

# Member Benefits Booklet



## Child Health Plan *Plus*

State Managed Care Network & Prenatal Care Program



If you need this document in large print, Braille, other formats, or languages, or read aloud, or need another copy, call 800-511-5010. For TDD/TTY, call 888-803-4494. Call Monday to Friday, 8 a.m. to 5 p.m. The call is free.

Si necesita este documento en letra grande, Braille, otros formatos o idiomas, o se lea en voz alta, o necesita otra copia, llame al 800-511-5010. Para TDD/TTY, llame al 888-803-4494. Llame de lunes a viernes, de 8 a.m. a 5 p.m. La llamada es gratis.

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## Welcome!

Welcome to Child Health Plan *Plus* (CHP+) State Managed Care Network! Our mission is to improve the health of the people we serve. Enrollment in this plan is voluntary.

CHP+ State Managed Care Network is a quality health plan that pays for many physical and mental health care services. Covered services include: outpatient care, emergency care, prescriptions, and hospital inpatient care.

This Booklet is a guide to your CHP+ benefits. Please read it carefully to become familiar with your benefits, including limitations and exclusions. Please keep this Booklet in a convenient place for quick reference. By learning how this coverage works, you can make the best use of your health care coverage. You can always request a Provider Directory or Member Booklet by telephone or in writing. You will receive it within 10 days.

This Booklet is also a guide to the CHP+ Prenatal Care Program. This program is more than just prenatal care. It offers many benefits during and after pregnancy, including visits to a doctor when you are sick, prescriptions, vision, and mental health services. The coverage is good through 60 days after the end of your pregnancy.

If you get other insurance, become covered by Health First Colorado (Colorado's Medicaid program), or move out of Colorado, you are no longer eligible for CHP+ State Managed Care Network or the CHP+ Prenatal Care Program.

You have the right to disenroll from the CHP+ State Managed Care Network at any time for any reason. You will need to contact the county that processed your CHP+ State Managed Care Network application and tell them that you want to disenroll.

For questions about coverage, call us between the hours of 8:00 a.m. and 5:00 p.m. Monday through Friday. We can be reached at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free). These numbers are also conveniently printed at the bottom of every page of this Booklet. You can also visit our website at [chpplusproviders.com/members.asp](http://chpplusproviders.com/members.asp) for more information and to find tips and tools on managing your health care.

### **DO YOU NEED SPECIAL HELP WITH THIS BOOKLET?**

If you need this book 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, or we can visit you in person. We are here to help. Just call us at 303-751-9051 or

800-414-6198 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free). Sign language and oral interpretation services are available in any language to members free of charge. To access these services, please contact us at the numbers listed above.

**TENEMOS ESTE LIBRO DISPONIBLE EN ESPAÑOL**

Si necesita información en español, llámenos al 303-751-9051, llamada gratuita 888-414-6198. Tenemos este libro en español.

Thank you for selecting CHP+ State Managed Care Network for your health care coverage. We wish you good health.



William P. Heller  
Director, Child Health Plan *Plus*  
Colorado Department of Health Care Policy and Financing

## Attention State Managed Care Network Members

The CHP+ Member Benefits Booklet gives you information about CHP+ State Managed Care Network and the CHP+ Prenatal Care Program. This Booklet also includes information about benefits and how both programs work. If you would like more information or have any questions, please call us at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

CHP+ State Managed Care Network and the CHP+ Prenatal Care Program are brought to you by CHP+ and Colorado Access. While you are enrolled in CHP+ State Managed Care Network or the CHP+ Prenatal Care Program, Colorado Access is responsible for claims processing, referral, authorizations, care management, and utilization review.

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 will take effect. This includes changes about your rights, benefits, copayments, and any other changes to procedures that you need to follow as a member of this plan. The terms of this Booklet cannot be changed by an employee of CHP+ or Colorado Access by giving incomplete or incorrect information.

We recognize the importance of accommodating the needs of all children and we strive to provide specialized care for each. All efforts will be taken to seek family or caretaker involvement for members who may not be able to manage their own health care decisions, including children. We provide alternative media formats for hearing and/or visually impaired members as needed.

If you need this Booklet or any other CHP+ document in another language, in large print, in braille, or on tape, call us at 303-751-9051 or 800-414-6198 (toll free), Monday through Friday, 8:00 a.m. to 5:00 p.m. TTY users should call 720-744-5126 or 888-803-4494 (toll free).

**Si necesita información en español, llámenos al 303-751-9051 o 800-414-6198 (llamada gratuita).**



## Contact Information

### IMPORTANT ADDRESSES

#### **CHP+ State Managed Care Network Customer Service**

PO Box 17580  
Denver, CO 80217-0580  
303-751-9051 or 800-414-6198 (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 about health care programs and resources)**

303-692-2229 or 800-688-7777 (toll free)

#### **Rocky Mountain Poison Center**

800-332-3073

### IMPORTANT WEBSITE ADDRESSES

#### [chplusproviders.com/members.asp](http://chplusproviders.com/members.asp)

This website has important information including the CHP+ State Managed Care Network Provider Directory, an electronic copy of the CHP+ Member Benefits Booklet, and more.

#### [CHPplus.org](http://CHPplus.org)

This website offers information on benefits, how to apply for CHP+ and other information for CHP+ members and families.

#### [coaccess.com](http://coaccess.com)

This website offers information on CHP+ State Managed Care Network, benefits, a provider directory, how to apply for CHP+, and other helpful information.

#### [Colorado.gov/peak](http://Colorado.gov/peak)

This website, called PEAK, is a quick and easy way for people in Colorado to get answers to questions about eligibility and on health and nutrition programs.

## Important Things to Know About CHP+

### WHAT IS COLORADO ACCESS?

Colorado Access is a Colorado-based, nonprofit health plan. While you are enrolled in CHP+ State Managed Care Network or the CHP+ Prenatal Care Program, Colorado Access is responsible for claims processing, referrals, authorization, care management, and utilization review. Colorado Access has a friendly staff to help you when you have questions about your coverage and benefits. You can call them at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

### MEMBER IDENTIFICATION CARE (ID CARD)

Your CHP+ Member ID card shows that you are a member of CHP+ State Managed Care Network or the CHP+ Prenatal Care Program. Bring this ID card with you when you get medical care. This includes all pharmacies (when you get prescription medications), doctors, hospitals, and any medical supplies. If you have not received your ID card, or need a new ID card, please call us at 303-751-9051 or 800-414-6198 (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 service. 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](mailto:compliance@coaccess.com) or call the Colorado Access Medicaid Compliance Officer at 720-744-5462 or to stay anonymous, call our Compliance Hotline at 877-363-3065 (toll free).

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## **PRIMARY CARE PROVIDERS (PCP)**

All members of CHP+ State Managed Care Network, the CHP+ Network and the CHP+ Prenatal Care Program 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 pediatrician. CHP+ Prenatal Care Program members may choose an OB/GYN as their primary care provider. Your PCP helps you get the care you need. He or she provides a wide range of health care services, including checkups, sick visits, shots, initial diagnosis and treatment, health supervision, management of chronic conditions, referrals to specialists when you need one, and ensuring continuity of patient care.

The State Managed Care Network has an obligation to ensure 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 facilitates member participation in the community.

Members with special health care needs may be allowed to have direct access/standing referral to their specialists as needed for their care. You should speak with your doctor about setting up a long-standing referral with a specialist. You can also call Colorado Access Customer Service if you have questions about this benefit.

If there is not an in-network provider for a covered service, we will refer you to a provider with the necessary expertise.

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.

## **Selecting or Changing your PCP**

You must choose an in-network PCP. There are no restrictions on who you may 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 of contracted 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 [chplusproviders.com/members.asp](http://chplusproviders.com/members.asp). Our Provider Directory online tool can also give you information on what languages contracted providers in your area speak other than English, and which providers are no longer accepting new patients.

Please call the PCP's office to make sure that the provider is accepting new patients.

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

Once you choose a PCP from the Provider Directory or online at [chplusproviders.com/ProviderDirectory/dsp\\_ProviderDirectory.asp](http://chplusproviders.com/ProviderDirectory/dsp_ProviderDirectory.asp), please call us at 303-751-9051 or 800-414-6198 (toll free) and let us know your choice. TTY users should call 720-744-5126 or 888-803-4494 (toll free). You will receive a new ID card with the name of your PCP.

### **IN-NETWORK PROVIDERS**

Make sure that your provider is in-network with CHP+ State Managed Care Network. If you receive care from a provider who does not accept CHP+ State Managed Care Network, you may have to pay for service you get.

### **REMEMBER**

- Show your CHP+ State Managed Care Network ID card when you get health care. Tell all your health care providers that you are covered by CHP+ State Managed Care Network or the CHP+ Prenatal Care Program. This includes all pharmacies (when you get prescription medications), doctors, hospitals, and any medical supplies.
- Choose your PCP. Call us and tell us the name of the in-network PCP you chose.
- When you get care, always make sure your provider is in-network. Except in an emergency, if you get services from a provider that is not part of CHP+ State Managed Care Network, these services may not be covered and you may have to pay for them. To find an in-network provider, please call us or visit us online at [chplusproviders.com/members.asp](http://chplusproviders.com/members.asp).
- Call us with any questions you have about your coverage at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

### **FREQUENTLY ASKED QUESTIONS FOR CHP+ PRENATAL CARE PROGRAM MEMBERS**

#### **Do I need a referral for prenatal care?**

No, you do not need a referral to see an in-network OB/GYN for any care related to your pregnancy. You can find out if your provider for prenatal care is in-network by calling us at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

**If my PCP provides prenatal care, do I have to see him or her for my prenatal care?**

No. You do not have to use your PCP for prenatal care. Colorado law allows for you to see an in-network OB/GYN for reproductive health care, even if your PCP provides these services.

**What if I need care for medical issues not related to my pregnancy?**

The CHP+ Prenatal Care Program is a comprehensive health care program for pregnant women. This means that the CHP+ Prenatal Care Program will cover medical needs unrelated to your pregnancy, as long as they are listed as covered benefits and considered medically necessary.

**How will the CHP+ Prenatal Care Program know when I have had my baby?**

After you have your baby, please contact CHP+ Eligibility and Enrollment as soon as possible so there are no problems covering the care for your new baby. The telephone number for CHP+ Eligibility and Enrollment is 800-359-1991. Please tell them the baby's name, date of birth, and the baby's social security number, if available. Your newborn child will be enrolled as of his or her date of birth. If you are unable to call CHP+ Eligibility and Enrollment yourself, a family member or your provider can call for you.

**What if I call Customer Service and they tell me that I am not eligible or I have problems filling a prescription?**

We will work with you to help answer all questions and will look into your eligibility status. You can also contact CHP+ Eligibility and Enrollment at 800-359-1991 to ask a representative if you are covered by the CHP+ Prenatal Care Program.

**How long does the CHP+ Prenatal Care Program coverage last?**

If you are eligible for the program, your coverage will start the date your completed application is submitted. Your coverage will continue for at least 60 days after the last day of the month in which your pregnancy ended. For example, if you give birth on June 26, your coverage would end on August 30.

**What doctors and clinics will care for me under the CHP+ Prenatal Care Program?**

For prenatal care, you may visit any in-network prenatal provider. For your other health care needs, see your primary care provider (PCP).

To get a list of prenatal providers in your area, please visit our website at [chpplusproviders.com/members.asp](http://chpplusproviders.com/members.asp) or call us at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

For regular medical care, you must see an in-network primary care provider (PCP). If you need help finding a PCP, please call us or visit our website at [chpplusproviders.com/member.asp](http://chpplusproviders.com/member.asp).

## Summary of Covered Benefits

This is a summary of the benefits you are entitled to while eligible for CHP+ State Managed Care Network. Copays may apply. See the copay table in this Booklet for more information.

Service	Available Benefits
Preventive Care	Covered in full when provided by your primary care provider (PCP). Includes immunizations (shots), checkups, and routine exams.
Reproductive Health Care Services	Covered in full when provided by an in-network provider. Includes well-women checkups.
Medical Office Visit	Primary care provider (PCP) visits and specialty visits covered.
Inpatient Hospital Stay	Covered in full.
Lab, X-ray, and Diagnostic Services	Covered in full.
Outpatient Prescription Drugs (Medications)	Covered in full if included on the formulary. Standard CHP+ copays (\$0 to \$10) apply.
Over-the-counter (OTC) Medications	A prescription from your provider is required. Coverage includes: <ul style="list-style-type: none"> <li>• Loratadine (generic Claritin)</li> <li>• Cetirizine (generic Zyrtec)</li> <li>• Prevacid</li> </ul>
Skilled Nursing Facility	Covered for up to 30 calendar days per benefit year or until the member reaches the maximum medical improvement.
Outpatient/Ambulatory Surgery	Covered in full.
Emergency Room and Urgent/After-hours Care	Covered in full for a life or limb-threatening emergency.
Emergency Transport/Ambulance Services	Covered in full for a life or limb-threatening emergency.
Vision Services	Coverage for age-appropriate preventive care and specialty care visits. There is a \$50 benefit for the purchase of lenses, frames or contacts per calendar year.
Audiological Services	Coverage for age-appropriate preventive care visits. CHP+ Prenatal Care Program members may receive hearing aids for congenital conditions and traumatic injuries.

Have questions? Need help? We are here to help you in the language you speak!

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Service	Available Benefits
Physical, Occupational, and Speech Therapy	For outpatient physical rehabilitation (physical, occupational, and/or speech therapy), the standard CHP+ coverage is limited to 30 visits per calendar year. For children ages 0-3, the benefit of physical, occupational, and speech therapy is unlimited.
Durable Medical Equipment	Maximum of \$2,000 per calendar year, excluding eyeglasses, contacts or hearing aids.
Home Health Care	Skilled services covered with pre-authorization.
Maternity Care	All prenatal and delivery visits are covered in full.
Behavioral or Mental Health	Coverage provided for medically necessary services and may require a pre-authorization.
Alcohol and Substance Abuse	Coverage provided for medically necessary outpatient services and may require a pre-authorization.
Transplant Services	Coverage provided for limited transplants with pre-authorization.
Dental Care	<b>Note:</b> Pre-HMO members receive emergency dental care only.

