Member Handbook 2026

Child Health Plan *Plus* (CHP+)

offered by Colorado Access

colorado access

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2026

Free Help in Your Language

Colorado Access Customer Service: 800-511-5010 (State Relay: 711)

English	ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge.
Español	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles.
中文	注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。
Việt	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí.
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Français	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement.
Русский	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно.
አማርኛ	ማሳሰቢያ፡- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ።
Soomaali	FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa.
العربية	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا.
Deutsch	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung.
فارسي	توجه: اگر [وارد کردن زبان] صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند.
Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format.
नेपाली	सावधान: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि निःशुल्क उपलब्ध छन्।
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Welcome!

Welcome to Child Health Plan *Plus* (CHP+) offered by Colorado Access! Signing up for this plan is your choice.

CHP+ is a health plan brought to you by Colorado Access. Colorado Access is a nonprofit health plan. Colorado Access has served CHP+ members since 1998. As a member, you can ask for information about the structure of Colorado Access. You can also ask for information about the operation of Colorado Access. Call us at the numbers listed below. Or go to our website at coaccess.com/about.

This handbook is a guide to your CHP+ benefits. The more you know about your benefits, the better they can work for you. Visit our website at coaccess.com/chp to learn more. You can also find tips and tools to help you with your health care on our website.

You can ask for a copy of this handbook, the provider directory, or anything on our website. It will not cost you anything. We will send it to you within five days.

If you have questions about your benefits, call us. We can answer your questions. Call Monday through Friday from 8:00 a.m. to 5:00 p.m. Call 800-511-5010 (toll-free) (State Relay 711).

If you get Medicaid or other insurance, or you move out of the Colorado Access service area, you can't be a member of our CHP+ plan. If this happens, tell us. Call our customer service team to let us know. Learn more in the *Coordination of Benefits and Subrogation* section.

As your CHP+ health plan, we will:

- Pay for covered services.
- Authorize specialty care you may need.
- Offer care coordination services to help you find providers or coordinate your care.

This handbook tells you your benefits and coverage. It covers benefits for children who have Presumptive Eligibility. It also covers benefits for pregnant people, children, and those eligible for the Prenatal Care Program.

If there are changes to your rights, benefits, or copays, we will tell you about them in writing 30 days before the change happens. We will tell you of any actions you need to take.

We know every member is different. We work hard to meet your health care needs. We want you, your family, or your caretaker to be part of your health care. That is why we make sure that we send you information in a format that you want.

You have the right to change your CHP+ health plan every year when you renew your benefits. You can also leave the CHP+ program at any time for any reason. To leave the CHP+ program, contact your county human services office or CHP+ customer service (800-359-1991).

Contact Information

Colorado Access
P.O. Box 17580
Denver, CO 80217-0580
800-511-5010 (toll-free)
State Relay 711
coaccess.com

State Child Health Plan *Plus* Customer Service
P.O. Box 17548
Denver, CO 80217
800-359-1991 (toll-free) (State Relay 711)
hcpf_chpplus@state.co.us

DentaQuest (CHP+ Dental Benefits)
888-307-6561 (State Relay 711)

988 Colorado Mental Health Line
Call or text 988. Texting is available in both English and Spanish.
Live chat at 988colorado.com. Live chat is available in both English and Spanish.

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1: Membership

This section tells you about being a member of CHP+ Offered by Colorado Access.

CHP+ ELIGIBILITY

To qualify for CHP+, you must:

- Be age 18 or younger OR a pregnant person
- Not have any other health insurance
- Meet the most current income guidelines for enrollment into CHP+ (see hcpf.colorado.gov/child-health-plan-plus)

CHP+ offered by Colorado Access is offered in these Colorado counties:
Adams, Alamosa, Arapahoe, Baca, Bent, Boulder, Broomfield, Chaffee, Cheyenne, Clear Creek, Conejos, Costilla, Crowley, Custer, Delta, Denver, Douglas, Eagle, El Paso, Elbert, Fremont, Gilpin, Huerfano, Jefferson, Kiowa, Kit Carson, Larimer, Las Animas, Lincoln, Logan, Mineral, Morgan, Otero, Park, Phillips, Prowers, Pueblo, Rio Grande, Sedgwick, Saguache, Summit, Teller, Washington, Weld and Yuma.

PRESUMPTIVE ELIGIBILITY

The Presumptive Eligibility program gives temporary medical coverage right away for those who qualify. The coverage lasts for at least 45 days. It lasts while your medical assistance application is processed. To qualify, you must:

- Be age 18 or younger OR a pregnant person
- Seem to qualify for CHP+ or Health First Colorado (Colorado's Medicaid program)
- Apply for medical assistance

Note: Dental services are not covered for children while in the presumptive eligibility program.

NEWBORN ENROLLMENT

If you become pregnant, call us. Call us at 800-511-5010 (toll-free) (State Relay 711). We can help you find a doctor if you need one. We also have other services for you. These services are through our prenatal program.

If you are enrolled in CHP+ when your baby is born, you must add your newborn to your case online. **You must let the state know about the baby and enroll your child**. You can:

- Call CHP+ customer service at 800-359-1991 after you have your baby. Tell them your baby's name, their date of birth, and your name.

- Report a change through your PEAK account. Visit colorado.gov/PEAK to do this.
- Use the Health First Colorado mobile app.
- Report the birth of your baby to the human services office of the county you live in. Or to a Medical Assistance (MA) site case worker near you.

Anyone can report the birth of your baby with these details. Your baby will be covered for at least 12 months once enrolled with CHP+.

Once your baby is added to your case and you have their state ID, you can take them to the doctor.

Your baby will have insurance under your CHP+ coverage. This is only for their first 30 days of life, until they get their own state ID number.

Your child will have at least 12 months of coverage once enrolled. Call us at 303-755-4138 if you need help to apply.

CHP+ PRENATAL CARE PROGRAM

CHP+ has a Prenatal Care Program. This is for pregnant women who qualify. There are no copays for prenatal care. With this program, you are covered for 12 months after your pregnancy ends.

Call our Eligibility Application Partner site at 855-221-4138 to see if you qualify for other programs. You can also email them at appassist@accessenrollment.org.

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 or certified nurse-midwife for any prenatal care. You do need a referral for care from an in-network doula. We can help you find out if your prenatal care provider is in our network. Call us at 800-511-5010 (toll-free) (State Relay 711).

If my primary care provider (PCP) does prenatal care, do I have to see them for my prenatal care?

No. You do not have to go to your PCP for prenatal care. Colorado law lets you see an OB/GYN or certified nurse-midwife who is in our network for reproductive health care. You are also allowed maternal care through doulas. This is allowed even if your PCP has these services.

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

The CHP+ Prenatal Care Program is a health care program for pregnant people. It covers medical needs that not linked to your pregnancy if they are covered benefits and considered medically necessary.

What if I call customer service and they tell me that I am not eligible?

We will work with you to help answer all questions. We will check your eligibility status. CHP+ customer service can also tell you if you are covered. Call them at 800-359-1991.

What providers will care for me with the CHP+ Prenatal Program?

You may see any prenatal provider in our network for prenatal care. See your PCP for other health care needs.

You can find a provider online at coaccess.com. There is a link to our directory on the homepage of our website. Or call us at 800-511-5010 (toll-free) (State Relay 711).

RENEWAL PROCESS

An annual renewal is required. This is to confirm that your information has not changed. It also gives you a chance to update your information. You will get a renewal notice in the mail. Please make sure your address is up-to-date so you can get important mail notices on time. Go to co.gov/peak to update your address, phone number, and email. If you have any questions about the status of your renewal, call CHP+ customer service at 800-359-1991.

If you lose your CHP+ coverage because you did not renew on time, you must reapply. You can reapply:

- Online through colorado.gov/peak.
- By mail, fax, or in person at your county office or application assistance site.

If you have questions about reapplying, call our eligibility application partner site at 855-221-4138 (toll-free). You can also email them at appassist@accessenrollment.org.

ID CARDS AND NEW MEMBER INFORMATION

Your ID card shows that you are a member of CHP+. All members get a CHP+ member ID card. Only the member on the card can use it to get services. Always bring your CHP+ ID card when you need medical care. Have your ID card ready when you call to make an appointment. You should show it to the receptionist when you sign in for your appointment. If you need a prescription, show the card to the pharmacy where you get it.

If you did not get your ID card or need a new ID card, call us.

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Co-ins (Copays)
PCP: $0.00 / $0.00
SCP: $0.00
Prescription/RX: $0.00 / $0.00
Lab and X-Ray: $0.00 / $0.00
ER/Urgent: $0.00 / $0.00
Inpatient Hospital: $0.00

Member Name: SAMPLE MEMBER
State ID#: X999999 DOB: 01/01/2059 Gender: X
Plan Name: Child Health Plan Plus
PCP: SAMPLE CLINIC
PCP Phone: (303) 333-3333
PCN: NVT RxGrp: CHPH RxBin: 610602
This ID card does not guarantee eligibility.
Check eligibility at www.coaccess.com
Card Issued: 07/02/2025

XH2741160884

- Show this ID card every time you see a healthcare provider.
- Your PCP will help you get the medical care you need.
- Get a referral from your PCP before you get care from a specialist or hospital (except in emergencies).
- If you can, call your PCP before going to the ER.
- If you have a true emergency, call 911 or go to the ER.
- If you are not sure what to do, call your PCP.
- To call us for a preauthorization, or to let us know of a hospital stay and other services that may be required, please call us at 1-800-511-5010.

FOR PROVIDERS

Send claims to:
Colorado Access Claims
PO Box 240389
Apple Valley, MN 55124

Check eligibility at
www.coaccess.com
Contact Customer Service at
1-800-511-5010

To protect your information:

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

Call us right away if you lose your ID card or if it is stolen. We will get you a new one.
Your new card will come in the mail in a few weeks.

CHANGING YOUR INFORMATION

If your name, address, or phone number change, call CHP+ customer service at 800-359-1991. You can also do this online. Go to co.gov/peak or download the PEAK app.

If you move, you must update your address within 31 days after you move. If you don't, you may not get important notices from us. We want to make sure you get important notices about your benefits and when to renew your health care coverage. If you don't get that important notice you must still submit your renewal application.

If you move to a place that is far from your primary care provider's (PCP's) office, you may choose a PCP that is closer to you. Call us to change your PCP assignment. We will send you a new ID card with this change.

OTHER HEALTH INSURANCE

If you have any other valid health insurance coverage, you cannot have CHP+. CHP+ is intended for children and pregnant people who do not have access to other insurance, including Health First

Colorado (Colorado's Medicaid program). You will be disenrolled from CHP+ if you get another health insurance while on CHP+.

There are limited exceptions to this rule. You can have Medicare, a dental plan, or a vision plan and still keep your CHP+ coverage.

