropriate supply, setting, or level of service that can safely be provided to the patient and which cannot be omitted, and is consistent with recognized professional standards

of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained as an outpatient).
- Cost-effective compared to alternative interventions, including no intervention (cost effective does not mean lowest cost).
- Not experimental/investigational.
- Not primarily for the convenience of the patient, the patient's family or the provider.
- Not otherwise subject to an exclusion under this Booklet

The fact that a provider may prescribe, order, recommend, or approve care, treatment, services, or supplies does not itself make such care, treatment, services, or supplies medically necessary.

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

Member – any person who is enrolled for coverage under CHP+ HMO.

Member advisory board – this board advises members about behavioral health issues that our members and their families are facing. The board meets quarterly (every three months).

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

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

Nephritis – infection or inflammation of the kidney.

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

Nutrition assessment/counseling – medical nutrition therapy provided by a qualified nutrition professional such as a registered dietitian with training in pediatric nutrition. Services provided by a registered dietitian may require preauthorization from us. Medical nutrition therapy includes nutrition assessment, support, and counseling to determine a treatment plan to increase nutritional intake to promote adequate growth, healing, and improved health.

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

Office of Member and Family Affairs – The Office of Member and Family Affairs can help you with understanding the mental health system, advocating for yourself, answering any questions, concerns and complaints, understanding what services you get, and knowing what your rights a responsibilities are.

Organ transplants – a surgical process that involves the removal of an organ from one person and placement of the organ into another person. Transplant can also mean removal of body substances, such as stem cells or bone marrow, for the purpose of re-implanting the removed organ or tissue in the the same person. Organ transplant benefits provided to members of CHP+ HMO may be subject to a lifetime maximum benefit.

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

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

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

Out-of-network provider – an appropriately licensed health care provider that has not contracted with us to provide services to our members. We may not cover services provided by an out-of-network provider unless preauthorization is obtained. A member may be financially responsible for services performed by an out-of-network provider unless stated otherwise in this Booklet, or a referral by the member's PCP is approved (authorized) by us.

Out-of-area services – covered services provided to a member of CHP+ HMO when he or she is outside the service area. See also CHP+ HMO service area.

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

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

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

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

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

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

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

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

Prescription drugs and medications –

> **Brand-name prescription drug:** The initial version of a medication developed by a pharmaceutical manufacturer or a version marketed under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted an exclusive patent to manufacture and market a new medication for a certain number of years. After the patent expires and FDA requirements are met, any manufacturer may produce the medication and sell the medication under its own brand name or under the medication's chemical (generic) name.
> **Formulary list:** A list of pharmaceutical products developed in consultation with providers and pharmacists and approved for their quality and cost-effectiveness.
> **Generic prescription drug:** Medications determined by the FDA to be bioequivalent to brand-name medications and that are not manufactured or marketed under a registered trade name or trademark. A generic medication's active ingredients duplicate those of a brand-name medication. Generic medications must meet the same FDA specifications as brand-name medications for safety, purity, and potency, and must be dispensed in the same dosage form

(tablet, capsule, cream) as the counterpart brand-name medication. On average, generic medications cost about half as much as the counterpart brand-name medication.
Legend drug: A medical substance dispensed for outpatient use, which, under the federal Food, Drug, and Cosmetic Act, is required to bear on its original packing label, "Caution: Federal law prohibits dispensing without a prescription." Compound medications that contain at least one such medicinal substance are considered to be prescription legend drugs. Insulin is considered a prescription legend drug under this Booklet.

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

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

Primary care provider (PCP) – the appropriately licensed and credentialed provider who has contracted with us to supervise, coordinate, and provide initial and basic care to our members, and who initiate a referral for specialist care, and maintain continuity of patient care.

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

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

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

Professional provider: a provider who is licensed or otherwise authorized by the state or jurisdiction where services are provided to perform designated health care services. For benefits to be payable, services of a provider must be within the scope of the authority granted by the license and covered by this plan. Such services are subject to review by a medical authority appointed by us. Other professional providers include, among others, certified nurse midwives, dentists, optometrists, and certified registered nurse anesthetists. Services of such a provider must be among those covered by this certificate and are subject to review by a medical authority appointed by us.
Facility provider: an inpatient and outpatient facility provider, as defined below:

Inpatient facility provider – a hospital, substance abuse treatment center, residential facility, hospice facility, skilled nursing facility or other facility that we recognize as a health care provider. These facility providers may be referred to collectively as a facility provider or separately as a substance abuse treatment center provider.
Outpatient facility provider – a dialysis center, home health agency or other facility provider such as an ambulatory surgery center (but not a hospital, substance abuse treatment center or hospice facility, skilled nursing facility or residential treatment center) recognized by CHP+ HMO and licensed or certified to perform designated health care services by the state or jurisdiction where services are provided. Services of such a provider must be among those covered by this plan and are subject to review by a medical authority appointed by us.