Exclusions: Services not shown above may not be covered. For more information, please call us at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free). This is for summary purposes only and does not guarantee coverage.

# 1: Member Rights

## AS A MEMBER, YOU HAVE THE RIGHT TO:

- Receive information regarding terms and conditions of your health care benefits.
- Use your rights without any adverse effects on the way you are treated.
- Be treated respectfully and with consideration. Be free from any form of restraint or seclusion used as a means of convincing you to do something you may not want to do.
- Receive all the benefits to which you are entitled under this Booklet.
- Obtain complete information from a provider regarding your health care in terms you can reasonably understand. This includes diagnosis, treatment, and prognosis. Get copies of your treatment records and service plans and ask us to change your records if you believe they are incorrect or incomplete.
- Receive quality health care through providers in a timely manner and in a medically-appropriate setting.
- Have an upfront (candid) discussion with providers about appropriate or medically necessary treatment options for your condition, regardless of the cost or benefit coverage including any alternative treatments that may be self-administered.
- Participate with your provider(s) in decision-making about health care treatment.
- Get a second opinion.
- Refuse treatment and be informed by a provider(s) of what will happen if you do so.
- Receive wellness information to help you stay healthy and maintain a healthy lifestyle.
- Express any concerns and complaints about care and services provided so that we can investigate and take appropriate action.
- File a complaint or appeal a decision with us as outlined in the [Complaints, Appeals & Grievances](#) section without fear of retaliation.
- Expect that your personal health information will be kept in a confidential manner.
- Make recommendations about the [Member Rights and Responsibilities](#) policies.
- Receive information about the administrative services organization (Colorado Access), the CHP+ managed care organizations (health plans), services, the practitioners and providers delivering care, and the rights and responsibilities of the members.
- Request information on participating provider compensation arrangements.
- Ask anything about physician incentive plans.
- Get family planning services. You must get services directly from any provider who is licensed or certified to provide such services. This does not depend on enrollment and a referral is not necessary.



- 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 about how to Get Involved at Colorado Access by going to our website <https://www.coaccess.com/partnering/getinvolved/> or contact our Member Outreach and Inclusion team at 720-744-5610.

### **RIGHTS AND RESPONSIBILITIES REGARDING CONTINUITY OF CARE**

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 DME provider up to 75 days as long as they, or their provider, work with us to transfer care.

#### **Responsibility:**

- 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.

### **RIGHTS AND RESPONSIBILITIES 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.

### **AS A MEMBER, YOU HAVE THE RESPONSIBILITY TO:**

- Use in-network providers and remember to show you CHP+ State Managed Care Network ID card.
- Maintain ongoing patient-provider relationships with the providers who give you care or coordinate your total health care needs.

- Give your providers complete and honest information about your health care status and history.
- Follow the treatment plan recommended by providers.
- Understand how to access care in non-emergency and emergency situations, and to know your out-of-network health care benefits, including coverage and copayments.
- Notify the provider or CHP+ State Managed Care Network about your concerns regarding the services or medical care you receive.
- Be considerate of the rights of other members, providers, and CHP+ State Managed Care Network staff.
- Read and understand your CHP+ Member Benefits Booklet.
- Pay all member payment requirements in a timely manner.
- Provide us with complete and accurate information about other health care coverage and/or benefits you may have or obtain.
- Work with your provider to understand your health care concerns and to develop treatment goals.
- Provide Colorado Access with written notice after filing a claim or an action against a third-party responsible for your illness or injury.

### **CHANGING MEMBER INFORMATION**

If your membership information changes in any way, such as your address or PCP, call us at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free). If your change cannot be made over the phone, we will explain how to make the change. Please call CHP+ Eligibility and Enrollment about the change as well, at 888-637-6557.

### **CHANGE OF RESIDENCE**

If you move or change permanent residences, you must call us at 303-751-9051 or 800-414-6198 (toll free), or 720-744-5126 or 888-803-4494 (toll free) for TTY users, and CHP+ Eligibility and Enrollment at 888-637-6557 within 31 days after you move or change permanent residences. If you do not call, you may not receive important notices, including renewal notices. If you do not receive a renewal notice because you did not report your address change (or any other reason) it does not mean you don't have to submit renewal application by your renewal date. If you move to a place that is far from your current primary care provider's (PCP's) office, you may choose a PCP that is closer to your new address. Please call us at 303-751-9051 or 800-414-6198 (toll free) if you would like to change your PCP. TTY users should call 720-744-5126 or 888-803-4494 (toll free).

## ADVANCE MEDICAL DIRECTIVES

The following information applies to members of the CHP+ Prenatal Care Program only. If you have any questions, please call us at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

Advance Medical Directives:

- Protect your right to make medical decisions and choices about your health care
- Help family members make decisions if you cannot.
- Help your doctor by telling them your wishes.
- Say what kind of medical care you want if you get too sick or hurt to talk or think clearly.

### There are three kinds of Advance Medical Directives:

#### 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 (also called a “Health Care Proxy”)

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) Directives

CPR is performed to get someone’s heart and/or breathing started again. If you have a “Do Not Resuscitate (DNR) 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 an Advance Medical Directive, it is important to talk to your doctor, family, and other people about your choices, or if you change them. 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+ State Managed Care Network by calling 720-744-5134 or 877-276-5184 (toll free). TTY users should call 888-803-4494. Please see the [Complaints, Appeals, & Grievances](#) section for more information.
- Call the Colorado Department of Public Health and Environment: 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 applicable state laws concerning advance medical directives, go to our website: [coaccess.com/advance-directives](https://coaccess.com/advance-directives).

## 2: About Your Health Care Coverage

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

CHP+ State Managed Care Network 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 the get preauthorization for services when they are needed. This will help ensure that the care you receive is medically necessary, performed in the right setting, and is otherwise a covered service.

### MEMBER IDENTIFICATION CARD (ID CARD)

Your CHP+ Member ID card shows that you are a member of CHP+ State Managed Care Network or the CHP+ Prenatal Care Program. Bring this ID card with you when you get medical care. This includes all pharmacies (when you get prescription medications), doctors, hospitals, and any medical supplies. If you have not received your ID card or need a new ID card, please call us at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

### CHANGING YOUR INFORMATION

If your membership information changes, such as changes to your address, or if you would like to change your primary care provider (PCP), call us at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free). Please also notify CHP+ Eligibility and Enrollment at 888-367-6557.

### PRENATAL CARE

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

### GETTING INFORMATION ABOUT YOUR HEALTH CARE PROVIDERS

To get information about health care providers, including doctors, nurses, specialists, and pharmacies, call the Colorado Division of Registration. 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 Division of Registration can be reached at 303-894-7891.

## PRIMARY CARE PROVIDERS (PCP)

All members of CHP+ State Managed Care Network and the CHP+ Prenatal Care Program must choose an in-network primary care provider (PCP). A PCP can be a family practice doctor, an internal medicine doctor, a pediatrician, or a general practitioner. CHP+ Prenatal Care Program members may choose an OB/GYN as their primary care provider. Your PCP helps you get the care you need. He or she provides a wide range of health care services, including checkups, sick visits, shots, initial diagnosis and treatment, health supervision, management of chronic conditions, referrals to specialists when you need one, and ensuring continuity of patient care.

Benefits are only provided for covered services, even if performed by your PCP or if your PCP referred you to have the service. This is regardless of medical necessity.

Please work with your PCP to coordinate care with specialists and to get pre-authorizations for services when they are needed.

- If you need to see a specialist for covered services, you need a referral from your PCP.
- If you need a covered service that your PCP cannot provide, you need a referral from your PCP.
- If your PCP refers you for a service that requires a preauthorization, your PCP's referral does not guarantee or imply coverage. Your PCP or the specialist should contact us to request a pre-authorization.

The State Managed Care Network has an obligation to ensure 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 facilitates member participation in the community.

Members with special health care needs may be allowed to have direct access/standing referral to their specialist as needed for their care. You should speak with your doctor about setting up a long-standing referral with a specialist. You can also call us if you have questions about this benefit.

If there is not an in-network provider for a covered service, we will refer you to a provider with the necessary expertise.

## Selecting a PCP

You must choose an in-network PCP. If you do not contact us to choose a PCP, one will be chosen for you. You can call us to change your PCP during your eligibility period at any time and for any reason. You can find a list of in-network PCPs in the Provider Directory. 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 [chpplus.com/members.asp](http://chpplus.com/members.asp). This directory will provide you with the address and phone number of the provider, as well as what languages the staff speaks, and if new patients are being accepted.

Please call the PCP’s office to make sure that the provider is accepting new CHP+ State Managed Care Network patients.

Once you choose a PCP from the Provider Directory please call us at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free). You will receive a new ID card with the name of your PCP on it.

**Going to see your PCP**

To visit a PCP, call your PCP’s office to make an appointment. The telephone number for the PCP can be found on your member ID card. When you call, tell the office that you are a member of the CHP+ State Managed Care Network or the CHP+ Prenatal Care Program. The office will help you make an appointment. When making an appointment with your PCP, you should be able to schedule urgently needed appointments within 48 hours, non-urgent care within two weeks, and well-child physical examinations within four months.

Remember this important information when you schedule your appointment:

<b>If your health concern is:</b>	<b>Your appointment should be within:</b>
Urgent	24 hours
Non-Urgent, symptomatic	7 days
Non-Urgent, non-emergent	30 days
Well Visits	30 days
Non-Urgent Behavioral Health/SUD	7 days

If you need to cancel your appointment with your PCP, please call him or her at least 24 hours before the appointment. Talk to your PCP’s office to find out if they have a cancellation policy. You should also notify the PCP’s office if you are going to be late for an appointment. The PCP may ask that the appointment be rescheduled.

Please call your PCP’s office for instructions on how to receive:

- Medical care after the PCP’s normal business hours.
- Medical care on weekends and holidays.

- Non-emergency care within the service area for a condition that is not life-threatening but that needs prompt medical attention.

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

### **Changing your PCP**

You may change your PCP to another in-network PCP at any time during your eligibility period. To change your PCP, please call us at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

When you change your PCP, you should have your medical records transferred from your old PCP's office to your new PCP's office. To have your medical records transferred, contact your former PCP. You are responsible for any charges related to transferring your medical records.

### **Referrals**

Your primary care provider (PCP) provides basic health and medical services. This includes routine and preventive care. Sometimes you might need to visit a specialist or other provider. Your PCP will help coordinate your care by giving you a referral. A referral is the formal recommendation given to you by your PCP to get care from a specialist or a different provider. Your PCP will make sure that all important referral information is given to the specialist. Once you get the referral from your PCP, it is your responsibility to make sure that the specialist is in-network and accepts CHP+ State Managed Care Network.

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 do not need a referral from your PCP for:

- An emergent or urgent situation.
- Care from an in-network OB/GYN provider or certified nurse-midwife for obstetric or gynecological care.
- Care from an in-network optometrist or ophthalmologist for a routine eye exam.
- Mental health services. You may self-refer for mental services. However, the services will require preauthorization from us and may be subject to benefit limits.



Always make sure that the services your PCP recommends are covered by CHP+ State Managed Care Network or the CHP+ Prenatal Care Program as explained in this Booklet. A PCP's referral does not always mean the service is covered.

### **OTHER HEALTH INSURANCE**

You can only qualify for CHP+ State Managed Care Network if you do not have any other health care insurance coverage. If you are covered by any other valid coverage, including Health First Colorado, individual (private), and group coverage, you are not eligible for CHP+ State Managed Care Network.

There are limited exceptions to this rule. CHP+ State Managed Care Network members can have the following insurance plans and still keep their CHP+ State managed Care Network coverage: Medicare, dental, and vision.

Members with COBRA health insurance coverage are eligible to apply for the Child Health Plan Plus (CHP+) program. Once the applicant is notified that he or she has been accepted to CHP+ and chooses to participate, he or she must terminate COBRA health insurance coverage. This means CHP+ members can have dual coverage with CHP+ and their COBRA coverage for a period of time. For the period of time which the member has both CHP+ and COBRA coverage, COBRA will be the primary insurance plan. **Remember:** CHP+ members must receive care from CHP+ participating providers in order for the care to be covered (paid for) by CHP+.

If you get other health insurance coverage while you are on CHP+, you must call CHP+ Eligibility and Enrollment at 800-359-1991 and notify them of the new coverage. If you are found to have other insurance coverage while you are on CHP+, your CHP+ coverage will end (be terminated) and you will be dis-enrolled from the CHP+ program. In some cases, coverage will retroactively terminate for the time period that 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).

### **NEWBORN CHILD ENROLLMENT**

If you become pregnant, please call us at 303-751-9051 or 800-414-6198 (toll free) and ask to speak to a prenatal care manager. TTY users should call 888-803-4494. This care manager can help you find a doctor for your pregnancy and coordinate your prenatal care.

Babies born to moms 18 years old and younger will be automatically covered under the mom's health plan for the first 30 days of life. Most babies born to teen mothers are eligible for Health First Colorado. However, some newborns may qualify for CHP+. You must contact CHP+ Eligibility and Enrollment at 800-359-1991 after you have your baby to apply for coverage for your newborn.

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Have questions? Need help? We are here to help you in the language you speak!

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Call us at 303-751-9051 or 800-414-6198 (toll free)

TTY for the deaf or hard of hearing 720-744-5126 or 888-803-4494 (toll free)

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Newborns that are born to mothers on the CHP+ Prenatal Care Program are guaranteed coverage under CHP+ for 12 months from the date of birth. Please call CHP+ Eligibility and Enrollment at 800-359-1991 to report your newborn and enroll them for coverage.