If you have COBRA health insurance coverage, you can apply for the CHP+ program. Once CHP+ has been approved, the COBRA health insurance coverage must be canceled. You can have CHP+ and COBRA coverage for a period of time. During that time, COBRA will be your primary insurance plan. **Remember: As a CHP+ member, you must get all non-emergency care from CHP+ providers in our network for the care to be covered by CHP+.**

If you get other coverage while you have CHP+, you must call CHP+ customer service at 800-359-1991 to tell them.

If you are found to have other insurance while you have CHP+, except the types listed above, your CHP+ coverage will end (be terminated). You will also be disenrolled from the CHP+ program. Sometimes we will go back and end your CHP+ coverage on the date that your other insurance became effective (started). This is called retroactive termination.

TERMINATION POLICY

Your CHP+ coverage will end if one of these things happens:

- You withhold details on your application or forms (commit fraud or misrepresent material facts). Or you are dishonest and try to gain a financial or material advantage.
- You permanently move outside of Colorado.
- You or your representative send a letter to cancel your coverage. This should be sent to the Colorado Department of Health Care Policy and Financing (HCPF). Coverage will stop at the end of the next month from the date they get the letter.
- You are unable to have a good patient-provider relationship with your health care providers. For example, not showing up for scheduled appointments or meeting your patient responsibilities.
- You are disruptive or abusive.
- You get other health insurance. If you get other insurance, or are found to have other insurance, you will be disenrolled and your CHP+ coverage will also end.
- You are no longer eligible for the program.
- You turn 19 years old. CHP+ coverage ends on the last day of the month of your 19th birthday, unless you are pregnant.
- Prenatal members coverage will end 12 months after the end of their pregnancy.

WHEN YOUR CHP+ COVERAGE ENDS

When coverage with CHP+ ends, the state will send you a Certificate of Creditable Coverage. It tells you how long you were covered by CHP+. You may need this letter as proof of prior coverage when you enroll with other health plans.

CHP+ benefits end on the date that your coverage ends. We will not pay for services when your coverage ends. This is even if CHP+ preauthorized the service.

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

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

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

You have the right to disenroll from the CHP+ program at any time. You may disenroll for any reason. Call us or CHP+ customer service (800-359-1991) to tell them you want to disenroll.

SUMMARY OF COVERED BENEFITS

This section provides an overview of your benefits. You can learn more in section 5: Member Benefits - Covered Services.

Provider Services	Covered Benefits
Preventive Care	Covered in full when given by a provider in our network. Includes immunizations (shots), checkups, and routine exams.
Family Planning/Reproductive Health	Covered in full when given by a provider in our network. Includes well-woman checkups.
Maternity and Newborn Care	All prenatal and delivery visits are covered in full.
Provider Office Services	In-network PCP visits and specialty visits are covered. Outpatient CHP+ copays apply.

Facility Services	Covered Benefits
Inpatient Hospital Services	Covered in full.
Lab, X-ray, and Diagnostic Services	Covered in full.
Skilled Nursing Services	Covered for up to 30 calendar days per benefit year.
Outpatient Facility Services	Covered in full
Emergency and Urgent Care Services	**Covered Benefits**
Urgent/After-hours Care, Emergency and Travel Outside of the Country	Covered in full for a life or limb- threatening emergency. Standard CHP+ copays apply. Coverage is not available for travel outside of the country.
Ambulance Transportation Services	Covered in full for a life or limb threatening emergency
Prescription Drugs	**Covered Benefits**
Outpatient Prescription Drugs (Medications)	Covered if included in the formulary. Coverage guidelines and standard CHP+ copays ($0 to $15) may apply.
Over-the-Counter (OTC) Medications	Certain OTC medications are covered with a prescription from your doctor. This includes vitamins and Tylenol. Standard CHP+ copays ($0 to $15) may apply.
Mental Health and Substance Use Disorders	**Covered Benefits**
Mental Health	Coverage given for medically necessary services. May require a preauthorization.
Substance Use Disorders	Coverage given for medically necessary outpatient services. May require a preauthorization.
Dental Services	**Covered Benefits**
Dental Care by DentaQuest	Covered by DentaQuest. Cleanings, exams, x-rays, fillings, and root canals. Go to DentaQuest.com and log in to your portal to learn more.

Other Services	Covered Benefits
Home Health Care and Home Infusion Therapy	Skilled services covered with preauthorization.
Human Organ and Tissue Transplant Services	Coverage given for limited transplants with preauthorization.
Durable Medical Equipment (DME)	Coverage for items as medically necessary.
Audiology Services	Coverage for preventive care visits that are appropriate by age.
Enhanced Benefits Offered by CHP+ Offered by Colorado Access	**Covered Benefits**
Vision Services	Coverage for preventive care and specialty care visits that is appropriate by age. The CHP+ benefit is one pair of glasses from an in-network provider per calendar year. If glasses are not sufficient for your vision, you may request contact lenses.
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. **As an EXTRA BENEFIT, CHP+ offered by Colorado Access members get 10 more outpatient visits. This is a total coverage of 40 outpatient visits per diagnosis per calendar year.** For children ages 0 to 3 there is no limit for the benefit of physical, occupational, and speech therapy.

Exclusions: If a service you need is not on the list above, it may not be covered. Please call us to learn more.

2: Member Rights and Responsibilities

As a member, you have the following rights:

- Receive information about Colorado Access, our services and providers, member benefits, and member rights and responsibilities, in your language and in a way you can easily understand.
- Be treated with respect and consideration for your dignity and right to privacy. Your personal information will only be released to others when you give permission or when allowed by law.
- Participate in decisions about your care, including the decision to refuse or stop treatment, except as provided by law.
- Receive clear information and have discussions about your condition and appropriate or medically necessary treatment options and alternatives, regardless of cost or benefit coverage, presented in a manner appropriate to your condition and ability to understand.
- Get care that is medically necessary from an adequate network of providers.
- Select or request a change to any primary care provider in our network.
- Get family planning services and family planning-related services directly from any licensed or certified provider, without referral.
- Receive services from a provider that provides reasonable accommodations and equipment, in your language or with free interpretation services.
- Access to care within timely appointment standards.
- Receive care for emergency conditions from any provider, in- or out-of-network, 24 hours a day, seven days a week.
- Get a second opinion on your diagnosis or treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Receive written notice of any decision Colorado Access makes to deny or limit services.
- File complaints or appeals about Colorado Access, its providers, or decisions about your care.
- Request and receive a copy of your medical records and request that they be fixed or corrected.
- Recommend changes to our member rights and responsibilities policy.
- Other rights guaranteed by law.

You have the right to exercise these rights without fear of retaliation.

As a member, you have the responsibility to:

- Use providers in our network, except in an emergency.
- Follow our rules and the rules described in your member handbook.
- Tell us if you have other health coverage, including Medicare. This also includes coverage from a claim or action against a third party responsible for your illness or injury.
- Work with your providers and be respectful to providers and Colorado Access staff.
- Pay any copays.
- Keep your personal information updated.
- Keep scheduled appointments and reschedule or cancel if you cannot make the appointment.
- Give Colorado Access and your providers any information needed to provide care, to the best of your ability.
- Follow the plans and instructions for care you have agreed to with your provider.
- Understand your health problems and participate in creating mutually agreed-upon treatment goals, to the best of your ability.

RIGHTS AND RESPONSIBILITIES REGARDING CONTINUITY OF CARE

If you, in the absence of continued services, would suffer serious detriment to your health, or be at risk of hospitalization or institutionalization, then you are considered as having special health care needs. This applies to you if you are more than three months pregnant and up to 12 months postpartum.

Members with special health care needs have other rights and responsibilities. These include the right to keep seeing your providers who are not in our network up to 60 days after you join our plan. It also means you have the responsibility to tell your medical providers that you have enrolled with us, so we can work with them to transfer care. This includes doctors, home health, and DME providers.

If you are more than three months pregnant, you have the right to see your current prenatal provider until after you deliver. You also have a responsibility to tell us you are pregnant. Please call CHP+ customer service at 800-359-1991 to report your pregnancy. You also need to tell us who is providing your care.

TRANSITION OF CARE

As a new CHP+ member, you may already be getting care from a provider. This may be for a certain medical condition. Examples of ongoing care are regular visits to an asthma specialist, or a behavioral health provider.

To make sure that this is not disrupted, you may need to transition your care. Transition of care means any ongoing care that needs to be switched (transitioned) to a new provider who is in our network and accepts your CHP+ plan. The switch is done so you can keep getting the care you need. This also makes sure you know the care is covered. And that the provider will be paid.

If you need help with transition of care, make an appointment to see your PCP. You can also call us to talk to a care coordinator.

If a CHP+ provider you are seeing tells us they will stop practicing or will stop seeing CHP+ members, we will let you know within 15 days of that notification. We will also help you find a new provider.

3: About Your Health Care Coverage

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

PROVIDERS IN OUR NETWORK

Make sure that your provider is in our network. If you get care from a provider who does not take your CHP+ plan, you may have to pay for the services you get. You can check if a provider is in our network by visiting coaccess.com. There is a link to our directory on the home page of our website.

Our online provider directory tool can tell you:

- Which providers are in your area, including their name, address, and telephone number.
- The provider's specialty and board certification.
- The languages other than English spoken by the provider. All providers speak English.
- Which providers accept new patients. Call the provider to make sure.

To find information about a provider's medical school attended or residency completed, call us or go to the provider's website. You can also call us to get help finding a pharmacy, or find a list of in-network pharmacies online at coaccess.com/members/chp.

To get in-network care and avoid bills:

- Always show your CHP+ member ID card when you get health care.
- Make sure your provider is in our network for any care except emergency care and family planning.
- Do not sign an agreement to pay a provider out-of-pocket for a covered service from a provider who does not accept CHP+. In most cases, you will be responsible for the bill.
- Call us if you have any questions about your coverage. Call us at 800-511-5010 (toll-free) (State Relay 711).

PRIMARY CARE PROVIDERS (PCPs)

All CHP+ members will be assigned to a PCP who is in our network. If you would like to choose another, please call us. It is your responsibility to choose a PCP who is in our network. A PCP can be a family medicine doctor, an internal medicine doctor, a general practitioner, an OB/GYN, or a pediatrician. Your PCP can help you:

- With checkups.
- Learn how to stay healthy.
- With sick visits.
- Take care of any chronic conditions.
- Get shots (vaccines).
- Find a specialist if you need it.
- Find out what's going on (diagnosis).
- Take care of what's going on (treatment).

We need to make sure appropriate services and accommodations are made available if you have special health care needs. Services must be given in a way that promotes independent living in the community.

Choose or change your PCP

You may choose any PCP in our network, and you can change your PCP at any time. You can find a provider in our online provider directory at coaccess.com, or you can call us to get help finding a provider.

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

Once you choose a PCP in our network, please call us at 800-511-5010 (toll-free) (State Relay 711). You will get a new member ID card that will have the name of your PCP on it.