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

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

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

Referral – We consider a referral to be a clinical communication between the primary care provider (PCP) and the specialty provider for the purposes of care continuity, treatment planning, and to provide a Medical Home. Office visits for non-participating specialist require preauthorization from CHP+ HMO and will be considered on a case-by-case basis for particular clinical needs.

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

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

- Payment of Colorado income tax.
- Employment in Colorado, other than that normally provided on a temporary basis to students.
- Ownership of residential real estate property in Colorado.

- State identification card or driver's license.
- Acceptance of future employment in the state of Colorado.
- Vehicle registered in Colorado.
- Voter registration in Colorado.
- Phone bill or utility bill from Colorado.

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

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

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

Second surgical opinion – a mechanism used by managed care organization to reduce unnecessary surgery by encouraging individuals to seek a second opinion before specific elective surgeries. In some cases, we may require a second opinion before a specific elective surgery.

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

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

Specialist – a professional, usually a provider, devoted to a specific disease, condition, or body part. Example: orthopedist – a provider who specializes in the treatment of bones and muscles.

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

Sub-acute medical care – medical care that requires less care than a hospital but often more care than a skilled nursing facility. Sub-acute medical care may be in the form of transitional care when a patient's condition is improving but the patient is not ready for a skilled nursing facility or home health care.

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

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

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

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

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

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

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

Utilization management – the evaluation of the appropriateness, medical need, and efficiency of health care services, procedures, and facilities according to established criteria or guidelines and under the provisions of the CHP+ HMO benefits.

Utilization review – a set of formal techniques using standardized criteria designed to monitor the use, or evaluate the clinical necessity, appropriateness, efficacy or efficiency, of health care services, procedures, or settings. Techniques include ambulatory review, prospective review, second opinion, certification, and concurrent review, care management, discharge planning and/or retrospective review. Utilization review also includes review to determine coverage.

This is based on whether a procedure or treatment is considered experimental/investigational in a given circumstance (except if it is specifically excluded in this Booklet) and review of a member's medical circumstances, when such a review is necessary to determine if an exclusion applies in a given situation.

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

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

DESIGNATION OF PERSONAL REPRESENTATIVE

You have the right to choose one or more people to act as your personal representative and make decisions about your medical care. Your personal representative will have access to your health information. This includes health records and protected health information that is created by or in the possession of Colorado Access/Access Health Colorado. By choosing a personal representative, you allow Colorado Access/Access Health Colorado to share your health information with your personal representative. You can limit how much health information he/she can see, and you can cancel it at any time. You must include a copy of your member ID card or driver's license with this form, so we can confirm your identity. All references to "member" in this form include a member, client, or beneficiary, as applicable.

- I understand that the rights I am giving to my personal representative will expire on the date that I am no longer a member or one year after the date of my signature below, whichever comes first.
- I understand that my designated personal representative may talk to someone else about my protected health information. My health information cannot be protected if my personal representative tells someone else.
- I understand that I can cancel my choice of personal representative at any time by following the instructions on the second page of this form.
- I understand that if I designate a personal representative, I will not be prevented from getting treatment, payment, enrollment, or eligibility for benefits.
- I understand that this form does not allow the release of any information concerning drug or alcohol abuse, psychological or psychiatric conditions or treatment, psychotherapy notes, HIV/AIDS testing or status, abortion, or sexually transmitted disease, if any.
- I understand that I can limit the amount of information that my personal representative is given. I limit the access of my personal representative to the following information:

_____

_____

DESIGNATION OF PERSONAL REPRESENTATIVE

I, _____ (print member name) understand all of the information above and choose the following person to act as my personal representative. I am a member of (check one):

☐ Access Behavioral Care ☐ Child Health Plan *Plus* ☐ Access Long Term Support Solutions

☐ Access Health Colorado ☐ Other (specify): _____

_____ _____
Name of Personal Representative | Relationship to Member

_____ _____
Member Signature | Member Date of Birth

_____ _____
Member ID Number or Driver's License Number | Date

ACCEPTANCE BY PERSONAL REPRESENTATIVE

I, _____ (print personal representative name) agree to act as the personal representative for the member listed above. I agree to meet my responsibilities as described in this form on behalf of the member. I agree to keep the information I receive about the member from Colorado Access/Access Health Colorado confidential.

_____ _____
Signature of Personal Representative | DL# or other identification (Used for identity verification only)

_____
Personal Representative Phone

DESIGNATION OF PERSONAL REPRESENTATIVE INSTRUCTIONS

A personal representative is someone you choose to have access to your protected health information. It could be a provider, an advocate, a lawyer, a family member, or any other person you trust.

If you would like to choose a personal representative, you can use this form to name the person you have chosen. You must fill this form out completely and provide all the documentation that is requested. **You must include valid identification, such as a copy of your member ID card, Medicaid or state ID card, or driver's license, so that we can confirm your identity.** You also need to have your personal representative complete and sign the Acceptance by Personal Representative section of the form before you send it to us.

This Designation of Personal Representative Form does not authorize the disclosure or re-disclosure of substance use disorder (drug or alcohol abuse) records, psychological or psychiatric conditions or treatment records, or psychotherapy notes. The disclosure or re-disclosure of these types of records requires a separate consent signed by you or your designated personal representative.