### **Adult Members in the CHP+ Prenatal Care Program**

We offer a prenatal program to women ages 19 and older who qualify for the program and are pregnant. Women in the CHP+ Prenatal Care Program are covered for 60 days after the month of delivery or the end of the pregnancy. Copays do not apply for medical or pharmacy services received for members in the CHP+ Prenatal Care Program.

### **Newborn Child Primary Care Provider (PCP) Assignment**

Your baby will be enrolled with your PCP on his or her date of birth. If your PCP only provides care to adults, the newborn child will be assigned to a PCP that provides care to children. If you would like to choose a different PCP for your baby, call us at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

### 3: Managed Care

To make sure you are getting the most appropriate health care, CHP+ State Managed Care Network and the CHP+ Prenatal Care Program uses some managed care tools or processes. Some of the tools or processes used include:

- Pre-authorization for health care services.
- Concurrent hospital review.
- Care management and disease education.
- Transition of care.

This section of the Booklet explains these managed care tools and processes. This section will also help you understand the steps for obtaining care.

#### PRE-AUTHORIZATION

Certain services require preauthorization. This includes some procedures, diagnostic tests, durable medical equipment, home health services, home IV services, and medications. Admissions to a hospital (except in emergency situations, as explained in this Booklet) require preauthorization. Please see the [Member Benefits – Covered Services](#) section in this Booklet for information on services that require preauthorization.

- The provider who schedules an admission or orders the procedure or services is responsible for requesting preauthorization.

When reviewing a request for preauthorization, we make sure the service or supply is:

- A covered benefit.
- Provided in the most medically-appropriate setting.

The preauthorization process may set limits on coverage available under this Booklet. For example, after reviewing a preauthorization request, we may determine that a limited number of visits will be covered. If your provider feels that you need more visits, he or she can request an additional preauthorization before you reach the visit maximum. Coverage is limited to the benefits outlines in this Booklet.

A preauthorization does not guarantee payment. Fraud or abuse may cause a denial of payment. Also, when a claim is received, it is reviewed using this Booklet as a tool for determining coverage. If the claim received describes a service that is not a covered benefit, the claim may be denied. The claim may also be denied if the service described on the claim is different than the service that was preauthorized.

If you have any questions about preauthorization, please call us at 303-751-9051 or 800-414-6198 (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. We will send you and your provider a letter for all adverse service determinations. You can appeal the decision by following the procedure in the [Complaints, Appeals & Grievances](#) section of this Booklet.

### **Covered Benefit Decisions**

To decide if a service is a covered benefit, we consider if the service is:

- Medically necessary
- Experimental/investigational
- Cosmetic
- Excluded under this coverage

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

- CHP+ State Managed Care Network's adopted medical policies and practice guidelines.
- Current peer-reviewed medical literature.
- Guidelines obtained from recognized national organization and professional associations.
- Consultations with specialists.

We do not promote or otherwise provide an incentive to our employees or provider reviewers for withholding the approval of benefits for medically necessary services to which the member is entitled.

### **MEDICALLY NECESSARY HEALTH CARE SERVICES**

CHP+ State Managed Care Network and the CHP+ Prenatal Care Program 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 policy
- Medical practice guidelines
- Professional standards
- Outside medical peer review

## Medical Policies

Our medical policies reflect current standards of practice and evaluate medical equipment, treatment, and interventions according to an evidence-based review of scientific literature. The benefits, exclusions, and limitations of a member's coverage take precedence over medical policy. This means that if a service is listed as excluded or not covered in this Booklet, it is not covered, regardless of whether or not it meets the standards set forth by the medical policy.

To make sure that medical policies are current, we review and update medical policies 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/investigation 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 a list of excluded services in the [Excluded Services](#) section.

## APPROPRIATE SETTING AND PREAUTHORIZATION

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

## Inpatient Admissions

Examples of inpatient settings include:

- Hospitals
- Skilled nursing facilities
- Hospice care

All inpatient stays require authorization. Your provider must contact us to ask for the authorization. We will review the request. If the request is approved, all covered services will be covered by CHP+ State Managed Care Network or the CHP+ Prenatal Care Program. We may ask for additional information to determine the medical necessity of any procedures.

**You may be held financially responsible (billed by the providers) for all charges related to an inpatient stay that is not authorized by us.**

We will authorize a specific number of days for the inpatient stay. If your provider requests more days, we will review the request. We may review the inpatient admission while you are in the hospital for a stay that goes over the number of days authorized.

- If we determine that additional time in the hospital is not medically necessary, we will let the hospital and the provider know of this determination.
- The hospital will let you know of this determination in a timely manner. If you decide to stay in the hospital after this notice, we will not pay for services after the recommended date of discharge. You will be responsible for all charges from after the recommended date of discharge.
- We will send you, your provider, and the hospital written notification of the decision. If you disagree with the decision, you can appeal by following the procedure in the [Complaints, Appeals & Grievances](#) section of this Booklet.

Your provider must request preauthorization from us before a scheduled inpatient admission. A preauthorization is valid only for a specific place and during specific dates. You must receive the approved service at the specific place and during the specific dates listed in the preauthorization. If you do not receive the service during the specific dates, or if you need additional services, your provider must contact us to request another authorization.

**Emergency (Unscheduled) Admissions**

We must be notified of an emergency admission within one business day of the admission. You are responsible for making sure that we have been notified of the emergency admission, unless you are unable to do so. An example of an emergency admission includes an admission involving an accident. Once we are notified, we will help the management of the hospital benefits and planning for covered medical services during hospitalization and after discharge. Failure to notify us may result in a reduction or denial of coverage.

**Appropriate Length of Stay**

We work with your providers to determine the appropriate length of an inpatient stay. 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.

### **Concurrent Review**

While you are in the hospital, we will review your medical care to make sure you are receiving appropriate and medically necessary hospital services. This is called concurrent review.

### **Outpatient Procedures**

Examples of outpatient settings include:

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

Outpatient services may be performed in a hospital on an outpatient basis or in a freestanding facility, such as an ambulatory surgery center.

Some procedures performed in an outpatient setting must be preauthorized. Your health care provider is responsible for requesting preauthorization. We may ask your provider for more information to determine if the service is medically necessary.

A preauthorization is valid only for a specific place and during specific dates. You must receive the approved service at the specific place and during the specific dates. If you do not receive the service during the specific dates, or if you need additional services, your provider must contact us to request another authorization.

### **RETROSPECTIVE CLAIM REVIEW**

Sometimes, in order to determine if a service that is submitted on a claim is a covered service, we may perform a retrospective claim review. This is when we review charges for services that have already been provided.

This is done to determine:

- If the services were preauthorized.
- The appropriateness of the services billed based on covered benefits, medical policy, and medical necessity.

We may request and review your medical records to help make payment decisions. If we determine that services are not covered, we will not pay for the charges.

## ONGOING CARE NEEDS

Ongoing care is coordinated through services such as utilization management, care management, and disease education.

### Utilization Management

Utilization management is used to determine if a service is medically necessary, delivered in the right setting and for the appropriate length of time. Care is compared to nationally recognized guidelines. Utilization review may be used to determine appropriate payment for covered services. However, the decision to obtain the service is made solely by you in conjunction with your provider, regardless of the payment/coverage decision made by us. 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 us. We will assist you in finding a different provider who will provide the covered services you need.

Our utilization management team is happy to explain our program and how services are covered. You may request information about our utilization management program to better understand how this program is used to determine the medical necessity of services. Please contact us at 303-751-9051 or 800-414-6198 (toll free) to learn more. 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 Education

We have a team of health care professionals called care managers. Our care managers will work with your PCP to help you get the care you need. Care managers can also help make sure your doctors are talking to each other. Our care managers may call you to talk about what special care you may need and to see if we can help. You can call them at 303-751-9051 or 800-414-6198 (toll free) if you need help managing your health care. TTY users should call 720-744-5126 or 888-803-4494 (toll free).

Care management is a way that we help members with serious illnesses or injuries. Care management is used when illnesses or injuries are so complex that individualized coordination of care is helpful. In such cases, a care manager may work with the member to help coordinate and facilitate the administration of medical care. A care manager may also help organize a safe transition from hospital to home care.



The care management program is designed to identify patients as early as possible who may benefit from care management and to see that issues related to care are assessed and addressed, documented, and resolved in a consistent and timely manner.

Once a member is in the care management program, nurses and other medical staff, called care managers, work with the member to help coordinate and facilitate medical care. The member may or may not have direct contact with the care manager. Care managers help create a care plan for the member. This will also help put the care plan into action, monitor the use and effectiveness of services, and determine if services are given in a timely manner and in the most appropriate setting.

We decide which members receive care management, and may not offer care management to all members with similar conditions. The care management program is tailored to the member. In certain circumstances involving intensive care management, we may, at our sole discretion, provide benefits for care that are 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. A decision in one case to provide extended benefits or approve care not listed as a covered service does not obligate us to provide the same benefits again to that member or to any other member. We reserve the right, at any time, to alter or cease providing extended benefits or approving care not listed as a covered service. In such cases we will notify the member in writing.

### ***Getting Involved in Care Management***

There are many ways for eligible members to become involved in the care management program.

- We can identify members that may benefit from the programs and outreach to them.
- Providers may refer their patients enrolled with CHP+ State Managed Care Network or the CHP+ Prenatal Care Program.
- A member may also contact us with questions about care management at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

## TRANSITION OF CARE

As a new member of CHP+ State Managed Care Network or the CHP+ Prenatal Care Program, you may have been receiving ongoing care from a provider for a certain medical condition. An example of ongoing care is prenatal/obstetrical care. To make sure that your ongoing care is not disrupted, we have a transition of care policy. If you need transition of care, schedule a visit with your primary care provider (PCP). Your PCP will help coordinate your ongoing care. If the doctor you are seeing for ongoing care is an out-of-network provider, you may need to switch to an in-network provider within 60 days, unless approved by us.

If a doctor or service provider you are seeing notifies us that he or she will stop practicing or will terminate his or her contract with us, then we will notify you within 15 days of that notification and we will assist you in transitioning to a new doctor or service provider.

## 4: What You Pay for Enrollment & Service

Cost sharing refers to how members share the cost of health care services with us. It defines what we are responsible for paying, and what the member is responsible for paying. Members satisfy the cost-sharing requirements through the payment of copayments as described in this section.

### **HOLD HARMLESS**

The contracts between us and our providers include a “hold harmless clause.” This clause says that you cannot be billed by the provider beyond what is paid by CHP+ State Managed Care Network in accordance with the fee schedule. The fee schedule is the amount the provider agrees to accept from us for services provided to members. If you are billed by an in-network provider, please call us at 303-751-9051 or 800-414-6198 (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-network provider and the service is not authorized.
- You receive any non-covered service.
- You receive services (for example, day surgery) without an authorization from us.
- You receive services when you are not covered by us.

### **SERVICES FROM OUT-OF-NETWORK PROVIDES**

Non-emergency services from out-of-network providers are not covered unless they are authorized by us. If services from 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.

### **ENROLLMENT FEE**

Depending on family size and income, some families may pay an annual fee of \$0, \$25 or \$75 to enroll one child and \$0, \$35, or \$105 to enroll two or more children. This enrollment fee is based on family size and income. There is no enrollment fee for the CHP+ Prenatal Care Program.

## COPAYMENTS

A copayment is a dollar amount you pay in order to receive a specific service, supply, or prescription medication. You should pay your copayment to your provider at the time of service or when getting a prescription medication.

CHP+ State Managed Care Network copayments are based on family size and income. Copayment amounts are listed on your ID card. The following table gives some examples of copayment amounts.

State Managed Care Network Benefits	Copay			
	<101% FPL	101%-150% FPL	151%-200% FPL	201%-250% FPL
Annual Deductible Individual Family	None None	None None	None None	None None
Out-of-Pocket Limit  Individual Family	None	5% of annual family income adjusted for family size	5% of annual family income adjusted for family size	5% of annual family income adjusted for family size
Emergency Care	\$3	\$3	\$30	\$50
Urgent/After Hour Care	\$1	\$1	\$20	\$30
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 Visits	\$0	\$2	\$5	\$10
Fluoride Varnish Application	\$0	\$0	\$0	\$0
Laboratory and X-ray	\$0	\$0	\$5	\$10
Preventive, Routine, and Family Planning Services	\$0	\$0	\$0	\$0
Maternity Care Prenatal	\$0	\$0	\$0	\$0

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State Managed Care Network Benefits	Copay			
	<101% FPL	101%-150% FPL	151%-200% FPL	201%-250% FPL
Delivery & Inpatient Well Baby Care	\$0	\$0	\$0	\$0
Mental Illness Care	\$0	\$2/office visit \$2/admission	\$5/office visit \$20/admission	\$10/office visit \$50/admission
Neurobiologically-based Mental Illness	\$0	\$2/office visit \$2/admission	\$5/office visit \$20/admission	\$10/office visit \$50/admission
Mental Disorders	\$0	\$2/office visit \$2/admission	\$5/office visit \$20 admission	\$10/office visit \$50/admission
All Other				
Inpatient	\$0	\$2	\$20	\$50
Outpatient	\$0	\$2	\$5	\$10
Outpatient Substance Abuse Treatment Services	\$0	\$2	\$5	\$10
Physical Therapy, Speech Therapy, and Occupational Therapy	\$0	\$2	\$5	\$10
Durable Medical Equipment	\$0	\$0	\$0	\$0
Transplants	\$0	\$0	\$0	\$0
Home Health Care	\$0	\$0	\$0	\$0
Hospice Care	\$0	\$0	\$0	\$0
Prescription Drugs	\$0	\$1/generic or brand name	\$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	\$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
Case Management	\$0	\$0	\$0	\$0
Dietary Counseling/ Nutritional Services	\$0	\$0	\$0	\$0

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State Managed Care Network Benefits	Copay			
	<101% FPL	101%-150% FPL	151%-200% FPL	201%-250% FPL
Lifetime Maximum	None	None	None	None
Pre-existing Condition Limitations	Not applicable	Not applicable	Not applicable	Not applicable
Therapies: Chemotherapy and Radiation	\$0	\$0	\$0	\$0

**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 pay a copayment for the rest of that calendar year.

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

- Save your copayment receipts from covered medical care and covered prescription medications. When you have reached your annual out-of-pocket limit, call CHP+ Eligibility and Enrollment at 800-359-1991.
- CHP+ Eligibility and Enrollment will ask for proof that you have reached your annual out-of-pocket limit. Send copies of your receipts as proof.