PCPs for Newborns

Your baby will be enrolled with your PCP on their date of birth. If your PCP only gives care to adults, your newborn will be assigned to a PCP that gives care to children. Call us if you would like to choose a different PCP for your newborn. Call 800-511-5010 (toll-free) (State Relay 711).

Going to see your PCP

If you need to see your PCP, call their office to make an appointment. Their phone number is on your ID card. When you call, tell them that you are a CHP+ member. They will help you make an appointment. Here are some things to know when you make your appointment:

If your health concern is:	Your appointment should be within:

Urgent	24 hours of the initial identification
Non-urgent or non-emergent substance use disorder or mental health services	7 days of your request
Non-urgent, sick care visit	7 days of your request
Non-symptomatic well care	1 month of your request. This is unless an appointment is required sooner to ensure the provision of screenings in accordance with the American Academy of Pediatrics (AAP) accepted Bright Futures schedule

Please ask your PCP how to get:

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

Call 911 in case of an emergency, or go directly to the nearest emergency room.

Call your PCP if you cannot go to your appointment. Call them at least 24 hours before you need to be there. Ask their office if there is a cancellation policy. You should also tell them if you are going to be late. They may ask you to change the appointment to another day.

Colorado Access pays for covered services only. This is even if they are done by your PCP or if they were referred or ordered by your PCP.

Referrals for Specialists

Colorado Access does not require a referral from your PCP for you to see a specialist or other provider in our network. However, the specialist may want a referral from your PCP before seeing you. Your PCP helps to coordinate your care and can refer you to a specialist.

If you have Special Health Care Needs, you may be allowed to have direct access or a standing referral to your specialist as needed for your care. Talk with your PCP about setting up a standing referral with a specialist.

You do not need a referral from your PCP for mental health services. But some services may need preauthorization. Some services may be subject to benefit limits.

If your PCP sends you for a service that needs preauthorization, it does not mean that the service will be covered and paid for.

If you get the referral from your PCP, you must make sure that the specialist is in our network. You must also make sure they accept CHP+.

You can call us to ask if the services are covered or need preauthorization. Call us at 800-511-5010 (toll- free) (State Relay 711).

You have the right to a second opinion at no cost. Call us if you need help finding a provider and making an appointment for a second opinion.

4: What You Pay for Services (Cost Sharing)

Cost sharing is how you share the cost of health care services with CHP+. It says what we will pay for. It also says what you will have to pay. You meet cost sharing requirements by paying your copays. Read on to learn more.

COPAYS

For some services, you may have a copay. A copay is a fixed amount you pay when you get a covered health care service, supply or prescription medication. You pay copays to your provider at the time of service. Or you pay a copay when you get a prescription medication.

CHP+ copays are $0 to $50 per visit. Your copay amount is on the front of your CHP+ ID card.

You need to pay the copay to your provider or pharmacy when you get services. There are no copays for preventive and outpatient behavioral health visits. There are also no copays for family planning or prenatal and postpartum care services.

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

CHP+ Benefit	Copay			
	Income Level 1	**Income Level 2**	**Income Level 3**	**Income Level 4**
Behavioral Health				
Outpatient Mental Health and Substance Use Disorders	$0	$0	$0	$0
Physical Therapy, Speech Therapy and Occupational Therapy	$0	$2	$5	$10
Durable Medical Equipment (DME)	$0	$0	$0	$0
Transplants	$0	$0	$0	$0
Home Health Care	$0	$0	$0	$0
Hospice Care	$0	$0	$0	$0
Prescription Medications. This includes covered over-the-counter (OTC) medications.	$0	$1	$3 – generic $10 – brand	$5 – generic $15 – brand
Kidney Dialysis	$0	$0	$0	$0
Skilled Nursing Facility Care	$0	$0	$0	$0
Routine Vision Services	$0	$0	$0	$0
Specialty Vision Services. This is when you see a vision provider for something other than a routine exam.	$0	$2	$5	$10
Audiology Services	$0	$0	$0	$0
Autism Evaluation	$0	$0	$0	$0
Dietary Counseling/Nutritional Services	$0	$0	$0	$0
Therapies: Chemotherapy and Radiation	$0	$0	$0	$0

BILLS FOR THINGS OTHER THAN COPAYS

The contracts we have with providers in our network stop them from billing you for more than what we pay and your copay. Call us if you are billed by a provider who is in our network for an approved and covered service. Call 800-511-5010 (toll-free) (State Relay 711).

WHEN YOU CAN BE BILLED FOR SERVICES

You might have to pay for services if:

- You get care from an out-of-network provider, except for emergency care, urgent care when you are away from home, family planning, and out-of-network services we preauthorize.
- You get any service that is not covered.
- You get services (for example, day surgery) without an authorization by CHP+.
- You get services when you are not eligible for CHP+.

SERVICES FROM OUT-OF-NETWORK PROVIDERS

Services from an out-of-network provider are not covered unless they are emergency services, urgent care when you are away from home, family planning services, or services we preauthorized. If services for a provider who is out-of-network are authorized, the copays for the authorized services are the same as copays for covered services received from a provider who is in-network.

Out-of-network billing procedures for covered services

It is your responsibility to make sure that the provider is in our network before you get any services. Call us if you need help finding an in-network provider.

See the *Urgent/After-Hours Care, Emergency Care and Travel Outside of the Country* section for more information.

In the case of emergency or urgent care, tell the hospital or urgent care provider to send the claim to Colorado Access:

Colorado Access Claims
P.O. Box 240389
Apple Valley, MN 55124

There are certain circumstances where you may be eligible for reimbursement if you paid a provider directly, such as paying for services outside of the U.S. To ask for a reimbursement, fill out a member reimbursement request form: coaccess.com/document/coa-member-reimbursement-request-form. Mail it with your proof of payment to:

Member Reimbursements
P.O. Box 17950
Denver, CO 80217-0580

If you need help with this, call us at 800-511-5010 (toll-free).

We will review your request. Reimbursement is not guaranteed. It depends on whether the service is covered by CHP+. If it is approved, we will send the reimbursement directly to you. The reimbursement you get will be at the out-of-network rate. This may not be the full amount that you paid to the provider.

Make sure that the providers you see are in-network so that they submit claims to us directly. If you have any questions about this, please call us.

ANNUAL OUT-OF-POCKET LIMIT

The out-of-pocket annual limit is the most you will pay in copays in a calendar year. The annual out-of-pocket limit is 5% of your household's gross income.

Once the copays you have paid for covered medical services during a calendar year reach the annual out-of-pocket limit, you do not have to pay a copay for the rest of that calendar year.

You must keep track of all the money you spend toward the annual out-of-pocket limit. This is your responsibility. Follow these steps to keep track:

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

5: Member Benefits – Covered Services

This part of the handbook tells you about benefits and covered services of CHP+.

If you have questions about a service or benefit, call us. Call 800-511-5010 (toll-free) (State Relay 711).

- CHP+ covers medically necessary and preventive services and supplies.
- CHP+ does not cover services listed as excluded or as exclusions in this handbook. To learn more, see the *General Exclusions and Limitations* section.
- CHP+ covers services that are standard medical practice for the illness, injury or condition being treated, and legal in the United States.
- The fact that a provider prescribes, orders, recommends, or approves a service, treatment, or supply does not make it medically necessary or a covered service. That means it does not guarantee that CHP+ will pay for it.

All covered services are subject to the conditions and limitations described in this handbook. This part of the handbook will review covered services in the following categories:

- Preventive care services
- Family planning/reproductive health
- Maternity and newborn care
- Provider office services
- Inpatient hospital services
- Outpatient facility services
- Urgent/after-hours care, emergency care and travel outside the country
- Ambulance transportation services
- Outpatient therapies
- Home health care and home infusion therapy
- Hospice care
- Human organ and tissue transplant services
- Medical supplies and equipment
- Dental-related services
- Food and nutrition therapy
- Mental health and substance use disorder care
- Outpatient pharmacy and prescription medication
- Audiology services

- Vision services

PREVENTIVE CARE SERVICES

Who should I see for preventive care services?

Go to your PCP for preventive care services. It is good for children and youth to see their PCP regularly for preventive services and follow the well-child visit schedule from the American Academy of Pediatrics. You/your child should see their PCP at the ages below.

Infancy	**Early Childhood**	**Mild Childhood**	**Adolescence**
Prenatal	12 Months	5 Years	11 Years
Newborn	15 Months	6 Years	12 Years
First Week	18 Months	7 Years	13 Years
1 Month	24 Months	8 Years	14 Years
2 Months	30 Months	9 Years	15 Years
4 Months	3 Years	10 Years	16 Years
6 months	4 years		17 Years
9 Months			18 Years

What preventive care services are covered?

Covered preventive care services are routine PCP well care visits.

- Regularly scheduled childhood and adult immunizations (shots).
- Flu and COVID-19 vaccines (shots and boosters).
- HPV vaccine. This is for both male and female members.
- Age-appropriate vision and hearing screenings.
- Health education from your PCP. This may mean information about how to prevent illness and injury. They may ask you age-appropriate questions during your visit. This will help them decide what to talk about during your health education talk.

What preventive care services are not covered?

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

- Immunizations you need for international travel or insurance, licensing, employment, or weight loss programs.
- Physicals or screening exams for non-medical purposes, like sports or pre-employment physicals.
- Any service that is not medically necessary.

PLANNING/REPRODUCTIVE HEALTH

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

Family planning/reproductive health services do not need preauthorization or referral for any provider. This is whether they are in our network or not in our network. This could be a PCP or OB/GYN.

What family planning reproductive health services are covered?

- Prescription birth control pills are covered. See the *Outpatient Pharmacy and Prescription Medication* section for more details. Prescription birth control does not have a copay.
- Depo-Provera for birth control needs.
- Fitting of a diaphragm or cervical cap.
- Surgical implantation and removal of an implantable contraceptive device.
- Fitting, inserting, or removing intrauterine device (IUD).
- IUDs, diaphragms, implantable contraceptive devices, and cervical caps given in a provider's office.
- Tests to diagnose a possible genetic illness or disease.
- Sexually transmitted infection (STI) or HIV testing and treatment.
- Termination of a pregnancy, regardless of reason

What family planning/reproductive services are not covered?

These family planning/reproductive health services are exclusions and **are not covered** :

- Reversal of sterilizations procedures.
- Some OTC contraceptive products such as spermicide.

- Preconception, paternity, or court-ordered genetic counseling and testing. For example, tests to determine the sex or physical characteristics of an unborn child.

MATERNITY AND NEWBORN CARE

This is about covered services and exclusions for maternity and newborn care.

Who should I see for maternity and newborn care?

An in-network OB/GYN, certified nurse midwife or family practice physician who delivers babies. For prenatal care, you can see an OB/GYN or a certified nurse midwife without a referral from your PCP. This is as long as they are part of our network.

What maternity and newborn care services are covered?

Your benefits include maternity and newborn care, including prenatal, labor and delivery, and postpartum care.