Mail or fax this completed form to:

ABC, CHP+, or RCCO	**Access Health Colorado**	**Access Long Term Support Solutions**
Colorado Access PO Box 17580 Denver, CO 80217-9691	Access Health Colorado PO Box 5846 Denver, CO 80217-9691	Access Long Term Support Solutions PO Box 17767 Denver, CO 80217-7767
Fax: 303-755-4148	Fax: 303-755-4148	Fax: 1-855-744-1723
Phone: 1-800-511-5010	Phone: 1-855-325-9426	Phone: 1-877-710-9993

You can also choose a personal representative in person or by phone. If you have questions or need help filling out this form, call us toll free at the number for your health plan listed above. TTY/TDD users call 1-888-803-4494.

HOW TO CHANGE OR CANCEL YOUR DESIGNATION OF PERSONAL REPRESENTATIVE

If you would like to change or cancel your current designated personal representative, you need to complete a Revocation of Personal Representative Form. Call the appropriate number listed above for more information. TTY/TDD users call 1-888-803-4494.

REVOCATION OF PERSONAL REPRESENTATIVE INSTRUCTIONS

If you have already chosen a personal representative, you can use this form to cancel your choice of personal representative. You must fill this form out completely and provide all the documentation that is requested. **You must include a copy of your member ID card or driver's license, so that we can confirm your identity.**

Mail of fax this completed form to:

ABC, CHP+, or RCCO	Access Health Colorado	Access Long Term Support Solutions
Colorado Access PO Box 17580 Denver, CO 80217-9691	Access Health Colorado PO Box 5846 Denver, CO 80217-9691	Access Long Term Support Solutions PO Box 17767 Denver, CO 80217-7767
Fax: 303-755-4148	Fax: 303-755-4148	Fax: 1-855-744-1723
Phone: 1-800-511-5010	Phone: 1-855-325-9426	Phone: 1-877-710-9993

You can also choose a personal representative in person or by phone. If you have questions or need help filling out this form, call us at the number listed for your health plan above. TTY/TDD users call 1-888-803-4494.

REVOCATION OF PERSONAL REPRESENTATIVE

You have the right to choose one or more people to act as your personal representative. You also have the right to cancel your choice of personal representative(s) at any time. By canceling your choice of personal representative you are canceling their right to make decisions about your health care. You must include a copy of your member ID card or drivers' license with this form, so we can confirm your identity.

- I understand that by canceling my choice of personal representative Colorado Access/Access Health Colorado will no longer share my health information with them.
- I understand that I have the right to choose another person(s) to act as my personal representative by filling out a new Designation of Personal Representative form.

REVOCATION OF PERSONAL REPRESENTATIVE

I, _____ (print member name), understand all of the information above and choose to cancel the personal representative privileges of the following person:

_____ _____
Name of Personal Representative | Relationship to Member

_____ _____
Member Signature | Member Date of Birth

_____ _____
Member ID Number or Driver's License Number | Date

I am a member of (check one):

☐ Access Behavioral Care ☐ Child Health Plan *Plus* ☐ Access Long Term Support Solutions

☐ Access Health Colorado ☐ Other (specify): _____

MEMBER GRIEVANCE FORM

LINE OF BUSINESS INVOLVED *(check all that apply)*

- ☐ Colorado Access Advantage
- ☐ Access Behavioral Care
- ☐ Access Health Colorado
- ☐ CHP+ offered by Colorado Access
- ☐ CHP+ State Managed Care Network
- ☐ Behavioral Healthcare, Inc.

MEMBER INFORMATION

Member name:

Medical ID number:

Name of member's DCR* or guardian (if applicable):

Phone:

*designated client representative

DESCRIPTION OF PROBLEM *(if needed, write on the back of this form or add another page)*

Date(s) of incident:

Person(s) or provider(s) involved:

Please explain:

Mail to:
Grievance and Appeals Department
PO Box 17950
Denver, CO 80217-0580

To speak with someone directly, call our Grievance and Appeals Department at 303-751-9021, or toll free at 1-888-214-1101. TTY/TDD users call 1-888-803-4494.

MEMBER REIMBURSEMENT REQUEST FORM

MEMBER INFORMATION

Member name:		ID Number:
Name of member's DCR* or guardian (if applicable):		
Address:		
City:	State:	Phone:

*designated client representative

DESCRIBE WHY YOU HAD TO PAY OUT OF POCKET AND THE SERVICE OR PRODUCT THAT WAS PROVIDED *(if needed, write on the back of this form or add another page)*

YOUR REQUEST CANNOT BE PROCESSED UNLESS THIS FORM IS COMPLETE.
Please include all itemized receipts or your request may be delayed.

MAIL TO
Colorado Access/Access Health Colorado
PO Box 17950
Denver, CO 80217-0580

To speak with someone directly, call 1-877-276-5184. TTY/TDD users call 1-888-803-4494.

Child Health Plan *Plus*

offered by Colorado Access

Colorado ACCESS