## 5: Membership

### ENROLLMENT PROCESS

In order to obtain CHP+ coverage, you must follow the CHP+ enrollment process. This process includes completing required forms.

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

### Renewal Process

You will need to reapply for CHP+ each year or you may need to reapply if you lose your coverage under CHP+ because you become eligible for another plan, such as Health First Colorado. If you have questions about when to reapply for CHP+ coverage, please call us at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

**Note:** Any services received before the effective date are not covered by CHP+ State Managed Care Network or the CHP+ Prenatal Care Program.

### ID Cards and New Member Information

CHP+ State Managed Care Network will send you a membership ID card. Your effective date will appear on your new ID card.

- ID cards are sent to all new members.
- A new ID card is sent each time the information on your ID card is changed (for example, you will receive a new ID card if you change your primary care provider).
- If you need a new ID, or if you do not receive your ID card, please call us at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

In addition to an ID card, you will also receive a new member packet. The new member packet includes the CHP+ Member Benefits Booklet and information about in-network providers.

### NEWBORN CHILD ENROLLMENT

If you become pregnant, please call us at 303-751-9051 or 800-414-6198. TTY users should call 720-744-5126 or 888-803-4494 (toll free). You also need to call when you have your baby. This will help coordinate your prenatal care and coverage for your newborn child. Also, please call CHP+ Eligibility and Enrollment at 800-359-1991 after you have your baby. Your baby will be covered under your benefit coverage for 30 days.

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**It is very important that you call CHP+ Eligibility and Enrollment at 800-359-1991 after you have your baby. Your baby will be covered under your coverage for 30 days only; you will then need to apply for coverage for your newborn child. A CHP+ Eligibility and Enrollment specialist can help you with that process. Most babies born to teen mothers are eligible for Health First Colorado; however, some newborn children may qualify for CHP+.**

### **Adult Members in the Prenatal Care Program**

Newborn children of women who are approved for the CHP+ Prenatal Care Program are automatically covered under CHP+ for 12 months from the date of birth. Please contact CHP+ Eligibility and Enrollment at 800-359-1991 to enroll your baby.

### **TERMINATION POLICY**

CHP+ member coverage ends on the first occurrence of one of the following events:

- Coverage with the CHP+ Prenatal Care Program terminated 60 days after the last day of the month in which the pregnancy has ended. For example, if you give birth on June 26, your coverage would end on August 30.
- The member has committed fraud or intentional misrepresentation of material fact.
- The member established permanent residence (moves) outside of Colorado.
- CHP+ receives written notification to cancel coverage for any member. Coverage will end at the end of the month following the written notification period.
- The member acts in a disruptive manner that prevents the orderly business operation of any CHP+ State Managed Care Network staff or provider, or is dishonestly attempting to gain a financial or material advantage.
- Having or obtaining other health insurance. If you obtain other insurance, or are found to have other insurance, you are no longer eligible for CHP+ for the time period the other insurance was effective.
- Ineligibility for the program, based on the guidelines set forth in the Children's Basic Health Plan eligibility rules.
- Upon the member's death.

### **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 states 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+ State Managed Care Network and the CHP+ Prenatal Care Program benefits end on the date that your coverage ends as described above. Except as stated below, we will not pay for services after your coverage ends, even if we preauthorized the service, unless the provider verified eligibility within two business days before each service was received.

If you are being treated at an inpatient facility when your coverage ends, we will continue to 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 this Booklet and 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 us for services provided after your coverage has ended.

You have the right to disenroll from the CHP+ State Managed Care Network at any time for any reason. You will need to contact CHP+ Eligibility and Enrollment at 800-359-1991 and let them know that 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).

## 6: Member Benefits – Covered Services

This section describes the benefits and covered services of CHP+ State Managed Care Network and, unless otherwise noted, the CHP+ Prenatal Care Program. In order to obtain covered services, members should follow the direction in this Booklet.

### Remember:

- We cover medically necessary and preventive services and supplies.
- We do not cover the services that are listed as excluded or as exclusions in this Booklet.
- We cover 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 and does not guarantee payment by us.
- If you have questions about a service or benefit, please call us at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

All covered services are subject to the exclusions listed in this section, in addition to the exclusions in other sections of this Booklet, including those listed in the [General Exclusions & Limitations](#) section of this Booklet. All covered services are subject to other conditions and limitations of this Booklet.

### MEMBER BENEFITS – COVERED SERVICES – PREVENTIVE CARE SERVICES

This section describes covered services and exclusions for preventive care.

#### Who should I see for preventive care services?

You should see your primary care provider (PCP) for preventive care services.

#### What preventive care services are covered?

Covered preventive services are routine PCP visits, like well-child exams and routine physical. Additional services provided are also covered and include:

- Regularly scheduled childhood and adult immunizations (shots).
- Age-appropriate vision and hearing and screening exams.
- Health education given by your PCP. This may include information about preventing illness and injury. Your PCP may ask you a series of age-appropriate questions during your visit. This will help your PCP decide on topics to talk about during your health education discussion.

We encourage parents and providers to follow the well-child visit schedule recommended by the American Academy of Pediatrics.

Infancy	Early Childhood	Middle 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 services are not covered?**

The following are not covered services (exclusions):

- Immunizations required for international travel.
- Services related to routine physical or screening exams and immunizations given primarily for insurance, licensing, employment, weight reduction programs, or for any non-preventive purpose.
- Any services not medical necessary.

**MEMBER BENEFITS – COVERED SERVICES – FAMILY PLANNING/REPRODUCTIVE HEALTH**

This section describes covered services and exclusions for family planning/reproductive health.

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

Any in-network reproductive health provider. This could be a PCP or OB/GYN. Family planning services do not require prior authorization or referral for in-network providers.

**What family planning/reproductive health services are covered?**

Birth control bills are covered. See the [Member Benefits – Covered Services – Prescription Medications](#) section for more information. In addition, covered family planning/reproductive health services include:

- Injection of 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 an Intrauterine Device (IUD).
- The purchase of 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 Infections) and HIV testing and treatment.

### **What family planning/reproductive health services are not covered?**

The following family planning/reproductive health services are not covered (exclusions):

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

### **MEMBER BENEFITS – COVERED SERVICES – MATERNITY AND NEWBORN CHILD CARE**

This section describes covered services and exclusions for maternity and newborn child care.

#### **Who should I see for maternity and newborn child care?**

You should see an in-network OB/GYN, certified nurse-midwife or family practice doctor 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 child care services are covered?**

Benefits are provided for maternity and newborn child care, including diagnosis, care during a pregnancy, 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 complications of pregnancy.
- Anesthesia services.
- Routine nursery care for a covered newborn child, including provider services.
- For newborn children, all medically necessary care and treatment of injury and sickness including medically diagnosed congenital defect and birth abnormalities.
- Tests to diagnose a possible genetic illness/disease.
- Circumcision of a covered newborn male.

- Laboratory services related to prenatal care, postnatal care or termination of a pregnancy.
- Spontaneous termination of pregnancy prior to full term.
- Elective termination of pregnancy, only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.
- Two antenatal ultrasounds are covered. After the second ultrasound, preauthorization is needed. The care management department will review the preauthorization request for a pending high-risk pregnancy.
- At-home, post-delivery, follow-up visits are covered at your residence by a provider, nurse or certified nurse-midwife when performed no later than 72 hours following you and your newborn child's discharge from the hospital. Coverage for the visit includes, but is not limited to:
  - Parent education
  - Physical assessments
  - Assessment of the home support system
  - Assistance and training in breast or bottle feeding
- Performance of any maternal or neonatal tests routinely performed during the usual course of inpatient care for the mother or newborn child, including the collection of an adequate sample for the hereditary disease and metabolic newborn child screening. At the mother's discretion, this visit may occur at the provider's office.
- We cover services performed by a participating certified nurse-midwife or a direct-entry midwife. The following services are covered benefits:
  - Advising, attending or assisting of a woman during pregnancy, labor, and natural childbirth at home, and during the postpartum period in accordance with C.R.S. 12-27-101 et. al. seq. that includes one metabolic screening, one postpartum visit, one prescreening visit, and the actual delivery and labor.
- We will not limit coverage for a hospital stay related to childbirth for the mother and newborn child to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. If the delivery occurs between 8:00 p.m. and 8:00 a.m., coverage will continue until 8:00 a.m. on the morning following the 48-hour or 96-hour coverage period. The mother's attending provider, after consulting with the mother, may discharge the mother and newborn child earlier, if appropriate.

Please see the [Membership](#) section of this Booklet for more information about newborn child coverage and enrollment.

### **What maternity and newborn child care services are not covered?**

The following services, supplies and care are not covered (exclusions). Services including, but not limited to:

- Preconception counseling
- Paternity testing
- Genetic counseling and testing (unless related to the determination of disease or other circumstances not excluded above)
- Testing for inherited disorders
- Screening for disorders
- Discussion of family history or test results to determine the sex or physical characteristics of an unborn child
- Storage costs for umbilical blood

### **MEMBER BENEFITS – COVERED SERVICES – PROVIDER OFFICE SERVICES**

This section describes covered services and exclusions for provider office services.

#### **Who should I see for provider office service?**

In order to receive these benefits, you must receive the medical care and services in the office of an in-network provider (unless otherwise authorized). Please work with your Primary Care Provider (PCP) to coordinate care with specialists and to get a preauthorization for services when it is needed.

#### **You do not need a referral for:**

- An in-network OB/GYN provider or certified nurse-midwife for obstetrical or gynecological care, or
- An in-network ophthalmologist or optometrist for routine eye care.

#### **For more information**

For preventive care, see the [Member Benefits – Covered Services – Preventive Care Services](#) section.

For family planning services, including maternity care, see the [Member Benefits – Covered Services – Family Planning/Reproductive Health](#) section.

For the treatment of alcoholism, substance abuse, or mental illness, see the [Member Benefits – Covered Services](#) section.

For information about receiving after-hours office services, call the PCP's office and request instructions; see the [Member Benefits – Covered Services – Emergency and Urgent/After-Hours Care](#) section.

For visits related to home health or hospice care, see the [Member Benefits – Covered Services – Home Health Care/Home Infusion Therapy](#) section and the [Member Benefits – Covered Services – Hospice Care](#) section.

For coverage of inpatient provider visits, see the [Member Benefits – Covered Services – Inpatient Facility Services](#) section.

For a service related to a dental accident, oral surgery, or temporomandibular joint (TMJ) disorder, see the [Member Benefits – Covered Services – Dental-Related Services](#) section of this Booklet.

### **What provider office services are covered?**

Benefits are provided for medical care, consultations, and second opinions to examine, diagnose, and treat an illness or injury when received in a provider's office.

A provider may also provide medication management for medical conditions or mental health disorders. Consultations and second opinions may be provided with a referral from your PCP. In certain cases, we may request that you get a second opinion. **If you need help finding a provider for a second opinion or setting up a second opinion appointment, please call 303-751-9051 or 800-414-6198 and ask to speak to a care manager. Care managers can assist you.**

Benefits are provided for office-based surgery and surgical services, which includes anesthesia and supplies. Such surgical fees include local anesthesia and normal post-operative care. Office-based surgical services are subject to preauthorization guidelines. See the [Managed Care](#) section of this Booklet for more information about preauthorization guidelines.

Benefits are provided for diagnostic services received in a provider's office when they are required to diagnose or monitor a symptom, disease or condition. Benefits for diagnostic services done in a provider's office include, but are not limited to, the following:

- X-ray and other radiology services
- Laboratory and pathology services
- Ultrasound services for non-pregnancy related conditions. For pregnancy-related ultrasounds, see the [Member Benefits – Covered Services – Maternity and Newborn Child Care](#) section.

Coverage is available for the following services related to allergy tests:

- Direct skin (percutaneous and intradermal) and patch allergy tests and RAST (radioallergosorbent testing)
- Allergy medications administered by injection in a provider's office
- Charges for allergy serum

Audiometric (hearing) and vision tests are also provider office services that are covered.

### **What provider office services are not covered?**

The following services, supplies, and care are not covered (exclusions):

- Any cost related to getting your medical records or reports or the transfer of 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 FACILITY SERVICES**

This section describes covered services and exclusions for acute inpatient care such as hospital care and ancillary professional services.

#### **Where can I get inpatient facility services?**

We do not cover services at an out-of-network facility unless the services are for emergency care or otherwise authorized by us.

All acute inpatient hospital admissions must be at an in-network facility. Acute inpatient services may be obtained at the following locations:

- An acute care hospital.
- A long-term acute care hospital.
- A rehabilitation hospital.



- Other covered inpatient facility.

### **What inpatient facility services are covered?**

**All inpatient services are subject to preauthorization by us or unscheduled admission notification guidelines.** See the [Managed Care](#) section of this Booklet 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 Services – Emergency and Urgent/After-Hours Care](#) section.

For dental services, see the [Member Benefits – Covered Services – Dental-Related Services](#) heading in this section.