Covered services are things like:

- Inpatient, outpatient, and provider office services (including prenatal care, such as prescription prenatal vitamins) for vaginal delivery, cesarean section, and problems (complications) with the pregnancy.
- Anesthesia services.
- Routine nursery care for newborns. This includes provider services.
- For newborns, all medically necessary care. And treatment of injury and sickness. This includes medically diagnosed congenital defects. And birth abnormalities.
- Circumcision for male newborns.
- Tests to find (diagnose) possible genetic illness or disease.
- Laboratory services for care related to a pregnancy.
- Spontaneous termination of a pregnancy prior to full term.
- Antenatal ultrasounds.
- Breast pumps. Please see the Medical Supplies and Equipment section for more details on how to get medical supplies like this.
- Lactation consultation.
- Doula services during prenatal, postpartum, and labor/delivery.
- Post-delivery, follow-up care visits are covered in your home if they are from a doctor, nurse, or certified midwife. This is covered for visits no later than 72 hours after you and your newborn leave the hospital. This visit includes:

- Making sure you and the newborn are checked out.
  - Checking out your home support system.
  - Help and training on how to breast or bottle feed.
  - Any maternal or neonatal tests for the mother or newborn. This includes getting samples for hereditary disease and metabolic newborn screenings. These are usually done while in the hospital after delivery. Or it may be done at the provider's office if the mother wants.
- We pay for services when done by a certified nurse midwife who is in our network. Covered services include Advising, attending, or assisting the parent during pregnancy, labor, and natural childbirth at home and during the postpartum period (C.R.S., 12- 37-101 et. al. seq.). This includes one metabolic screening, one postpartum visit, one prescreening visit, and the actual delivery and labor.

We will cover at least a 48-hour hospital stay for the mother and newborn after a vaginal delivery. If the delivery is by cesarean section, we will cover at least a 96-hour hospital stay. If the delivery is between 8:00 p.m. and 8:00 a.m. coverage will last until 8:00 a.m. on the morning after the 48-hour or 96-hour coverage period. After talking with the mother, the provider may let the mother and newborn go home (discharge) earlier, if it is appropriate.

Please see the *Member Benefits - Covered Services* section to learn more about newborn coverage and enrollment.

What maternity and newborn care services are not covered?

These are exclusions for maternity and newborn care services and are **not covered**. This is not a complete list:

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

PROVIDER OFFICE SERVICES

This is about covered services and exclusions for provider office services.

Who should I see for provider office services?

You must get your medical care and services in the office of a provider who is in our network unless we preauthorize it. Please work with your PCP to help you coordinate your care when you need to see a specialist.

What provider office services are covered?

- Medical care, talking with a provider before you get any services (consultations).
- Second opinions to examine, find out what's going on (diagnose) and treat an illness or injury when you get it in a provider's office.
    - If you think you need a second opinion, you may talk to another provider who is in our network. This is a consultation. You should talk with your PCP before you get a second opinion. They may suggest you get a second opinion.
    - Call us if you need help to find a provider for a second opinion. Or if you need help to make a second opinion appointment. Call us at 800-511-5010 (toll-free). A care manager can help you.
- Help from your providers to manage your medicine. This is medication management.
- Surgery and surgical services done in the provider's office. This includes anesthesia and supplies. Surgical fees include local anesthesia and normal post-operative care. You may need to get a preauthorization before the surgical services are done in the provider's office. See the *Managing Care* section to learn more.
- Diagnostic services done in the provider's office to diagnose or monitor a symptom, disease, or condition. These include, but are not limited to:
    - X-ray and other radiology services.
    - Laboratory and pathology services.
    - Ultrasound services for conditions other than pregnancy. For pregnancy-related ultrasounds, see *Maternity and Newborn Care*.
- Allergy tests for these services:
    - Direct skin (percutaneous and intradermal), patch allergy tests, and radioallergosorbent testing (RAST).
    - Allergy medications given by injection in the provider's office.
    - Allergy serums.
- Audiometric (hearing) and vision tests.

What provider office services are not covered?

These are exclusions for provider office services and are **not covered**:

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

INPATIENT HOSPITAL SERVICES

Where can I get inpatient hospital services?

All acute inpatient hospital stays must be at a facility that is in our network. They include:

- An acute care hospital.
- A long-term acute care hospital.
- A rehabilitation hospital.
- Other inpatient hospital that is in our network.

What inpatient hospital services are covered?

All inpatient services are subject to preauthorization or rules for unscheduled admission notification. See the *Managing Care* section to learn more.

For accident or emergency medical care, see the *Urgent/After-Hours Care, Emergency Care and Travel Outside of the Country* section.

For dental services, see the *Dental-Related Services* section.

Facility Services

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

- Charges for semi-private room (with two or more beds) and general nursing services.
- Use of an operating room, recovery room, and related equipment.

- Medical and surgical dressings, supplies, surgical trays, casts, and splints when supplied by the facility while inpatient.
- Prescribed medications while inpatient.
- A room in a special care unit once authorized by CHP+. 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. This is for medically necessary care to restore and/or improve lost functions after an injury or illness.

Inpatient rehabilitation benefits have a limit of up to 30 days per calendar year. You must get these services within six months from the date when the illness or injury occurred.

Ancillary Services

Many providers work together to give you all the care you need. Covered ancillary services include, but are not limited to:

- Diagnostic tests to find out what's going on (diagnostic), like laboratory, x-rays, CT scans, or MRIs.
- Chemotherapy and radiation therapy.
- Dialysis treatment.
- Respiratory therapy.
- Physical, occupational, and/or speech therapy.
- Charges for processing, transportation, handling, and administration of blood.
- Professional services. These are the surgical and medical care given during an inpatient admission. Some examples of professional services:
    - Provider services for the medical condition(s) during an inpatient admission.
    - Surgical services. This includes normal post-operative care.
    - Anesthesia and anesthesia supplies and services for a covered surgery.
    - Intensive medical care for constant attendance and treatment when the member's condition requires it for a prolonged period of time.
    - Surgical assistant or assistant surgeons. This is as determined by CHP+ medical policy. We do not cover and pay for surgical assistants for all surgical procedures.
- Surgical services for the treatment of morbid obesity. These services are subject to meeting the criteria in the CHP+ medical policy. The hospital that performs the morbid

obesity surgery must be designated and approved to perform specific services for this benefit.

- Reconstruction of a breast on which a mastectomy has been performed or surgery and reconstruction of the other breast to produce a symmetrical appearance. Benefits are given for physical complications for all stages of mastectomy. This includes lymphedemas. If you choose not to have surgical reconstruction after a mastectomy, we will pay for an external prosthesis.
- Talking with another provider in our network. This is for consultations. This includes second opinions.
- Medical care by two or more providers at the same time because of multiple illnesses.
- Medical care for an eligible newborn. See the *Maternity and Newborn Care* section.
- Long-term acute care facilities. These give long-term critical care services to members with serious illness or injury. Long-term acute care is for members with complex medical needs. This includes members with high-risk pulmonary disease with ventilator or tracheostomy needs. It also includes members who are medically unstable. And it includes members who need extensive wound care. Or who have post-operative surgery wounds and members with closed head or brain injuries. CHP+ requires preauthorization for admission. CHP+ also requires preauthorization for continued stay. See the *Managing Care* section for more.
- Skilled nursing facilities. These provide skilled nursing care, therapies, and protective supervision for patients who have uncontrolled, unstable, or chronic conditions. Skilled nursing care is given under medical supervision for the non-surgical treatment of chronic conditions or care during the recovery from an acute disease or injury. Skilled nursing facility coverage does not include care for chronic medical needs. Skilled nursing care must be preauthorized by CHP+. Benefits are available for up to 30 calendar days per benefit year, per diagnosis, or until you reach the maximum medical improvement, whichever is sooner. If there is a need for you to stay longer, another preauthorization is required. See the *Managing Care* section of this handbook for details.

What inpatient facility services are not covered?

We will not pay for services you get at a hospital that is not in our network unless it was for an emergency or authorized by CHP+.

These inpatient facility services are **not covered** inpatient facility services:

- Inpatient provider services received on a service date that facility charges were denied.
- Private room expenses when semi-private rooms are available. This is unless your medical condition requires you to be isolated to protect you from exposure to

dangerous bacteria and diseases. Conditions that require isolation include, but are not limited to, severe burns and those according to public health laws.

- Admissions related to non-covered services or procedures.
- Room and board and related services in a nursing home.
- Custodial and/or maintenance care that helps you with activities of daily living. Admissions to custodial care facilities or similar institutions are not covered. If you leave a hospital or other facility against medical advice, we will not pay any of the care you got while you were there.
- Room and board charges from the facility for the day you were discharged.
- Procedures that are only cosmetic in nature.
- Any service or care for the treatment of sexual dysfunction.
- Personal comfort and convenience items such as televisions, telephones, guest meals, and personal hygiene items.
- Surgical services for refractive keratoplasty. This includes radial keratotomy or Lasik. It also includes any procedure to correct visual refractive defect.
- Other procedures not routinely performed during the main surgery.

It is your responsibility to follow the medical advice of your provider. If you don't, and then get injured or ill, you may need to have surgery or another procedure. If this happens, we will not pay for it. This is because you were not following medical advice (non-compliant).

For example, if you do not take your prescribed medicine after you have your tonsils removed (tonsillectomy), you could get an infection. To remove the infection would not be covered. You would have to pay for that procedure.

OUTPATIENT FACILITY SERVICES

Where can I get outpatient facility services?

All outpatient facility services must be at a facility in our network. This plan does not cover outpatient facility services at a facility that is not in our network. This is unless services are for an emergency or preauthorized by us.

You can get outpatient facility services at:

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

- An outpatient hospital clinic.

What outpatient facility services are covered?

Some outpatient facility services require preauthorization. See the *Managing Care* section to learn more.

See the *Urgent/After Hours Care, Emergency Care and Travel Outside of the Country* section for more about emergency care.

See the *Dental-Related Services* section for more about covered dental services.

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

- Use of an operating room, recovery room, and related equipment.
- Medical and surgical dressings, supplies, surgical trays, casts, and splints. This is 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:

- Diagnostic services such as laboratory and x-ray tests. For example, CT scan or MRI.
- Medical and surgical dressings, supplies, surgical trays, casts, and splints. This is when given by a provider in our network 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:

- You are not eligible for Medicare. Or you are covered by Medicare but do not have a Medicare supplemental insurance policy. See the *Coordination of Benefits and Subrogation* section.
- Services are given by a dialysis provider who is in our network.

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

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

Professional services are surgical and medical care. Some of the covered professional services include, but are not limited to:

- 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 the CHP+ medical policy. CHP+ does not pay for surgical assistants for all surgical procedures.
- Consultation by another provider. This is when asked for by your provider.
- Staff consultation required by facility rules are not covered.

What outpatient facility services are not covered?

It is your responsibility to follow the medical advice of your provider. If you don't, and then get injured or ill, you may need to have a surgery or another procedure. If this happens, we will not pay for it. This is because you were not following medical advice (non-compliant).

For example, if you do not take your prescribed medicine after you have your tonsils removed (tonsillectomy), you could get an infection. To remove the infection would not be covered. You would have to pay for the procedure.

The following are exclusions. They are not covered outpatient facility services:

- Procedures that are just cosmetic in nature.
- Any services or care for the treatment of sexual dysfunction.
- Personal comfort and convenience items such as televisions, telephones, guest meals, or personal hygiene items.
- Surgical services for refractive keratoplasty. This includes radial keratotomy or Lasik. It also includes any procedure to correct visual refractive defect.
- Other procedures routinely performed during the main surgery.
- Peripheral bone density scans.

URGENT/AFTER-HOURS CARE, EMERGENCY CARE AND TRAVEL OUTSIDE OF THE COUNTRY

Urgent/after-hours care

Urgent care means situations that are not life-threatening but require medical attention right away. This is so you don't get a more serious health issue.

Urgent care is not considered a life or limb-threatening emergency. It does not require the use of an emergency room. If you choose an urgent care center, when appropriate, instead of an emergency room, your out-of-pocket cost may be lower.

Where can I get urgent/after-hours care?

Urgent and after-hours care you get within the CHP+ service area is covered only when it is given by an in-network PCP, urgent care center, or urgent care provider.

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

To find places you can get urgent care, please visit coaccess.com. There is a link to our directory on the homepage of our website. Or call us at 800-511-5010 (toll-free) (State Relay 711).

Emergency Care

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

Call 911 in case of emergency. Or go to the nearest hospital or medical facility.

Where can I get emergency care?

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

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

If you are unable to get to a hospital in our network, go to the nearest medical facility. You do not need a preauthorization for in-network or out-of-network emergency care.

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

You can find a provider online at coaccess.com. There is a link to our directory on the homepage of our website. Or call us at 800-511-5010 (toll-free) (State Relay 711).

What emergency care services are covered?

- Care that is needed to stabilize a health condition. If a person who has basic knowledge of health services would have believed that an emergency medical condition was life or limb-threatening, then an emergency existed. This means that you believed that your life was in danger because of the illness or emergency. Or that one of your limbs was in danger (for example, you thought that you broke your leg). Preauthorization is not required for these services.
- Post-stabilization services. 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 done after you are stabilized from an emergency condition to keep your condition stable. Under certain circumstances, they may be done to improve or resolve your condition. Your copay for out-of-network post-stabilization providers will be the same as it is for in-network services. Out-of-network providers cannot charge a higher copay for post-stabilization services.

What emergency care services are not covered?

The following are **not covered** emergency care services:

- Emergency services for things that are not an emergency
- Follow-up care received in an emergency room. For example, removal of stitches or dressing changes. Get follow-up care from your primary care provider (PCP).

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

If you are admitted to the hospital, the emergency room copay will be waived. You do not have to pay it. Tell the hospital to inform us of your admission within one business day of when you get admitted. They need to let us know so we can authorize your care. We will authorize a certain number of days of care based on medical necessity, as determined by our medical policies and guidelines.

If you are treated at an out-of-network hospital for an emergency, tell the hospital to send the itemized bill to Colorado Access. The information is on the back of your member ID card.

Colorado Access Claims
P.O. Box 240389
Apple Valley, MN 55124

If the out-of-network hospital accepts payment from CHP+, the hospital is reimbursed directly. You are responsible for any copay amount that may apply.

If the hospital will not accept payment from CHP+, you must pay the hospital directly. After you pay the hospital, you can ask us to reimburse you. Do this by submitting proof that you paid for the service. An example of proof you paid is a receipt from the hospital that shows the payment or payments you made.

To ask for reimbursement, complete a member reimbursement request form. This can be found online at coaccess.com/document/coa-member-reimbursement-request-form. Mail the form with your receipt to:

Colorado Access
P.O. Box 17470
Denver, CO 80217

If you need help with this process, please call us. Call 800-511-5010 (toll-free). We will look at your request. Reimbursement is not guaranteed. It depends on if the service is covered.

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

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

Travel Outside the Country

Care provided to you outside of the United States is not covered.

AMBULANCE TRANSPORTATION SERVICES

This section is about covered services and exclusions for ambulance transportation services.

What ambulance transportation services are covered?

- Emergent or medically necessary ambulance transportation services are offered 24 hours a day, seven days a week.
- 911 calls for ambulance services.
- When you ride in an ambulance from one hospital to another because the first hospital is too full to accept new patients (on divert).

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

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

The following ambulance transportation services **are not covered**:

- Commercial transport by air or ground. Or private aviation or air taxi services.
- Transportation by private car/automobile, commercial vehicle, public transportation, or wheelchair ambulance (ambu-cab).
- Ambulance transportation if you could have been transported by automobile or commercial or public transportation without endangering your health and/or safety.
- If you elect not to get transport to an emergency facility after an ambulance has been called, then you are responsible for any charges.
- Ambulance transportation from an emergency facility to your home.
- Non-emergent transportation services are not covered. If you take a taxi or bus (public transportation) to and from your doctor's appointment or pharmacy, you will have to pay for it.

THERAPIES

The section is about covered services and exclusions for outpatient therapies, including physical therapy (PT), occupational therapy (OT), and speech therapy.

Where can I get outpatient therapy?

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

What outpatient therapies are covered?

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

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

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

Physical Therapy

Physical therapy is given to:

- Relieve pain.
- Restore function.
- Prevent disability following illness, injury or loss of a body part. Or for developmental delay.
- 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 and hydrotherapy and heat. They also include the application of physical agents and biomechanical and neuro-physiological principles and devices.

Occupational Therapy

Occupational therapy is a treatment that works to improve fine and gross motor skills. It also works to improve motor planning. Tasks and skills that occupational therapists might focus on could be holding and controlling a pencil, using scissors, or throwing and catching.

Speech Therapy

Speech therapy is for the correction of speech impairment that results from illness or injury. Or 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 they are not limited to the maximum visits.

What outpatient therapy services are not covered?

The following outpatient therapy services are **not covered**:

- Formula for any medical condition that does not meet the above requirements.
- Cardiac rehabilitation programs. Unless it follows a major cardiac event.
- Maintenance therapy. Or care done after you have reached your rehabilitative potential. This is as determined by CHP+.
- Home programs for ongoing conditioning and maintenance.
- Therapies for learning disorders, stuttering, voice disorders or rhythm disorders. This is unless specifically listed above in covered services. 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. These are as determined by CHP+.
- 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 said in this member handbook.
- Occupational therapies for diversional, recreational, or vocational therapies. For example, hobbies, arts, and crafts.
- Acupuncture care.

HOME HEALTH CARE AND HOME INFUSION THERAPY

Who can give home health care and home infusion therapy?

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

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

- Home health care services are covered only when needed to prevent hospitalization.
- Prior hospitalization is not required for home health care services.
- To get home health services, you must have a written order from your provider. They will work with the home health agency to set up a care plan. A registered nurse from the home health agency will coordinate the services in the care plan.
- All home health care and home infusion therapy services require a preauthorization from CHP+. CHP+ has the right to review treatment plans at any time while you are getting home health care or home infusion therapy services.
- Covered home health care services include the following:
- Professional nursing services performed by a registered nurse (RN) or a licensed practical nurse (LPN) on a defined schedule of visits.

- Certified nurse aide services. This is if under the supervision of a registered nurse or a qualified therapist with professional nursing services.
- Physical therapy done by a licensed physical therapist.
- Occupational therapy. This is if done by a licensed occupational therapist or certified occupational therapy assistant.
- Respiratory and inhalation therapy services.
- Speech and hearing therapy and audiology services.
- Medical or social services.
- Medical supplies, including respiratory supplies. And durable medical equipment for rental or purchase, such as oxygen, appliances, prostheses, and orthopedic appliances.
- Formulas for metabolic disorders, total parental nutrition, enteral nutrition and nutrition products. And formulas for gastronomy tubes are covered for documented medical needs. This includes attainment of normal growth and development.
- Intravenous (IV) medication and other prescription medications that are not usually available through a retail pharmacy.
- Nutritional counseling. This is by a nutritionist or dietitian.
- Home infusion therapy. This is also known as home IV therapy or home injection therapy. Benefits for home infusions therapy include a combination of services in the home. This includes nursing, durable medical equipment, and pharmaceutical services.
- Covered home infusion therapy services include, but are not limited to antibiotic therapy, hydration therapy, and chemotherapy and intramuscular, subcutaneous, and continuous subcutaneous injections. See the *Food and Nutrition Therapy* section for details.

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

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

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

HOSPICE CARE

Who can provide covered services?

Hospice care may be given in your home or in an inpatient facility. Hospice services must be through a hospice program that is in our network.

What hospice services are covered?

- We must preauthorize inpatient or home hospice services for a terminally ill member before care is received.
- To be eligible for home or inpatient hospice benefits, you must have a life expectancy of six months or less. This must be certified by the attending provider.
- Hospice care includes medical, physical, social, psychological, and spiritual services that stress palliative care for patients.
- We will first approve hospice care for three months.
- Benefits may continue for up to two more periods of three months, for a total of nine months. These do not have to be consecutive periods of three months.
- After the three benefit periods, we will work with the provider and the hospice provider to decide if hospice care is the best care for you.
- We have the right to review treatment plans while you are getting hospice care.
- Coverage for hospice care is available for these services in a member's home:
    - Hospice provider visits
    - Skilled nursing services of 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, there is more information in the *Medical Supplies and Equipment* section.
    - Services from a licensed or certified therapist for physical, occupational, respiratory, and speech therapy.
    - Medical social services done 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 given to help you cope with a specified medical condition. This must be recommended by a provider.
    - Services of a home health aide under the supervision of a registered nurse.
    - Nutrition assessment, counseling, and support for things like intravenous feeding, hyperalimentation, and enteral feeding.

    - There are also benefits for inpatient hospice accommodation and services.
- Respite care: This is total care that is given to terminally ill patients for a short period of time. It is so that the family of the patient can have a short break.
    - The patient may be placed in respite care. This is for a period not to exceed five continuous days for every 60 days of hospice care.
    - The patient may not be placed in respite care for more than two respite care stays during a hospice care benefit period. One hospice care benefit is equal to three months.
    - Mental health respite care is a covered benefit.
    - All requests for respite care must come from a mental health provider that is in our network.
    - All mental health respite care requires preauthorization and medical record review.
    - Respite care is based on medical necessity. It is reviewed by a CHP+ behavioral health medical director.

What hospice services are not covered?

The following are exclusions. They are not covered hospice services:

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

HUMAN ORGAN AND TISSUE TRANSPLANT SERVICES

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

Who can provide human organ and tissue transplant services?