Inpatient facility services that are covered include:

- Facility Services – Many services are provided in the inpatient hospital setting. Some of the covered services include, but are not limited to, the following examples:
  - Charges for a semi-private room (with two or more beds) and general nursing services for the treatment of medical conditions and rehabilitation care, which is part of an acute care hospital stay.
  - 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 as part of an inpatient admission.
  - Prescribed medications and medicines given during an inpatient admission.
- A room in a special care unit approved by us. 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.
  - These 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 in the inpatient hospital setting to provide comprehensive care to patients. Some covered ancillary services include, but are not limited to, the following:

- Diagnostic services, such as laboratory and X-ray tests (for example, CT scan, 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
    - Professional services 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 examples:
      - 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 assistants or assistant surgeons as determined by our medical policy. Surgical assistants for all surgical procedures are not covered.
      - Surgical services for the treatment of morbid obesity. These services are subject to meeting the criteria included in our medical policy. The hospital performing the morbid obesity surgery must be designated and approved to perform specific covered services provided under 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 provide coverage for an external prosthesis.
  - 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 child (also see the [Member Benefits – Covered Services – Maternity and Newborn Child Care](#) section). If you need help

finding a provider for a second opinion or setting up a second opinion appointment, please call 303-751-9051 or 800-414-6198 (toll free) and ask to speak to a care manager. Care managers can assist you.

- Long-Term Acute Care Facility
  - Long-term acute care facilities 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.
  - We require preauthorization for admission and for continued stay. See the [Managed Care](#) section of this Booklet for information about preauthorization guidelines.
- Skilled Nursing Facility
  - Skilled nursing facilities 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 and acute disease or injury.
  - When skilled nursing care is preauthorized, benefits are available for up to 30 days per calendar year, or until we determine that the member has reached maximum medical improvement, whichever is sooner. Authorization for admission and for continued stay is required. See the [Managed Care](#) section of this Booklet for information on preauthorization guidelines.

### **What inpatient facility services are not covered?**

The following inpatient facility services are not covered (exclusions):

- Consultations or visits related to any non-covered service.
- Inpatient provider services received on a day for which facility charges were denied.
- Telephone consultations.
- Private room expenses when semi-private rooms are available, unless the member's medical condition requires isolation to protect the member from exposure to dangerous bacteria and diseases (conditions that require isolation include, but are not limited to, severe 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 for exceptions.
- Room and board and related services in a nursing home.
- Custodial care facility admissions or admissions to similar institutions.
- Charges related to the non-compliance of care if the member leaves a hospital or other facility against the medical advice of the provider.
- Facility room and board charges for the day of discharge.
- Surgical benefits for subsequent procedures to correct further injury or illness resulting from noncompliance with prescribed medical treatment. An example of a non-covered subsequent procedure is the removal of infected tissue directly caused by not taking prescribed medication after a tonsillectomy.
- Procedures which are solely cosmetic in nature.
- Custodial and/or maintenance care (this is care that helps you with activities of daily living).
- 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 meals, articles for personal hygiene 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.

## **MEMBER BENEFITS – COVERED SERVICES – OUTPATIENT FACILITY SERVICES**

This section describes 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. Outpatient facility services at an out-of-network facility, unless services are for an emergency or otherwise authorized by us, are not covered.

Outpatient facility services may be obtained at the following locations:

- an acute hospital outpatient department
- an ambulatory surgery center
- a radiology center
- a dialysis center
- an outpatient hospital clinic

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## What outpatient facility services are covered?

**Note:** Some outpatient facility services require a preauthorization. See the [Managed Care](#) section of the 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 – Emergency and Urgent/After-Hours Care](#) section for information about emergency care.

For covered dental services, see the [Member Benefits – Covered Services – Dental-Related Services](#) section.

Covered outpatient facility services include:

- 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, 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 & Subrogation](#) section), and
  - when services are performed by an in-network dialysis provider.
- Home dialysis services require preauthorization by CHP+ State Managed Care Network. 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 our medical policy. We do not cover surgical assistants for all surgical procedures.
  - Consultation by another provider when requested by the member’s provider.
    - Staff consultations required by facility rules are not covered.

### **What outpatient facility services are not covered?**

The following services, supplies, and care are not covered (exclusions):

- Surgical benefits will not be provided for subsequent procedures to correct further injury or illness resulting from noncompliance with prescribed medical treatment. An example of a non-covered subsequent procedure is the removal of infected tissue directly caused by not taking the medication that was prescribed after a tonsillectomy.
- Procedures 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 meals, articles for personal hygiene 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 – EMERGENCY AND URGENT/AFTER-HOURS CARE**

This section describes covered services and exclusions for emergency care and urgent care including after-hours care.

### **Urgent/After-Hours Care**

Urgent care means situations that are not life-threatening but require medical attention right away to prevent serious issues to your health. 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 reduced.

### ***What urgent/after-hours care is covered?***

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 the CHP+ State Managed Care Network service area is covered only when it is provided by an in-network PCP or urgent care center or an urgent care provider.

When you are temporarily out of the CHP+ State Managed Care Network 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 with 48 hours.

### **Emergency Care**

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

Emergency care is 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 function or serious dysfunction of a bodily organ or part, or would place the person's 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.

Emergency care that is provided at in-network and out-of-network hospitals or other facilities is covered.

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 your condition makes it impossible to do so, you should notify your PCP within 48 hours of receiving emergency care.

For locations where you can get emergency care, please see our website and Provider Directory located at [chplusproviders.com/ProviderDirectory/dsp\\_ProviderSearch.asp](http://chplusproviders.com/ProviderDirectory/dsp_ProviderSearch.asp). Type in hospital or urgent care.

### ***What emergency care services are covered?***

We cover emergency care that is necessary to screen and stabilize, if a prudent layperson having average knowledge of health services and medicine acting reasonably would have believed that an emergency medical condition or life- or limb-threatening emergency existed. This means that you believe 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 you broke your leg).

Post-stabilization care 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 an enrollee is stabilized.
- Provided to maintain the stabilized condition, or under certain circumstances (see below), to improve or resolve the enrollee's 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 for post-stabilization care.**

### ***What happens if I am admitted to the hospital after I receive emergency care?***

If you are admitted into the hospital, the emergency room copayment is waived.



We must be notified by the provider within one business day of admission for authorization for continued care after the emergency admission.

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:

CHP+ State Managed Care Network  
P.O. Box 17470  
Denver, CO 80217

- If the out-of-network hospital accepts payment from us, then the hospital is reimbursed directly. You will be responsible for any copayment amount that may apply.
- If the hospital will not accept payment from us, then you are responsible for paying the hospital directly.
  - After you pay the hospital, you may request reimbursement from us 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.
  - We will review your request. Reimbursement is not guaranteed and depends on whether the service provided is covered as indicated in this benefits Booklet.
  - 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 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 services, supplies, and care are not covered (exclusions):

- 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 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 the hospital know that the itemized bill from the hospital must be sent to:

CHP+ State Managed Care Network  
P.O. Box 17470  
Denver, CO 80217

If the hospital agrees to bill us 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 us, then 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 the 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 require medical records for the services received. You are responsible for providing 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 describes covered services and exclusions for covered ambulance services. Only emergent or medically necessary ambulance services are a covered benefit.

#### **What is a covered ambulance service?**

- 911 calls for ambulance services.
- Ambulance transports from one hospital to another hospital when the first hospital is on divert (too full to accept new patients).
- Ambulance transports from one hospital to another hospital when the first hospital is not equipped to provide the appropriate level of care you need.

#### **What ambulance transportation services are covered?**

We cover local 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 to take you from your home or the scene of an accident or medical emergency to the closest hospital with appropriate emergency facilities, or from one hospital to another for a medically necessary transport by ambulance for continuing inpatient or outpatient care.

### ***Air Ambulance***

- Air ambulance is only a covered benefit when terrain, distance, or the member's physical condition requires the services of an air ambulance. We will determine on a case-by-case basis if transport by air ambulance is a covered benefit. If we determine that ground ambulance could have been used, the level of benefits will be limited to those for transport by ground ambulance. You will be responsible for the remainder of the bill.

### **What transportation services are not covered?**

The following services, supplies, and care are not covered (exclusions):

- 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 no 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 residence.
- Non-emergent transportation services. Non-ambulance transportation such as a taxi or public transportation is not a covered benefit. This includes transportation to and from doctor office visits or to and from a pharmacy.

### **MEMBER BENEFITS – COVERED SERVICES – OUTPATIENT THERAPIES**

This section describes covered services and exclusions for physical therapy, speech therapy, and occupational therapy.

#### **Where can I get outpatient therapy?**

All care must be received from an in-network licensed physical therapist, a licensed speech therapist or a licensed occupational therapist.

#### **What outpatient therapies are covered?**

Physical, occupational, and/or speech therapy are covered.

The standard CHP+ coverage is limited to 30 visits per diagnosis per calendar year.

The service must be initiated within six months of the date the injury or illness occurred.

For children ages 0-3, the benefit for physical, occupational, and speech therapy is unlimited.

This unlimited benefit lasts through the end of the month that the child turns 3 years old.

- After the third birthday, outpatient therapy (physical, occupational, and/or speech therapy) coverage is limited to the standard CHP+ coverage of 30 visits per diagnosis per year.

The following services are a covered benefit for children ages 0-5 with a congenital defect or birth abnormality; the duration and number of visits are based on medical necessity:

- Learning disorders
- Stuttering
- Voice disorders
- Rhythm disorders

This benefit extends through the end of the month in which the child turns 5 years old.

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

- There is a documented condition or 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.
- 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, developmental 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 biochemical and neuro-physiological principles and devices.

## ***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.

## ***Occupational Therapy***

Occupational therapy is therapy that helps you regain independence.

### **What outpatient therapy services are not covered?**

The following services, supplies, and care are not covered (exclusions):

- 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 us.
- 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 us.
- 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 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/HOME INFUSION THERAPY**

This section describes covered services and exclusions for home health care and home infusion therapy.

### **Who can provide home health care/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/home infusion therapy services are covered?**

**Home health care services** are covered only when they are necessary as alternatives to hospitalization.

- Prior hospitalization is not required for home health care services.

In order to receive home health services, you must have a written order from your provider. Your provider will work with the home health agency to establish a care plan. A registered nurse from the home health agency will coordinate the services in the care plan.

All home health care/home infusion therapy services require preauthorization from us. We reserve the right to review treatment plans at any time while you are receiving home health care or home infusion therapy.

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 a 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, appliance, prostheses, and orthopedic appliances.
- 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.
- Intravenous (IV) medications 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 infusion 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:

- Antibiotic therapy, hydration therapy, chemotherapy, and 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/home infusion therapy services are not covered (exclusions)?**

The following services, supplies, and care are not covered:

- 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 describes covered services and exclusions for hospice care.

### Who can provide covered hospice 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 pre-authorize inpatient or home hospice services for a terminally ill member before care is received.

To be eligible for home or inpatient hospice benefits, the member 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 initially approve hospice care for a period of three months.

- Benefits may continue for up to two additional three-month periods for a total of nine months. These do not have to be consecutive three month periods. After the exhaustion of three benefit periods, we will work with the provider and the hospice provider to determine the appropriateness of continuing hospice care.
- We reserve the right to review treatment plans while the member is receiving hospice care.

Coverage for hospice care is available for the following services in the member's home:

- Provider visits by hospice providers.
- Skilled nursing services performed by a registered nurse (RN) or a 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 Service – Medical Supplies and Equipment](#) section.
- Drugs and medications for a terminally ill child that are supplied by the hospice provider. If the medications are not supplied by the hospice provider, see the [Member Benefits – Covered Services – Prescription Medications](#) 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 accommodations 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. Mental health respite care is not a covered benefit.

- 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 benefit period (one hospice care period is equal to three months).

#### **What hospice services are not covered?**

The following services are not covered (exclusions):

- 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 describes covered services and exclusions for organ and tissue transplants.

#### **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:

- Hearts
- 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 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.
- Cornea.

Services are covered based on criteria established by the medical community and by us. A referral from your PCP and preauthorization from us is needed before human organ and tissue transplant services.

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 us for each specific covered service provided under this section.
- CHP+ State Managed Care Network 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 us or our designee. Approval for such covered services will be at our sole discretion.
- 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 us. 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 program will only provide benefits for covered services up to the cost of the semi-private room rate unless we determine that a private room is medically necessary.
- Services and supplies furnished by the hospital.
- Prescribed medications used in the hospital.
- Whole blood, administration of blood, and blood processing.
- Medical and surgical dressings and supplies.
- Care provide 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 operating and treatment rooms.
- Diagnostic services, including a referral for evaluation.
- Rehabilitative 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 the 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 examination 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 us.
- 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 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 maximum benefits of \$10,000 per transplant – which is part of the maximum lifetime benefit for organ transplants under this “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 the 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 the CHP+ State Managed Care Network, 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, foundations, and government programs.
- If the donor is a member of CHP+ State Managed Care Network, and the recipient is not, benefits will not be provided for the donor or recipient expenses.
- 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 or 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 the procurement of a donor organ or organ tissue that has been sold rather than donated.

### ***Maximum lifetime benefit for 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 hospitalization and medical services related to the transplant, and any subsequent hospitalizations and medical services related to the transplant. The travel, lodging, and donor expense coverage also apply toward maximum lifetime benefit for organ transplants.
- A service or supply is considered transplant-related if it directly relates to a transplant covered under this 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 "Organ Transplant" benefit.
- If a member received a CHP+ State Managed Care Network 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 this Booklet.

### **What human organ and tissue transplant services are not covered?**

The following services, supplies, and care are not covered (exclusions):

- Services performed at any hospital that we have 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 we have designated and approved to provide such services.
- Services for donor searches or tissues matching, or personal living expenses related to donor searches or 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.
- Any transplant, treatment, procedure, facility, equipment, drug, device, service, or supply that requires federal or other governmental agency approval which is not granted at the time services are provided and 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 includes services for implantation, removal, and complications. 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 describes 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 appliance described in this section are covered benefits only if supplied by an in-network provider.

### What supplies and equipment are covered?

The benefits described in this section are allowed up to the maximum benefit payment.

- Medical and surgical supplies are not subject to the maximum payment of \$2,000 per calendar year.

### Remember:

- Supplies are subject to preauthorization requirements. See the [Managed Care](#) section for information about preauthorization requirements.
- Covered supplies and equipment must meet our medical policy criteria.

### ***Medical supplies***

- Disposable items received from an in-network provider and required for the treatment of an illness or injury on an inpatient or outpatient basis are covered. Benefits are provided for the following:
  - Syringes
  - Needles
  - Diabetic testing strips
  - Surgical dressings
  - Splints
  - Other similar items that treat a medical condition
- For more information about supplies received from a pharmacy, see the [Member Benefits – Covered Services – Prescription Medications](#) section.

### ***Oxygen and equipment***

- Benefits are provided for oxygen and the rental of the equipment needed to administer oxygen (one stationary and one portable unit per member). Preauthorization is required from us.

**Durable medical equipment** (this is sometimes called DME) is covered if it is medically necessary and prescribed by an in-network provider.

- Durable medical equipment includes items like crutches, wheelchairs, breathing equipment, and hospital beds.
- Durable medical equipment generally can withstand repeated use and must serve a medical purpose.
- Durable medical equipment can be rented or purchased. This decision is up to us.
  - 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 we 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.

**Orthopedic appliances** – benefits are provided for the purchase, fitting, and repairs of, and the needed adjustments to, orthopedic appliances.

- Orthopedic appliances include items like a knee brace.
- An orthopedic appliance is a rigid or semi-rigid supportive device that helps increase the use of a malfunctioning body part, limb, or extremity, limiting or stopping the motion of a weak or poorly functioning body part.
- We cover the most appropriate model that adequately meets your medical needs.

**Prosthetic devices** – benefits are provided for the purchase, fitting, repair, and replacement of, and the needed adjustments to prosthetic devices.

- A prosthetic device replaces all or part of a missing body part or extremity (leg or arm) to increase the member's ability to function.

The purchase, fitting, repair, and replacement and the need for adjustments of, prosthetics for arms and legs are excluded from the annual dollar amount DME benefit limit. All other prosthetic devices, unless specifically listed in this Booklet, are subject to the annual dollar amount DME benefit limit.

**Other appliance** – benefits for other appliances include the following:

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- 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.
- Oxygen and oxygen equipment.

### **Payment limit**

If your doctor has ordered the following medically necessary items, these items will not be subject to the maximum payment of \$2,000:

- Durable medical equipment used during a covered admission or covered outpatient visit that is owned by the facility.
- Medical supplies (including casts, dressings, and splints used in lieu of casts) used during covered outpatient visits.
- Surgically implanted prosthetics or devices authorized by us before you receive the device (including cochlear implants).
- Insulin pumps and related supplies.

The following items are subject to the \$2,000 benefit payment limit per calendar year. We will not pay for any cost after the \$2,000 limit has been reached.

- Oxygen and oxygen equipment.
- Orthopedic appliances.
- Crutches.
- Glucometers.
- The rental or approved purchase of durable medical equipment, including repairs, when prescribed by a provider and required for therapeutic use (for example, wheelchairs and walkers).
- Prostheses and orthopedic appliances or devices (for example, neck brace); their fitting, adjustment, repairs, or replacement because of wear or a change in your condition which causes you to need a new appliance. The purchase, fitting, repair, and replacement and the need for adjustments of prosthetics for arms and legs are excluded from the annual dollar amount DME benefit limit. All other prosthetic devices, unless specifically listed in this Booklet are subject to the annual dollar amount DME limit.

**What services are not covered?**

- Comfort, luxury, or convenience items, supplies, equipment, and appliances (for example, wheelchair sidecars or a cryocuff unit). Equipment or appliances 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).
- 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, dressings, thermometers, heating pads, and petroleum jelly.
- Air conditioners, purifiers, humidifiers, dehumidifiers, special lighting, or other environmental modifiers, surgical supports and corset 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 lift), telephone arms, home modifications to accommodate wheelchairs, wheelchair convenience items, wheelchair lifts, and vehicle modifications.
- Dental prostheses, hair/cranial prosthesis, 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 for any covered medical supply or equipment that is identified in this section.
- Orthopedic shoes not attached to a brace (except for members with diabetes).

**MEMBER BENEFITS – COVERED SERVICES – DENTAL-RELATED SERVICES**

This section describes covered services and exclusions for dental-related services.

**Dental Coverage -**

Coverage for routine dental care is **not** covered during the pre-HMO period. Dental Coverage is limited to accident-related dental services. Routine dental care is covered for prenatal members in the CHP+ Prenatal Program.

**What dental-related services does CHP+ State Managed Care Network and the CHP+ Prenatal Care Program cover?**

CHP+ State Managed Care Network covers accident-related dental services, inpatient services for dental-related services, and cleft palate and cleft lip conditions.

The CHP+ Prenatal Care Program covers the accident-related dental services described below.

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 of this Booklet for more information about preauthorization guidelines.

***Accident-related dental services:***

- Coverage is provided for accident-related dental repairs to sound 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.

***Dental anesthesia – CHP+ State Managed Care Network 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 orofacial and dental trauma.

***Inpatient admission for dental care***

- When medically necessary, CHP+ State Managed Care Network covers inpatient facility services related to dental care, including room and board.
- DentaQuest covers eligible dental services.

**Cleft lip and cleft palate** – CHP+ State Managed Care Network 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.

**Fluoride varnish services** provided by your PCP in his or her office. Fluoride varnish may also be provided by an in-network dentist. When provided by a dentist, these services are covered by DentaQuest under the routine dental benefit. Note: This service is not covered for the CHP+ Prenatal Care Program.

- Covered services must be provided by your assigned in-network PCP and does not require preauthorization.
- CHP+ State Managed Care Network covers up to two fluoride varnish treatments in a calendar year for children ages 0-4.
- Before your PCP provides the varnish, he or she will also perform a risk assessment.
- In order to be covered, your PCP must have received the appropriate training for the fluoride varnish treatment.

#### **What fluoride varnish services are not covered (exclusions)?**

The following fluoride varnish services are not covered:

- Fluoride varnish for children ages 5 and older.
- Fluoride varnish services obtained from an out-of-network provider.
- Fluoride varnish services obtained from a provider who is not a PCP.

- Fluoride varnish services provided by a dentist may be covered by the routine dental benefit. Please contact DentaQuest at 888-307-6561 (TTY 711) for information.
- Fluoride varnish treatment that does not include a risk assessment performed by your PCP.

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

Routine dental services are not covered during the pre-HMO period for children.

The following services, supplies, and care are not covered:

- 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, except 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 (TMJ) joint 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 SERVICES**

This section describes covered services and exclusions for food and nutrition services.

#### **Who can supply food and nutrition services?**

An in-network licensed therapist or home health agency must provide the nutrition services.

Covered medical foods require a prescription from your provider and must be obtained through an in-network pharmacy and are subject to the pharmacy copayment.

#### **What food and nutrition services are covered?**

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

The durable medical equipment (DME) 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 nutrition is delivery of nutrients by a tube into the 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/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 us.

### **Medical Foods**

- We cover medical foods for home use for metabolic disorders.
- Covered medical foods must be prescribed by your provider.
- We cover 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, tyrosinemia, homocystinuria, histidinemia, urea cycle disorders, hyperlysinemia, glutaric acidemias, methylmalonic academia, and propionic academia.
- This benefit does not include medical foods for members with lactose or soy intolerance.

**Other medical nutrition** – We also cover the following services:

- Diagnosis of diabetes – inpatient nutrition counseling, outpatient nutrition and self-management training and follow-up visits for members diagnosed as diabetic.

- 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 formulas 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 of 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 needs, including attainment of normal growth and development, including growth failure.
- Feeding appliances and feeding evaluations that are medically necessary in conditions where oral/esophageal conditions make normal food intake inadequate.
- Obesity/overweight – nutrition assessment and therapy using pediatric weight management standards. Obesity is defined as greater than the 95<sup>th</sup> percentile weight for height or greater than 95<sup>th</sup> percent Body Mass Index (BMI) for age (using the DCD/NCHS Growth Grids).
- Nutrition assessment and therapy when medically indicated, including but not limited to, conditions such as spina bifida, cystic fibrosis, cerebral palsy, dysphagia, cleft lip/palate, food 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 a 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.

### **When food and nutrition services are not covered (exclusions)?**

The following services, supplies, and care are not covered:

- Enteral feedings, except as provided previously in this section.
- Tube feeding formula except as provided in this section.
- Weight loss programs, exercise equipment, exercise classes, health club memberships, personal trainers, prescription or over-the-counter medications for weight loss, or obesity treatment (except medically necessary surgical treatment or as provided

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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.
- Breast feeding education and baby formulas.
- Feeding clinics.

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

This section describes 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.

We 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 a preauthorization. You must call us at 303-751-9051 or 800-414-6198 (toll free) to determine if the mental health services you are receiving require preauthorization. TTY users should call 720-744-5126 or 888-803-4494 (toll free).

- If you do not get preauthorization, or if you receive services from a provider other than the provider we preauthorized, 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 authorization is required. If the mental health professional you are seeing is out-of-network, then authorization for additional visits will be required. A care manager may assist in transitioning your treatment to an in-network provider if appropriate.

We 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** – We cover outpatient mental health services. Covered outpatient treatments do not require preauthorization if the provider is in-network with us. Covered services include, but are limited to:

- Individual counseling;
- Family counseling;
- Group counseling; and
- Case management services.

**Medication management** – We cover medication management of mental health conditions by a medical provider, psychiatrist, or nurse with prescriptive authority (this is a nurse that is legally allowed to write prescriptions).

**Day treatment** – Day treatment services are for specific mental health and educational needs and are sometimes part of the child’s 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+ State Managed Care Network case manager can help you:

- Get the right care from doctors, providers, schools, and other programs.
- Find resources (such as food, clothing, and housing).
- If you would like information about case management, please call us at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

### **Emergency services**

Please see the [Member Benefits – Covered Services – Emergency and Urgent/After-Hours Care](#) 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** – We cover medically necessary inpatient stays to treat mental health conditions. Covered inpatient stays require preauthorization. An inpatient stay is 24-hour mental health services provided for you in a hospital for the care of a mental illness. Covered services include:

- Provider visits received during a covered admission;
- Inpatient semi-private room or ancillary services;
- Group psychotherapy; and
- Medication management.

### **Residential treatment service**

The same services covered as inpatient services are also covered for residential treatment services.

Residential treatment services are services in a licensed residential treatment facility that can provide day services and 24-hour supervision after day program.

Residential treatment requires preauthorization and is 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. Covered services require 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 us with questions about preauthorization at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 720-744-5126.

**More services** – If you have questions about other mental health services that are not listed, please call us at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

**Autism spectrum disorder** – Treatment for the diagnosis of autism spectrum disorder is a covered benefit when the treatment is medically necessary, appropriate, effective, or efficient. Such treatment includes evaluation and assessment, habilitative or rehabilitative care such as occupational therapy, physical 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](#) section of this Booklet for details.

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**Applied Behavioral Analysis (ABA) therapy is not a covered benefit of Child Health Plan Plus.****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.

We 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 require preauthorization. You must call us at 303-751-9051 or 800-414-6198 (toll free) to determine if the substance abuse services you are receiving require preauthorization. TTY users should call 720-744-5126 or 888-803-4494 (toll free).

- If you do not get preauthorized, or if you receive services from a provider other than the provider we preauthorized, the service will not be covered.

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

If you are receiving services from a substance abuse provider 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 authorization for additional visits will be required. A care manager may assist in transitioning your treatment to an in-network provider if appropriate.

We 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?***

We cover 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 services, supplies and care are not covered (exclusions):

- Private room expenses.
- Vocational services (includes but is not limited to, resume writing, interview skills, work skills, training, and career development).
- Psychosocial treatment (includes, but is not limited to, home and budget skills).
- Biofeedback.
- Psychoanalysis or psychotherapy that a member may use as a 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, primary 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+ State Managed Care Network.
- **Applied Behavioral Analysis (ABA) therapy is not a covered benefit of Child Health Plan Plus.**

### **MEMBER BENEFITS – COVERED SERVICES – PRESCRIPTION MEDICATIONS**

This section describes covered services and exclusions for outpatient pharmacy prescription drugs and medications.

#### **Where can I get prescription medications?**

CHP+ State Managed Care Network includes a nationwide network of retail pharmacies. The pharmacy network is large and includes most pharmacies in Colorado.

A list of in-network pharmacies is in your Provider Directory, which can be found online at [chpplusproviders.com/members.asp](http://chpplusproviders.com/members.asp). You can also call us at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 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+ State Managed Care Network ID card to the pharmacist.

### **How do I fill a prescription through CHP+ State Managed Care Network's mail-order pharmacy service?**

You can use the network mail order pharmacy service to fill prescriptions for what are called "maintenance drugs." These are medications that you take on a regular basis, for a chronic or long-term medical condition. "Maintenance drugs" are the only medications available through the mail order service. When you order prescription medications through our mail order pharmacy service, you must order at least a 60-day supply, and no more than a 90-day supply of the medication.

If you would like to use this mail order service, please call us at 303-751-9051 or 800-414-6198. TTY users should call 720-744-5126 or 888-803-4494 (toll free). We will send you the mail order prescription forms. Please take the form to your primary care provider (PCP) or specialist. Your PCP or specialist will help you complete the form. Remember the mail order pharmacy service is for "maintenance drugs" that you take on a regular basis, for chronic or long-term medical conditions. You are not required to use our mail order services to get an extended supply of maintenance drugs.

It usually takes 10 to 14 days to process your order and ship it to you. However, sometimes your mail order may be delayed. The mail order service will call you if there will be a delay of more than 10 days. They will help you decide whether to wait for the medication, cancel the mail order, or fill the prescription at a local retail pharmacy.

### **Do I have a prescription medication copayment?**

Some members of CHP+ State Managed Care Network have a prescription medication copayment. If you have a copayment, your copayment amount will be listed on your CHP+ State Managed Care Network ID card.

Adult women on the CHP+ Prenatal Care Program do not have copays for any prescription medications.

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, a separate copayment is 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.

We do 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?**

We cover a 30-day supply of a prescription medication from an in-network pharmacy or up to a 90-day supply from the mail order service.