Covered transplant services must be done 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 given for services directly related to these transplants:

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

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

These guidelines must be met to get covered human organ or tissue transplant services:

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

Hospital, Medical, Surgical, And Other Services

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

Hospital covered services

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

Medical covered services

- Inpatient and/or outpatient professional services.
- Intensive medical care given 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 given at the same time 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 given at the same time during the hospital stay when the nature or severity of your condition requires skills of separate providers.
- Consultation services given by another provider at the request of the attending provider. This is other than staff consultations required by hospital rules and regulations.
- Home, office, and other outpatient medical care visits for examinations and treatment.

Surgical covered services

- Surgical services in connection with covered human organ and tissue transplants. Separate payment will not be made for pre-operative and post-operative services. They will also not be made for more than one surgical procedure performed at the same time.

- Services of a surgical assistant in the performance of such covered surgery as allowed by CHP+.
- Administration of anesthesia ordered by the provider.

Other covered services

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

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

- When both the recipient and the donor are members of CHP+, 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 given or available to the donor from any other source.
- This includes, but is not limited to, other insurance coverage, grants, foundation, and government programs.
- If the donor is a member of CHP+, and the recipient is not, benefits or expenses will not be given for the donor or recipient.

- Donor expenses are paid only after a member's initial claims for the transplant have been processed. No coverage is available to the donor after they have been discharged from the transplant facility.
- No benefits will be given for procurement of a donor organ or organ tissue which is not used in a covered transplant procedure. This is unless the transplant is canceled due to the member's medical condition or death and the organ cannot be transplanted to another person.
- No benefits will be given for procurement of a donor organ or organ tissue that has been sold rather than donated.

Maximum lifetime benefit for human organ transplants

- Coverage for all covered organ transplants and all transplant-related services. This includes travel, lodging, and donor expenses or organ procurement, and 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. These are things like hospitalizations and medical services related to the transplant and any subsequent hospitalization and medical services related to the transplant. The travel, lodging and donor expenses coverage is also applied toward the maximum lifetime benefit for organ transplant.
- A service or supply is considered transplant-related if it directly relates to a transplant covered under this handbook. And if it is received during the transplant benefit period. This is 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 get a transplant evaluation. Covered services received during the evaluation will be subject to the maximum lifetime benefit for organ transplants. They are also subject to the limitation of this Human Organ Transplant benefit.
- If you receive a covered transplant (for example, heart transplant) and later require another transplant of the same type (for example, another heart transplant) the covered charges for the new transplant are applied to the remaining (if any) maximum lifetime benefit available per member.
- Payments under the organ transplant benefit are not applied to other specified benefit maximums.
- Expenses for covered transplant-related services in excess of the maximum lifetime benefit for organ transplants are not payable under this provision or any other portion of the CHP+ handbook.

What human organ and tissue transplant services are not covered?

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

- Services performed at any hospital that CHP+ has not designated and approved to provide human organ and tissue transplant services for the organ or tissue being transplanted.
- Services performed if you are not a suitable transplant candidate as determined by the hospital CHP+ has chosen and approved to provide such services.
- Services for donor searches or donor matching. Or personal living expenses related to donor searches or donor tissue matching. This is for the recipient or donor, or their respective family or friends.
- Any experimental or investigational transplant, treatment, procedure, facility, equipment, drug, device, service, or supply, including any associated or follow-up service or supply.
- Transplants of organs other than those listed previously in this section. This includes non-human organs. Services and supplies related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition that are in any way related to the artificial and/or mechanical heart or ventricular/atrial assist devices or the failure of those devices as long as any of the specified devices remain in place. This exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

MEDICAL SUPPLIES AND EQUIPMENT

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

Where can I get medical supplies and equipment?

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

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

The benefits described in this section are allowed up to the maximum benefit payment of $2,000 per calendar year. Some supplies are subject to preauthorization requirements. See the *Managing Care* section for details.

- Covered supplies do require a prescription from a licensed provider.

- Covered supplies and equipment must meet CHP+ medical policy criteria.
- To learn more about supplies from a pharmacy, see the *Outpatient Pharmacy and Prescription Medication* section.
- Durable medical equipment (DME) includes items like:
  - Crutches.
  - Wheelchairs and supplies.
  - Breathing equipment such as nebulizers.
  - Hospital beds.
  - Breast pumps.
  - All pumps and related supplies (other than insulin pumps).
- Durable medical equipment can be rented. It can also be purchased. This decision is up to CHP+. 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.
- Rental costs must not be more than the purchase price. It will be applied to the purchase price.
- Medical equipment repair, maintenance and adjustment due to normal usage are covered. This is only if CHP+ 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. This is as part of the inpatient hospital admission.

Prostheses and orthopedic appliance or devices – A prosthetic device replaces all or part of a missing body part or extremity (arms and legs) to increase your ability to function. The purchase, fitting, repair and replacement, and the need for adjustments for prosthetics for arms and legs are excluded from the annual dollar amount durable medical equipment benefit limit. All other prosthetic devices, unless specifically listed in the CHP+ handbook, are subject to the annual dollar amount durable medical equipment limit.

Benefits for other appliances include:

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

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

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

- Medical, surgical, and oxygen supplies.
- Medical supplies:
    - Medical supplies used during covered outpatient visits. This includes casts, dressings, and splints in lieu of casts.
- Disposable items received from a provider in our network and required for the treatment of an illness of injury on an inpatient or outpatient basis are covered. Benefits are given for the following examples, but are not limited to:
    - Syringes.
    - Diabetic testing strips.
    - Insulin pumps and supplies.
    - Needles.
    - Splints.
    - Other similar items that treat a medical condition.
- Durable medical equipment used during a covered admission or covered outpatient visit that is owned by the facility.
- Surgically implanted prosthetics or devices authorized by CHP+ before you get the device. This includes cochlear implants.
- Orthopedic shoes for members with a diagnosis of diabetes only.
- Oxygen and oxygen supplies:
    - Benefits are offered for oxygen. And the rental of the equipment needed to administer oxygen. One stationary and one portable unit per member.
    - Preauthorization may be required from CHP+.
- Prosthetic and orthopedic appliances or devices
    - The purchase, fitting, repair and replacement, and the need for adjustments for prosthetics for arms and legs are excluded from the yearly dollar amount durable medical equipment benefit limit. All other prosthetic devices and orthopedic appliances are subject to the yearly dollar amount durable medical equipment limit, unless specifically listed in this handbook.

What services are not covered?

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

- Comfort, luxury or convenience 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).
- The standard CHP+ benefits do not cover items available without a prescription. This includes over-the-counter items or items usually found in the home for general use. This includes, but is not limited to, bandages, gauze, tape, cotton swabs, dressing, thermometers, heating pads and petroleum jelly.
- Air conditioners, purifiers, humidifiers, dehumidifiers, special lighting or other environmental modifiers, surgical supports and corsets or other articles of clothing, whirlpools, hot tubs, saunas, flotation mattresses, and biofeedback equipment.
- Self-help devices that are not medical in nature. This is regardless of the relief or safety they may give for a medical condition. This includes, but is not limited to, bath accessories (including bathtub lifts), telephone arms, home modifications to accommodate wheelchairs, wheelchair convenience items, wheelchair lifts, and vehicle modifications.
- Dental prostheses, hair/cranial prostheses, penile prostheses, or other prostheses for cosmetic purposes.
- Orthotic shoe inserts, except for members with diabetes.
- Home exercise and therapy equipment.
- Consumer beds, adjustable beds or waterbeds.
- Repairs or replacements needed due to misuse or abuse of any covered medical supply or equipment that is identified in this section.
- Orthopedic shoes not attached to a brace, except for members with diabetes.

DENTAL-RELATED SERVICES

Routine dental coverage – DentaQuest

Routine dental coverage for CHP+ members is through DentaQuest. Call them at 855-225-1729 (State Relay 711) if you have questions about your covered dental services. Routine dental coverage is not available for members who are enrolled in the Presumptive Eligibility program.

What dental-related services does Colorado Access cover?

DentaQuest covers most dental services, but we provide coverage related to dental-related health conditions. We cover accident-related services, inpatient services for dental-related services, and

cleft palate and cleft lip conditions. This handbook explains coverage for health conditions. It should not be considered as the member's dental coverage. All health-related dental services and supplies are subject to preauthorization guidelines. See the *Managing Care* section to learn more.

Accident-related dental services include:

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

What dental services can be performed by my PCP?

Fluoride varnish services

This section is about covered services and exclusions for fluoride varnish services when given by a primary care provider (PCP) office. The fluoride varnish may also be given as a routine dental service from a dentist in the DentaQuest network.

Where can I get covered fluoride varnish services?

You can get fluoride varnish services from a PCP in our network.

Fluoride varnish services from your PCP

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

Fluoride varnish benefits not covered (exclusions)

- Children age 5 and older.
- Services obtained from a PCP who is not part of our network.
- Services obtained from a provider who is not a PCP.

- Fluoride varnish treatment that does not include a risk assessment performed by the PCP.

Colorado Access covers the following dental anesthesia services:

General anesthesia when given in a hospital, outpatient surgical facility, or other facility. For dental anesthesia services to be covered, you must:

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

Inpatient admission for dental care

When medically necessary, Colorado Access covers inpatient facility services related to dental care, including room and board. DentaQuest covers eligible dental services.

Cleft lip and cleft palate

Colorado Access covers the following services in connection with cleft lip and/or cleft palate when given by or under the direction of a provider and are included to the extent medically necessary.

These are covered 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 maximum of 30 therapy visits, but additional visits are covered as medically necessary.

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

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

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

FOOD AND NUTRITION THERAPY

Who can supply food and nutrition services?

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

What food and nutrition services are covered?

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

The durable medical equipment and supplies related to food and nutrition services are subject to a payment limit. See the *Medical Supplies and Equipment* section.

All services must be preauthorized. See the *Managing Care* section to learn more about these guidelines.

- Enteral therapy and Total Parenteral Nutrition (TPN)
  - Enteral therapy is delivery of nutrients by a tube into gastrointestinal tract.
  - Medically necessary and non-custodial nursing visits for enteral nutrition are covered under the home health benefits. These services are usually given by a home health agency. See the *Home Health Care and Home Infusion Therapy* and the *Hospice Care* sections to learn more.
- 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. This is for the first 21 days after a hospital discharge.
  - If medically necessary, more days may be allowed up to a maximum of 42 days per calendar year as determined to be medically necessary and when preauthorized by CHP+.
- Medical foods
  - CHP+ covers medical foods for home use for metabolic disorders.
  - Covered medical foods must be prescribed by your provider.
  - CHP+ covers medical foods that are appropriate for inherited enzymatic disorders involved in the metabolism of amino, organic, and fatty acids. This includes phenylketonuria, maternal phenylketonuria, maple syrup urine disease, tyrosinemia, homocystinuria, histidinemia, urea cycle disorders, hyperlysinemia, glutaric acidemias, methylmalonic acidemia, and propionic acidemia.
  - This benefit does not include medical foods for members with lactose or soy intolerance.
- Other medical nutrition. The following are also covered services:
  - Members with a diagnosis of diabetes – inpatient nutrition counseling, outpatient nutrition and self-management training, and follow-up visits for members diagnosed as diabetic.
  - Members in hospice care – nutrition assessment, counseling, and support, such as intravenous feeding, hyperalimentation, and enteral feeding.
  - Formulas for metabolic disorders, total parenteral nutrition, enteral nutrition and nutrition products, and formula for gastrostomy tubes are covered for documented medical needs. This includes attainment of normal growth and development. Enteral formula is covered under the home health care benefit. Payment for formula must be preauthorized. It will be considered only if there is a gastrointestinal disorder (including the oral cavity) or malabsorption syndrome. Or a condition that affects growth pattern or the normal absorption of nutrition. Cost of pumps, tubing and other supplies for administration of formulas given by tube or vein are included.