We cover certain over-the-counter (OTC) medications with a prescription from your provider. Coverage includes:

- Loratadine (generic Claritin).
- Cetirizine (generic Zyrtec).
- Prevacid.

Coverage guidelines and quantity limits may apply. Please see the CHP+ State Managed Care Network formulary list for more information. The formulary list is available online at [chplusproviders.com/members.asp](http://chplusproviders.com/members.asp).

For these medications to be covered by us, 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 or three pill packs by mail order service.

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 us to determine medical necessity.

We may, at our sole discretion, establish quantity limits for specific prescription medications.

Covered services will be limited based on medical necessity, quantity limited established by us, or utilization guidelines.

## **Formulary List**

- We use a formulary list. This is a list of covered medications.
- The current formulary list is available at [chpplusproviders.com/members.asp](http://chpplusproviders.com/members.asp). If you would like a paper copy, please contact us at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 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 item on the formulary list is not a guarantee of coverage.

## **Prescription medication preauthorization**

- Certain prescription medications or the prescribed quantity of a particular medication may require preauthorization. A list of prescription medications that require preauthorization can be found on the formulary list.
- If you need a prescription medication that requires preauthorization, the provider who prescribed the medication should contact us.
- If preauthorization is denied, you can appeal the decision by following the instructions in the [Complaints, Appeals & Grievances](#) section of this Booklet.
- If your doctor does not get the preauthorization, and you try to fill the prescription, the in-network retail pharmacist will let you know that the medication requires preauthorization. You should then contact the provider who prescribed the medication and ask him or her to send information to us. If you need help, please call us at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

**Inpatient pharmacy benefits** – We cover 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 Facility 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/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 a medication that is covered by CHP+ State Managed Care Network?**

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

Colorado Access  
Reimbursements  
P.O. Box 17950  
Denver, CO 80217-0950

- You will have 180 days from the date you paid for the prescription to submit the itemized receipt.
- 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 necessity 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 medication dispensed in excess of a 30-day supply are not reimbursable.

**What prescription medications are not covered?**

The following services, supplies, and care are not covered (exclusions):

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- Prescription medication and supplies received from an out-of-network pharmacy.
- Unless specifically noted above or in the formulary list, non-prescription and over-the-counter medications are not covered. This includes herbal or homeopathic preparations; prescription medication 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 if the member receives a prescription order from a provider.
- Medications prescribed for weight control or appetite suppression.
- Medications or preparation used for cosmetic purposes to promote or prevent hair growth, or growth or medication cosmetics, including, but not limited, 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. We may, at our sole discretion, waive this exclusion in whole or in part for a specific new FDA-approved medication product or technology.
- Any medication used to treat infertility.
- Standard CHP+ State Managed Care Network 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.
- CHP+ State Managed Care Network benefits do not cover vitamin or mineral supplements, except for prenatal vitamins.
- Delivery charges for prescriptions.
- Charges for the administration of any medication, unless it is dispensed in the provider’s office or through 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 us at our 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 medication dispensed for the purpose of international travel.

## **MEMBER BENEFITS – COVERED SERVICES – AUDIOLOGY SERVICES**

This section describes covered audiology services.

### **Where can I get audiology services?**

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

### **What audiology services are covered?**

The following services are covered:

- Age-appropriate hearing screenings for preventive care.
- Newborn child 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 alterations 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.

The CHP+ Prenatal Care Program covers hearing aids for congenital and traumatic injuries.

## **MEMBER BENEFITS – COVERED SERVICES – VISION SERVICES**

This section describes covered services and exclusions for vision services.

### **Where can I get covered vision services?**

You must receive routine and specialty vision services from an in-network ophthalmologist or optometrist.

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?**

The following are covered vision services:

- Routine vision services do not require preauthorization.

- We cover age-appropriate vision screening and routine eye exam.
- One routine eye exam is covered per calendar year.
- The CHP+ State Managed Care Network benefit provides a \$50 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.
- We cover specialty vision services with a referral from your primary care provider (PCP).
  - A specialty vision service is when you see a vision provider for something other than a routine exam.
  - Specialty vision services require a preauthorization.

### **What vision services are not covered?**

The following vision services are not covered (exclusions):

- Vision therapy.
- Specialty services received without a preauthorization.
- 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+ State Managed Care Network or the CHP+ Prenatal Care Program. The list of exclusions 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 303-751-9051 or 800-414-6198 (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 excluded, or is not a covered benefit.
- If a service is not covered, then all services performed in conjunction with that service are not covered.

- We may not cover any services not obtained from the member's primary care provider (PCP) except as set forth in the [Member Benefits – Covered Services](#) section of this Booklet.
- We are the final authority for determining if services and supplies are medically necessary for the purpose of payment.

**CHP+ State Managed Care Network will not cover the following services, supplies, situations, or related expenses. This is not intended to be an all-inclusive list of non-covered services:**

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

**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, reiki therapy, herbal medicine, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergetic 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 is not a covered benefit.

**Before effective date** – This coverage does not cover any service received before the member's effective date of coverage with CHP+ State Managed Care Network.

**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 doctor (DO); care provided by a chiropractor is not a covered benefit.

**Chronic pain** – This coverage does not cover any 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 the member in the 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.
- Assistance with feeding.
- Oral hygiene.
- Routine skin and nail care.
- Suctioning.
- Toileting (assistance going to the bathroom).
- Supervision of medical equipment or its use.

**Dental services** – This coverage does not cover dental services during the pre-HMO period for children, except as provided 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 the 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 the discharge date indicated in the

preauthorization from us. 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+ State Managed Care Network or the CHP+ Prenatal Care Program and another insurance coverage, such as Health First Colorado or a commercial plan, at the same time. You can be eligible or covered by commercial insurance and Medicare while enrolled with CHP+ State Managed Care Network.

**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. We do 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 determined 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 appropriate preauthorization has been obtained.

**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 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 the hair loss.

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

**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 contributing cause was the result of your being engaged in an illegal occupation.

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

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

**Maintenance therapy** – This coverage does not cover any treatment that does not significantly enhance or increase the member's functioning or productivity, or care provided after the member has reached the member's maximum medical improvement as determined by us, 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 nutrition therapy** – This coverage 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.

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**Non-covered providers of service** – This coverage does not cover services and supplies prescribed or administered by a provider or other person, 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 therapist.
- 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 the 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 radio or televisions.
- Voice synthesizers or other communication devices, except as specifically allowed by us.

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

**Other insurance** – If it is discovered that you have other insurance then CHP+, CHP+ has the discretion to coordinate with commercial insurance. This would make CHP+ secondary payor to the commercial insurance you have. The information that CHP+ obtains regarding your commercial information will be reported to the Department (HCPF). This will cause your current CHP+ benefits to become terminated.

**Over-the-counter (OTC) products** – This coverage does not cover over-the-counter non-medication items and other items usually stocked in the home for general use, including, but not limited to, bandages, gauze, tape, cotton swabs, dressing, thermometers, heating pads, and petroleum jelly. This coverage does not cover laboratory test kits for home use, including but not limited to, home pregnancy tests and home HIV tests.

**Over-the-counter (OTC) drugs/medications** – Unless noted as covered in this Booklet (see the [Member Benefits – Covered Services – 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 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.

**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 for which 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, or routine screening.

- Ultrasounds are covered as described in this Booklet. Two antenatal (prenatal) ultrasounds are covered. After the second ultrasound, preauthorization is required. This gives us a chance to review the care for pending high-risk pregnancy.

**Reduction mammoplasty** – This coverage 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 coverage does not cover sales, service, or other taxes imposed by law, that apply to covered services.

**Temporomandibular joint (TMJ) surgery or therapy/orthognathic surgery** – This coverage does not cover services related to temporomandibular joint (TMJ) surgery, except for temporomandibular joint 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 any 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, and 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.

## 8: Administrative Information

This section describes administrative information that you may find helpful while enrolled in CHP+ State Managed Care Network or the CHP+ Prenatal Care Program.

### ENROLLMENT FEE

Some families may pay an annual fee of \$0, \$25, or \$75 to enroll one child and \$0, \$35, or \$105 to enroll two or more children. This enrollment fee is based on family size and income. Most families will not have to pay an annual enrollment fee or make copayments. There is no enrollment fee for the CHP+ Prenatal Care Program.

### COPAYMENTS (COST-SHARING)

Copayments are paid when you see a doctor or when prescription medications are purchased. The standard CHP+ copayments range from \$0 to \$20 per visit. Your copayment amount will be listed on your CHP+ State Managed Care Network ID card. You are responsible for paying the copayment to your provider or pharmacy at the time of service. There are no copayments for preventive visits. In addition, there are no copayments for family planning services or prenatal care services.

### CHP+ STATE MANAGED CARE NETWORK ID CARD

Your CHP+ State Managed Care Network ID card shows that you are a member of CHP+ State Managed Care Network of the CHP+ Prenatal Care Program. The ID card has the information you need when you see a provider or get a prescription. Always carry your CHP+ State Managed Care Network ID card. Have it handy when you call for an appointment and show it to the receptionist when you sign in for an appointment. Also, show your ID card to the pharmacist whenever you fill prescription medications. The member named on the ID card is the only person authorized to use the card.

### CHANGING MEMBER INFORMATION

If your membership information changes in any way, such as your address or primary care provider (PCP), call us at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free). If the change cannot be made over the phone, we will explain how to make the change. Please call CHP+ Eligibility and Enrollment about the change as well at 888-367-6557.

### CHANGE OF RESIDENCE

If you move or change permanent residence, you must call us at 303-751-9051 or 800-414-6198 (toll free) and CHP+ Eligibility and Enrollment at 888-367-6557 within 30 days after you move or change permanent residences. TTY users should call 720-744-5126 or 888-803-4494 (toll free).

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If you do not call, you may not receive important notices, including renewal notices. Failure to receive a renewal notice because you did not report your address change (or any other reason) does not relieve you of the responsibility to submit a renewal application by the renewal date. If you move to a location that is far from your current PCP's office, you may choose a PCP that is closer to your new residence. Please call us at 303-751-9051 or 800-414-6198 (toll free) if you would like to change your PCP. TTY users should call 720-744-5126 or 888-803-4494 (toll free).

## HOW TO FILE CLAIMS

### In-Network

When an in-network provider bills us for covered services, we will pay the appropriate charges for the covered service directly to the provider. 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 the applicable copayment when you receive covered services.

### Out-of-Network

Services performed by an out-of-network provider (one who is not contracted to provide services for CHP+ State Managed Care Network) will be covered only in an emergency as described under the [Member Benefits – Covered Services – Emergency and Urgent/After-Hours Care](#) section or when preauthorized by us.

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/CHP+ State Managed Care Network  
P.O. Box 17470  
Denver, CO 80217

- If the out-of-network hospital accepts payment from us, then the hospital is reimbursed directly. You will be responsible for any applicable copayment amount that may apply.
- If the hospital will not accept payment from us, then you are responsible for paying the hospital directly.
- After you pay the hospital, you may request reimbursement from us 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 at

[coaccess.com/general-forms-information](https://coaccess.com/general-forms-information) 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 303-751-9051 or 888-214-1101 (toll free).

- We will review your request. Reimbursement is not guaranteed and depends on whether the service provided is covered as indicated in this Booklet.
- 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 be responsible for non-emergency and non-urgent care services received 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 with us before you receive services.
- If you have any questions about a provider, or need help finding an in-network provider, call us at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

**Where and when to send claims**

Providers must file claims within 180 days after the date of service or as otherwise agreed upon by us 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/CHP+ State Managed Care Network  
P.O. Box 17470  
Denver, CO 80217

## **OVERPAYMENTS**

If we make an overpayment, the provider or the ineligible person may be required 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 cause 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 a delay caused by any of these events.

## **CHANGES TO THE CHP+ MEMBER BENEFITS BOOKLET**

No agent or employee of CHP+ State Managed Care Network or Colorado Access may change this Booklet by giving incomplete or incorrect information, or by contradicting the terms of this document. Any such situation will not prevent us from administering this Booklet in strict accordance with its terms. Oral or written statements do not supersede the terms of this Booklet.

## **FRAUDULENT INSURANCE ACTS**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, and denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Insurance fraud causes the cost of health care coverage to go up. You can help decrease these costs by doing the following:

- Be wary of offers to waive copayments. This practice is usually illegal.
- Be wary of mobile health testing labs. Ask what insurance company will be charged for the tests.
- Always review this Booklet received from us. If there are any discrepancies (differences), call us at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).
- Be very cautious about giving health insurance coverage information over the phone.



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.
- You've been promised free goods, such as medical equipment or gift cards, for providing your medical identification to someone.

If you suspect fraud, you should contact us.

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 apply for coverage or in receiving or filing for benefits.

### **INDEPENDENT CONTRACTORS**

We have an independent contractor relationship with in-network providers. Providers are not agents or employees of CHP+ State Managed Care Network, and Colorado Access employees are not employees or agents of any of the CHP+ State Managed Care Network's in-network providers. We have no control over any diagnosis, treatment, care, or other service provided to a member by any facility or professional providers. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the member while receiving care from any in-network providers by reason of negligence or otherwise.

We may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include, but is not limited to, administrative services, prescription medication and/or substance abuse services. These subcontracted organization or entities may make benefit determinations and/or perform administrative, claims payment, or customer service duties on behalf of us, if authorized.

### **NOTICE OF PRIVACY PRACTICES**

We are committed to protecting the confidentiality of your medical information to the fullest extent of the law. In addition to the laws to govern your privacy, we have our own privacy policies and procedures to help protect your information. We are required by law to give you notice of the legal duties and privacy practices. If you would like a copy of the notice, visit [coaccess.com/privacy-security-of-member-information](https://coaccess.com/privacy-security-of-member-information) or call Customer Service.

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**NO WITHHOLDING OF COVERAGE FOR 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 for 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 Booklet.

We do not design, calculate, award, 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.

**SECTION AND PARAGRAPH HEADINGS**

The headings used throughout this Booklet are for reference only and are not to be used to interpret the provisions of the Booklet.

**PHYSICAL EXAMINATIONS AND AUTOPSIES**

We have the right and opportunity, at our expense, to request an examination of a person covered by us 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 State 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 date of issue of this coverage, no misstatements, except fraudulent misstatements, made by the member in the application for coverage will be used to void the coverage (terminate coverage) or to deny a claim for a loss incurred or a disability (as defined in the policy) commencing after the expiration of such one-year period.

The foregoing policy provision shall not be so construed to affect any legal requirement for avoidance of a policy or denial of a claim during such initial one-year period, or to limit the application of information in this provision in the event of misstatement with respect to age or

occupation or other insurance. After this policy has been in force for a period of one year during the lifetime of the member (excluding any period during which the member is disabled), it shall become incontestable as to the statements contained in the Enrollment Application and Change form.

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.

## **9: Coordination of Benefits & Subrogation**

We do not coordinate benefits with any other coverage except Medicare. Qualifying for CHP+ State Managed Care Network is contingent upon the absence of other insurance coverage excluding the Colorado Indigent Care Program and the 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+ State Managed Care Network.

If you get other coverage, you must call CHP+ Eligibility and Enrollment at 800-359-1991. If you are found to have other insurance, your CHP+ 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). The exceptions to this rule are Medicare and dental.

### **COORDINATION OF BENEFITS**

We will coordinate benefits for members who have Medicare as their primary insurance coverage, or a stand-alone dental or vision plan, in this case, CHP+ State Managed Care Network 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 Workers' 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 Workers' Compensation Act.

### **AUTOMOBILE INSURANCE PROVISIONS**

We will coordinate the benefits of CHP+ State Managed Care Network of the CHP+ Prenatal Care Program 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 Reparation Act or Colorado Revised 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 we coordinate benefits with complying policies**

CHP+ State Managed Care Network and the CHP+ Prenatal Care Program 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 we are 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, we 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 its rights under this certificate 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.

**What happens if a member does 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 [Coordination of Benefits & Subrogation](#) section.

**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 paid by us on your behalf if the third-party later settles with you for any amount, or if the member recovers any damages in court.

**CHP+ State Managed Care Network'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+ State Managed Care Network or the CHP+ Prenatal Care Program, then the following must occur:

- You must promptly notify us of your claim against the third-party.
- You and your attorney must provide for the amount of benefits paid by us in any settlement with the third-party or 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 our 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 before you receive nonemergency services.

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

## **10: Complaints, Appeals & Grievances**

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 the right to appeal. This means you can ask for a review of a CHP+ State Managed Care Network action or decision about what services you get.
- Call our Grievance and Appeals department at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

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

### **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 health 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. To request a designated client representative form, please contact our Grievance and Appeal department at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).

### **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 us 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 other.

#### **Examples of grievances might include:**

- The receptionist was rude to you.
- Your provider would not let you look at your mental health records.
- Your plan of service does not have the things that you want 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 CHP+ State Managed Care Network Grievance and Appeals department at 303-751-9051 or 800-414-6198 (toll free). TTY users should call 720-744-5126 or 888-803-4494 (toll free).
- You can fill out the grievance form on the website and send it to us.
- You can write us a letter. Call us if you want help writing your grievance.

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Have questions? Need help? We are here to help you in the language you speak!

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Call us at 303-751-9051 or 800-414-6198 (toll free)

TTY for the deaf or hard of hearing 720-744-5126 or 888-803-4494 (toll free)

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- Other people can help you or your representative with a grievance.
- Your provider can help you.
- You or your representative can call the Colorado Department of Health Care Policy and Financing at 303-866-3513 or 800-221-3943 (toll free).

### **How to file a grievance with CHP+ State Managed Care Network**

You or your representative can call or write the CHP+ State Managed Care Network Grievance and Appeals department. You can do this at any time after the problem happened.

Colorado Access  
Grievance and Appeals Department  
PO Box 17950  
Denver, CO 80217-0950  
Phone: 303-751-9051 or 800-414-6198 (toll free)

You can also find this [grievance form](https://www.chpplusproviders.com/members.asp) on our website at <https://www.chpplusproviders.com/members.asp>

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 you are concerned about, and who has the right experience, will review your grievance.
- 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.
- Within 15 business days after we receive your call or letter, we will send you a response letter stating what we found, how we fixed it, or we will let you know that we need more time. You will receive a letter from us after we finish the review.

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 your concern is final.

### **How to contact the Colorado Department of Health Care Policy and Financing**

Once you have completed the grievance process as outlined in this Booklet, and if you are still unhappy with the decision, you or your representative can contact the Colorado Department of

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Have questions? Need help? We are here to help you in the language you speak!

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Call us at 303-751-9051 or 800-414-6198 (toll free)

TTY for the deaf or hard of hearing 720-744-5126 or 888-803-4494 (toll free)

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Health Care Policy and Financing at the address below. They will review your case. Their decision about your concern is final.

Colorado Department of Health Care Policy and Financing  
SMCN Health Plan Manager  
1580 Grant Street  
Denver, CO 80203

Phone: 303-866-3646

Let them know that you are a CHP+ State Managed Care Network member. Tell them what the problem is. Tell them how you want it fixed.

The Colorado 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 Colorado 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 an “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 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.
- When we deny your request to seek care outside of our network if you live in a rural area.

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 a 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 those requirements are met:

- your appeal has been sent to us within the required timeframes by you or your provider;
- a CHP+ State Managed Care Network provider has asked that you receive the services;
- the time period that the approval (authorization) of the services has not ended; and
- 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 getting 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 of the services ends.

**Examples 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 60 calendar days from the date on the letter saying what action we have taken, or plan to take.
- You or your representative can call the CHP+ State Managed Care Network Grievance and Appeals department to start your appeal. The phone number is 303-751-9051 or 800-414-6198 (toll free). Tell them you are a CHP+ State Managed Care Network member. Tell them you want to appeal the 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 an 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

- 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. The section [Expedited \(“Rush”\) Appeals](#) tells you more 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.
- If you appeal an action to lower, change, or stop an authorized service, you must file your appeal on time. On time means within 60 days of receiving a notice of adverse benefit determination.

### ***Continuation of Benefits***

If you want to continue receiving previously approved benefits while going through the appeals process, you will have to file within 10 calendar days after receiving the notice of adverse benefit determination, or before the effective date of the termination or change in services, whichever is later.

### **What happens with an appeal?**

After we receive your phone call or letter, you will get a letter within two calendar 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 medical 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 decision.

We will make a decision and notify you within 10 business days from the days we get your request. 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 decision from us fast. You or your representative can ask for an expedited “rush” appeal. For a rush appeal, a decision would be made within 72 hours, 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 rushed 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:

- After you have completed the appeal process, if you are not happy with our decision about your appeal.
- The request must occur within 120 days of the date on our appeal decision letter (adverse benefit determination)
- **A request for a state fair hearing must be in writing.**

**A REQUEST FOR A STATE FAIR HEARING MUST BE IN WRITING**

- If your request is about a treatment that has not 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 your request is about treatment that has been approved before, you or your DCR 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 Street, 4<sup>th</sup> 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 Administrative Law Judge (ALJ) will review our decision or action. Then the ALJ will make a decision. The decision of the ALJ is final.

We encourage you to file with the 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 ALJ'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, Colorado Access will promptly approve those 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 303-751-9051 or 800-414-6198 (toll free). 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, for the purposes of 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 injection.

**Acupuncture services** – treatment of a disease or condition by inserting special needles along specific nerve pathways are 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 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 weekend and holidays.

**Alcoholism and substance abuse** – conditions defined by usage that continues 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 treatment. 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 rooms, 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 different 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 feeling or numbness in a specific area without causing loss of consciousness and is usually injected with a local anesthetic drug 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 of \$25 to enroll one child and \$35 to enroll two or more children. This enrollment fee is based on family size and income. There is no enrollment fee for CHP+ Prenatal Care Program.

**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 any applicable in-network provider discounts or adjustments.



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

**Calendar year** – a period of a year that begins January 1 and ends December 31.

**Care management** – this is a way that we help 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, nurse, doctor, or social worker) who works with members, providers, and CHP+ State Managed Care Network to coordinate services deemed medically necessary for the member.

**Chemical dependency** – dependence on either alcohol and/or other substances; for example, drugs. See also [Substance Abuse](#).

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

**CHP+ Member Benefits Booklet** – this document explains the benefits, limitations, exclusions, terms and conditions of a CHP+ member’s health coverage. This document also services as a contract between CHP+ State Managed Care Network and its members.

**CHP+ State Managed Care Network provider** – also known as an in-network provider. This is a professional health care provider or facility (for example, a provider, hospital, or home health agency) that contract with us to provide services to our member. In-network providers agree to bill us directly for services provided and to accept the payment amount (provided in accordance with the provision 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+ State Managed Care Network service area** – the geographic area where enrollment in CHP+ State Managed Care Network 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+ State Managed Care Network 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 benefits 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 any amendment made to the Booklet or rider added to the Booklet.
- Authorized in advance by us if such preauthorization is required.

**Cryocuff** – a specially 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 of withdrawal from the physical effects of alcohol or another substance.

**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 service 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+ State Managed Care Network or the CHP+ Prenatal Care Program 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 function 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, procedure, treatment, service, or supply:

- Cannot be legally marketed in the United States 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 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, procedure, 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/medications, 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 us. 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 subsections (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 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 written protocol(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 CHP+ State Managed Care Network. 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 our 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 initiative** – projects to promote healthier lifestyles and help our members to 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 agency** – an agency licensed by the Colorado Department of Public Health and Environment to provide hospice care in Colorado. A hospice is a centrally administered program of palliative (care that controls pain and relieves symptoms), supportive and interdisciplinary team services providing physical, psychological, spiritual, and sociological care for terminally ill individuals and their families, within a continuum of inpatient care, home health care and follow-up bereavement services available 24 hours a day, 7 days a week.

**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 with information such as the member’s name, ID number, PCP, and copayment amount (if applicable). This is also known as the CHP+ State Managed Care Network member ID card.

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

**In-network provider** – a provider that is contracted with CHP+ State Managed Care Network.

**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 the 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 series include:

- 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+ State Managed Care Network, 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 the safe and adequate care could not be obtained as an outpatient).
- Cost-effective compared to alternative intervention, 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 subjected to 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 medications) required for the treatment of an illness or injury.

**Member** – any person who is enrolled for coverage under CHP+ State Managed Care Network.

**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 of 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 without training in pediatric nutrition. Services provided by a registered dietitian may require preauthorization from CHP+ State Managed Care

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Have questions? Need help? We are here to help you in the language you speak!

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Call us at 303-751-9051 or 800-414-6198 (toll free)

TTY for the deaf or hard of hearing 720-744-5126 or 888-803-4494 (toll free)

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Network. 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 helping you know what your rights and responsibilities are.

**OMT** – stands for Osteopathic Manipulative Therapy, 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.

**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 treatment and re-implanting the removed organ or tissue into the same person. Organ transplant benefits provided to members of CHP+ State Managed Care Network 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.

**Out-of-network provider** – an appropriately licensed health care provider that has not contracted with us. Services provided by an out-of-network provider may not be covered unless a 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+ State Managed Care Network when he or she is outside the service area. See also [CHP+ State Managed Care Network service area](#).

**Out-of-pocket annual maximum** – the total amount (cost sharing) a member may be responsible for during a specified period as described in this Booklet. This 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 more services, payment will be made at 100% 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 95<sup>th</sup> percentile or Body Mass Index (BMI) greater than the 95<sup>th</sup> percentile. Obesity in children has long-term consequences that becomes major health issues later in life. Treatment plans are standard pediatric weight management programs medically supervised by medical professional 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.

**PCP** – stands for primary care provider. It is the appropriately licensed and credentialed provider who has contracted with us to supervise, coordinate, and provide initial and basic care to members, initiate a referral for specialist care, and maintain continuity of patient care.

**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+ State Managed Care Network provider or an out-of-network provider. An in-network pharmacy is contracted with us to provide covered medications to members under the terms and conditions of this Booklet. An out-of-network pharmacy is not contracted with us.

## 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 Food and Drug Administration (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 bio-equivalent 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 medicinal 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." Compounded medications that contain at least one such medicinal substances 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+ State Managed Care Network pharmacy and therapeutics committee defines the medications and criteria for coverage, including the need for preauthorization for certain medications.

**Private-duty nursing services** – services that require the training, judgement, 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+ State Managed Care Network 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 Booklet. 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 Booklet 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 is 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 is 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+ State Managed Care Network 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 certificate and are subject to review by a medical authority appointed by us.

**Radiation therapy** – X-ray, radon, cobalt, betatron, telocobalt, radioactive isotope, and similar treatment 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** – authorization given to a member of CHP+ State Managed Care Network to visit another provider. The member’s PCP generally initiates a referral.

**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 purposes of this agreement, to be a primary resident of the state, as evidenced 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 or 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 organizations 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 intensity 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 (for example, an orthopedist is someone 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 that 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 leads 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, castings, treatment of fractures and dislocations, electrical, chemical or medical destruction of tissue, endoscopic examinations, anesthetic epidural procedure, 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+ State Managed Care Network, at its sole discretion, determines which surgeries do or do not require a surgical assistant.

**Ultrasound** – a radiology imaging technique that uses high frequency sound 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 CHP+ State Managed Care Network and the CHP+ Prenatal Care Program 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, 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 under 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, etc.), 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.

## Discrimination is Against the Law

Colorado Access complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Colorado Access does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Colorado Access:

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

If you need these services, contact Customer Service.

If you believe that Colorado Access has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

The Director of Member Affairs  
Colorado Access  
11100 E Bethany Dr.  
Aurora, CO 80014  
800-511-5010  
TTY 888-803-4494

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Director of Member Affairs is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

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

# Child Health Plan *Plus*

## State Managed Care Network & Prenatal Care Program

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