- Nutrition assessment and therapy for infants and children requiring special formulas, feeding by enteral tube or by parenteral route, or with documented medical need. This includes attainment of normal growth and development including growth failure.
- Feeding appliances and feeding evaluation that are medically necessary in conditions where oral/esophageal condition make normal food intake inadequate.
- Obesity/overweight – nutrition assessment and therapy using pediatric weight management standards. Obesity is defined as great than the 95th percentile weight for height. Or it is defined as greater than 95th percent body mass index (BMI) for age (using the CDC/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, foods allergies and intolerance, hyperlipoproteinemia, seizure disorders, eating disorders, congenital heart disease, renal failure, cancer, AIDS, Prader-Willi Syndrome, and Rett Syndrome.
- Human breast milk from a milk bank. This is when it is required for the survival of the infant. Breastfeeding equipment such as breast pumps and supplemental nutrition system (SNS) when a fragile infant's growth is failing, and it is considered in the best interest of the infant to continue breastfeeding.

What food and nutrition services are not covered?

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

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

MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE

Mental Health

How do I get mental health services?

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

Some mental health services may require preauthorization. Go to coaccess.com/providers/resources/um/ or call us to determine if the mental health service requires preauthorization. Call us at 800-511-5010 (toll-free) (State Relay 711). If you do not get preauthorization or if you get services from a provider other than the provider preauthorized by CHP+, the services will not be covered. Counselors who know sign language and sign language interpreters are available.

If you are getting services from a mental health professional at the time of your enrollment, please call us to see if authorization is required. If the mental health provider you are seeing is not in our network, you will need an authorization for more visits. A care manager will help you change your care to a provider in our network, if needed. CHP+ must be notified about all emergency admissions by the next business day. This includes those that are on weekends or holidays.

What mental health services are covered?

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

- Individual counseling.
- Family counseling.
- Group counseling.
- Care management services.
- Medication management – CHP+ covers medication management of mental health conditions by a medical provider, psychiatrist, or nurse that is legally allowed to write prescriptions (prescriptive authority).
- Day treatment – day treatment services are for specific mental health and educational needs and are sometimes part of the individual education plan (IEP). Covered day treatment services require preauthorization. Day treatment services include, but are not limited to:

  - Individual counseling.
  - Family counseling.
  - Group counseling.
  - Educational support services.
- Care management – A CHP+ case manager can help you:
  - Get the right care from doctors, providers, schools, and other programs.
  - Help you find resources (such as food, clothing, and housing).

Emergency Services – Please see the *Urgent/After-Hours Care, Emergency Care and Travel Outside of the Country* section for more details. If you have a mental health emergency or crisis, go directly to the nearest emergency room. Or call 911. You can get emergency services 24 hours a day, seven days a week.

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

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

Residential treatment services – the same services covered as inpatient services are also covered for residential treatment services. Residential treatment services are services in a licensed residential facility that can provide day services and 24-hour supervision after day program. Residential treatment services require preauthorization. They are approved only if the charges are equal to or less than partial hospitalization.

Home-based services – these are specialized mental health services that you get in your home. This is when traditional mental health services have not been effective.

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. Mental health evaluations and assessments do not require authorizations. But the services that are recommended as the result of an evaluation might require preauthorization. Call us if you have questions about this.

Autism spectrum disorder – treatment for the diagnosis of autism spectrum disorder is a covered benefit when the treatment is medically necessary, appropriate, habilitative or rehabilitative care,

such as physical therapy, occupational therapy, and speech therapy for fine and gross motor delays, and psychiatric/psychological services. See the *Mental Health and Substance Use Disorder Care* section to learn more. Applied Behavioral Analysis (ABA) therapy is not a covered benefit of CHP+.

More mental health services – if you have questions about other mental health services that are not listed, please call us. Call 800-511-5010 (toll-free).

What mental health and substance use disorder services are not covered?

The following mental health and substance use disorder services are exclusions and are **not covered**:

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

Smoking cessation programs

If you smoke and want to quit, talk to your primary care provider (PCP). They can give you more resources. They can also help you create a plan to quit smoking.

You can also call the Colorado Quitline if you need help to quit smoking. Call them at 800-QUITNOW (800-784-8669). You must be at least 15 years old to participate in the Quit Program. The Quit Program services are a benefit of CHP+. When you call, tell them your CHP+ ID number. Services will be free of charge.

Substance Use Disorders

How do I get substance use disorder services?

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

Some services may need to be preauthorized. You can call us to find out if a substance use disorder service requires preauthorization: 800-511-5010 (toll-free) (State Relay 711). If you do not get preauthorization or if you get services from a provider other than the provider that was preauthorized by CHP+, the services will not be covered. You will have to pay for them.

Substance use disorder providers who know sign language and sign language interpreters are available.

If you are getting services from a substance use disorder provider when you enroll, call us. We can tell you if an authorization is needed. If the mental health professional you are seeing is out-of-network, then authorization for more visits will be needed.

A care manager may help transition your treatment to a provider in our network if appropriate. CHP+ must be notified about all emergency admissions by the next business day. This includes those that occur on weekends or holidays.

What substance use disorder services are covered?

CHP+ covers medically necessary outpatient and inpatient substance use disorder treatments.

- Most covered outpatient services do not require authorization.
- Inpatient substance use disorder treatments require authorization.
- Residential substance use disorder treatment requires authorization.

OUTPATIENT PHARMACY AND PRESCRIPTION MEDICATION

Where can I get prescription medication?

CHP+ has a large nationwide network that includes most Colorado pharmacies and all Costco pharmacies. You do not need a Costco membership to use a Costco pharmacy. To find pharmacies in our network, look online at coaccess.com/members/chp or call us at 800-511-5010 (toll-free) (State Relay 711). You can also look online on our pharmacy benefit manager's member portal: https://memberportal.navitus.com/landing.

Be sure to show your CHP+ ID card at the pharmacy. You may also give your state ID number and the following information: BIN number (610302), PCN (NVT), and Rx Group Number (CHPH).

Does my pharmacy benefit include prescription delivery?

You can get prescriptions delivered through Costco Pharmacy the same day for $0 with Instacart. To use this benefit, simply call your local Costco and let the pharmacy staff know you would like to transfer your prescription(s). In most cases, they can contact your current pharmacy to complete the transfer. When filling the prescription, request that the prescription be delivered to your home. You may need to live within a certain radius to qualify for delivery services.

Do I have a prescription medication copay?

Some members of CHP+ have a prescription medication copay. If you have a copay, the amount will be listed on your CHP+ ID card. If you have a prescription medication copay, the retail pharmacy will ask for it before they give you the medication.

If you are filling more than one prescription, you need to pay separate copays for each covered medication or supply. If the retail price of the medication is less than your copay amount, you will pay the retail price. The copay will not be lowered by any discounts or rebates.

What prescription medications are covered?

CHP+ covers a 30-day supply of prescription medication from a pharmacy in our network. Prescription contraceptives can be covered for up to a 12-month (one-year) supply after a three-month fill. This includes oral contraceptives (the Pill), contraceptive patches, and vaginal ring contraceptives.

Some prescription medications that are taken daily may qualify for a 90-day supply of medication. You can ask your doctor if your medication qualifies for this. Coverage guidelines and quantity limits may apply. Please see the formulary list to learn more. You can find it at coaccess.com/providers/resources/pharmacy.

For these medications to be covered by CHP+, you need a prescription from your doctor. Bring the prescription to a retail pharmacy in our network. Please read the heading *"Where can I get prescription medication?"* in this section to learn more.

If you purchased a prescription medication without using your ID card, you can submit a prescription drug claim form for review. You can find this form at coaccess.com/members/services/forms/.

- Contraceptives are covered for up to three pill packs (normally 84 days) at a retail pharmacy in our network for the first fill. After your first fill of a three-month supply, these prescriptions are eligible to be filled for up to a one-year supply.
- When medically necessary, you can get a one-month vacation override. You can get this if you are traveling out of the CHP+ service area.
- For certain prescription medications, the prescribing provider may be asked to send more information to CHP+ to determine medical necessity.
- CHP+ may, at its sole discretion, establish quantity limits for specific prescription medications.
- Covered services will be limited based on medical necessity, quantity limits established by CHP+, or utilization guidelines.
- CHP+ covers over 200 over-the-counter (OTC) medications with a prescription from your doctor, such as Tylenol and vitamins.
- CHP+ covers several OTC medications when prescribed by a pharmacist. These are covered if the pharmacist is enrolled with the state, the medication is listed in the CHP+ formulary list and the prescription is consistent with the state of Colorado's Pharmacist OTC Prescriptive Authority List.
- Epi-Pens are covered with a prescription from your doctor.

Formulary list

CHP+ uses a formulary list. This is a list of medications covered by CHP+. The current list can be found at coaccess.com/document/chp-hmo-formulary. If you would like a paper copy, please call us. Call 800-511-5010 (toll-free) (State Relay 711).

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

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

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

Prescription medication

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

If your doctor does not get prior authorization, and you try to fill the prescription, the in-network retail pharmacist will let you know that the medication requires preauthorization. You will need to contact the provider that prescribed the medication. You must ask them to send information to CHP+. If you need help, please call us.

Inpatient pharmacy benefits

CHP+ covers medications given during a covered inpatient stay when the medications are billed by a hospital or other facility. See the *Inpatient Hospital Services* section to learn more about this.

Other benefits

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

If you do not get certain supplies, equipment, and appliances through a pharmacy in our network, they may be covered as medical supplies or durable medical equipment. See the *Medical Supplies and Equipment* section for benefit details about medical supplies and durable medical equipment.

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

If you do not have your ID card when you go to a pharmacy in our network, or you fill a prescription at a pharmacy not in our network, 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:

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

2. Mail the receipt and a reimbursement form (coaccess.com/document/coa-member-reimbursement-request-form) to:

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

This request must be completed within 120 days from when you purchased the medication. We will review your request for reimbursement and the receipt. If the medication that you paid for is not on the formulary list or requires preauthorization, we may ask for information from the provider that prescribed the medication. This will help us review the medical need of the medication.

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

What prescription medications are not covered?

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

- Prescription medications and supplies from a pharmacy that is not in our network.
- Unless specifically noted above or in the CHP+ formulary list, non-prescription and OTC medications are not covered. This includes herbal or homeopathic preparations; prescription medications with an OTC 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 you get a prescription order from a provider.
- Medications prescribed for weight control or appetite suppression.
- Medications or preparations used for cosmetic purposes to promote or prevent hair growth, or medicated cosmetics including, but not limited to, Rogaine®, Vaniqa®, and Tretinoin (sold under such brand names as Retin-A®).
- Any medication, product or technology within six months of the Food and Drug Administration (FDA) approval. CHP+ may, at its sole discretion, waive this exclusion in whole or in part for a specific new FDA-approved medication product or technology.
- Any medications used to treat infertility.

- Standard CHP+ benefits do not cover special formulas, food or food supplements. This is unless they are for metabolic disorders. See the *Food and Nutrition Therapy* section for details.
- Delivery charges for prescriptions.
- Charges for the administration of any medication. This is unless it is dispensed in the provider's office or though home health services.
- Medications given as samples to the provider.
- Antibacterial soap/detergent, toothpaste/gel, shampoo, or mouthwash/rinse.
- Hypodermic needles, syringes or similar devices. This is 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. This includes support garments and other non-medicinal supplies (regardless of intended use).
- Prescription medications dispensed in quantities that exceed the applicable limits. These limits are established by CHP+ at its sole discretion.
- Refills that exceed the quantity prescribed by the provider or that are refilled more than one year from the date of such order.
- Prescription medications intended for the treatment of sexual dysfunction or inadequacy, regardless of origin or cause (including medications, such as Viagra®, for the treatment of erectile dysfunction).
- Prescription medications dispensed for the purpose of international travel.

AUDIOLOGY SERVICES

Where can I get audiology services?

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

What audiology services are covered?

The following audiology services are covered:

- Age-appropriate hearing screenings for preventive care.
- Newborn hearing screening and follow-up for a failed screen.
- One hearing aid every five years. More hearing aids can be given if medically necessary, such as:
    - A new hearing aid when alteration to the existing hearing aid cannot adequately meet your needs.

- Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is given according to accepted professional standards.

VISION SERVICES

Where can I get covered vision services?

You must get routine and specialty vision services (office visits for routine eye exams) from an ophthalmologist or optometrist that is in our network. Routine eye exams are not covered if you go to a provider who is not in our network.

Lenses, frames, and/or contacts can be purchased from an in-network or out-of-network provider. These are subject to benefit limits. You can find an in-network provider at coaccess.com or call us.

What vision services are covered?

- Routine vision services do not require preauthorization.
- Age-appropriate vision screenings and routine eye exams.
- One routine eye exam is covered per calendar year.
- The CHP+ benefit is one pair of glasses from an in-network provider per calendar year. If glasses are not sufficient for your vision, you may request contact lenses.
- Specialty vision services to contracted providers. A specialty vision service is when you see a vision provider for something other than a routine exam.
- Some specialty vision treatments may require authorization.

What vision services are not covered?

These vision services are exclusions and are not covered:

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

6: General Exclusions and Limitations

This list of exclusions describes services that are not covered by CHP+. This is not a complete list of all services, supplies, conditions, or situations that are not covered services. If you have questions about covered benefits or exclusions, please call us.

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. Learn more in the *Member Benefits – Covered Services* section and others in this booklet.

Remember:

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

NON-COVERED SERVICES

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

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

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

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

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

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

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

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. This is except to provide treatment for heavy metal poisoning.

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

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

Clinical research – This coverage does not cover any services or supplies offered as part of clinical research. This is unless it is 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 that come 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 or investigational.

Convalescent care – Except as otherwise specifically given, 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. This is 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 given 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 cosmetic service that is not covered.

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. This is unless those services would otherwise be covered under this booklet.

Custodial care – This coverage does not cover care primarily for the purpose to assist you in activities of daily living or in meeting personal rather than medical needs, and which is not a specific treatment for an illness or injury. Custodial care cannot be expected to substantially improve a medical condition. It 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:

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

Dental services – Dental services are given by DentaQuest unless specifically listed in the *Dental-Related Services* section. Children with Presumptive Eligibility do not have access to routine dental services.

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

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

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

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

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

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 or investigational.

CHP+ does not cover experimental or investigational treatment or procedures that are not proven to be effective. This is as determined by medical policy. Or, if no medical policy is available, as determined by appropriate medical or surgical authorities selected by us.

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

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

Hair loss – This coverage does not cover treatment for hair loss (except for alopecia areata), including, but not limited to, medications, wigs, hairpieces, artificial hairpieces, hair or cranial

prosthesis, hair transplants, or implants, even if there is a provider prescription, and a medical reason for hair loss.

Hypnosis – This coverage does not cover services related to hypnosis. This includes 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 a contributing cause was the result of you being engaged in an illegal act.

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

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

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

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. This is unless the services were preauthorized.

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

Medical nutritional therapy – This plan does not cover vitamins, dietary or 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. This is except as given in the *Dental-Related Services* section unless it has medical basis, and as mandated by state law.

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

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

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

- Adoption or surrogate expenses.
- Educational classes and supplies not given by your health care provider. This is 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. This is regardless of medical condition or disability.
- Membership fees for spas, health clubs, or other such facilities, or fees for personal. trainers. This is even if medically recommended. Also regardless of any therapeutic value.
- Personal convenience items such as air conditioners, humidifiers or exercise equipment.
- Personal services such as haircuts, shampoos, guest meals, and radios or televisions.

Orthotics – This coverage does not cover orthotic shoe inserts, unless medically necessary, whether functional or otherwise. This is regardless of the relief they provide.

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

Over-the-counter (OTC) drugs/medications – Unless noted as covered in this booklet (see the *Outpatient Pharmacy and Prescription Medication* section) or the formulary list, this coverage does not cover non-prescription and over-the-counter medications. This includes herbal or homeopathic preparations; prescription medications with an over-the-counter bioequivalent, even if it is written as a prescription, and medications not requiring a prescription by federal (including medications requiring a prescription by state law, but no federal law), except for injectable insulin. Some prescription medication may not be covered even if you get a prescription order from a provider.

Post-termination benefits – This coverage does not cover benefits for care received after coverage is terminated. This is except as given in the *Membership* section. Follow-up care is not covered post-termination. This is 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. This is except as given in the *Member Benefits – Covered Services* section.

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

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

Reduction mammoplasty – This plan does not cover reduction mammoplasty. This is unless given 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.

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

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

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

Third-party liability (subrogation) – This coverage does not cover services and supplies that may be reimbursed by a third party. See the *Other Legal Information* section to learn more.

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

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

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

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

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

Workers' compensation – This coverage does not cover services and supplies for a work- related accident or illness. See the *Other Legal Information* section to learn more.

HOW WE EVALUATE POTENTIAL NEW BENEFITS

When a new treatment or technology emerges, we review the available information to decide if we will cover it. We look at state and federal law and guidance. We also look at the scientific evidence, including clinical trial results published in authoritative, peer-reviewed scientific or medical journals, documents filed with the FDA, and the opinions of consulting providers and experts in the field.

7: Managing Care

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

- Preauthorization for health care services.
- Concurrent hospital review.
- Care management and disease management.
- Advance medical directives.

PREAUTHORIZATION FOR HEALTH CARE SERVICES (PRE-APPROVAL)

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

For some services, you need to get preauthorization from us before you can get the service. This includes some procedures, testing to find out what is going on (diagnostic tests), medical equipment, home health services, and medicine. When you have to stay at the hospital (get admitted), your provider will need to get pre-approval. This is not required in emergency situations. Please see the *Member Benefits – Covered Services* section to learn more.

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

We look at every preauthorization request. We need to make sure the service or supply is a covered service and the right service for you, in the right place.

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

Preauthorization does not mean a service or supply will be covered (paid for). A claim will still be denied if there is suspected fraud or abuse. If we receive a claim for a service that is not covered, the claim may not be denied. The claim may also be denied if the service on the claim is different than the service that was preauthorized. If you have any questions about this, please call us.

Adverse Benefit Determinations (Denial of Services)

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

Covered Benefit Decisions

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

- If the service is right for you (medically necessary);
- If the service is experimental or still being investigated;
- If the service is cosmetic, and
- If the service is excluded under this coverage. To help make this decision, we use many tools, such as:
- Our medical policies and practice guidelines;
- Current medical information;
- Guidelines from well-known national organizations and professional groups, and
- Meetings with specialists.

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

MEDICALLY NECESSARY HEALTH CARE SERVICES

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

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

Medical Policies

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

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

Experimental/Investigational and/or Cosmetic Procedures

We will not pay for any services, procedures, surgeries or supplies that we consider experimental/investigational and/or cosmetic. Since these services are not covered, we will not

pay for complications that are the result of any service, procedure, surgery, or supply that we consider experimental/investigational and/or cosmetic.

Excluded Services

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

APPROPRIATE SETTING

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

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

Scheduled Inpatient Admissions

Examples of inpatient settings include:

- Hospitals.
- Skilled nursing facilities.
- Hospice care.

All inpatient stays require pre-approval (preauthorization). Your provider must contact us to ask for the authorization before scheduling inpatient admissions. A preauthorization is good only for a specific place and during specific dates. You can only get the approved service at the specific place and during the specific dates listed in the preauthorization.

If you do not get the service during the specific dates, or if you need more services, your provider must contact us again to ask for another authorization. We will review the request. If the request is approved, all covered services will be paid for.

We may ask for more details to make sure the service is a medical necessity. Some of the things used to help make this decision are medical policies and medical care guidelines. The medical care guidelines include inpatient and surgical care optimal recovery guidelines. By using these guidelines and encouraging education, you are more likely to have better outcomes.

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

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

If we find that more time in the hospital is not medically necessary, we will let the hospital and provider know the day you should go home (recommended date of discharge). The hospital will let you know about our decision in a timely manner.

If you decide to stay in the hospital after they let you know, we will not pay for the services you get after the date we think you should go home (recommended date of discharge). You will have to pay for all charges after the recommended date of discharge.

We will send you, your provider, and the hospital a written letter (notification) about our decision. If you do not agree with the decision, you can appeal by following the steps in the *Appeals* section.

Emergency (Unscheduled) Admissions

It is your responsibility to make sure that we know about an emergency admission within one business day of being admitted. This is unless you are unable to do so. An example of an emergency admission is when you are admitted to the hospital after an accident or serious illness. Once we know, we will help you manage your hospital benefits.

We will also help you plan during hospitalization and after you are let go (discharged). If you do not make sure that we know of an emergency admission, your claims may not be paid. Or your coverage may be denied.

Outpatient Procedures

Examples of outpatient settings include:

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

Outpatient services may be performed in a hospital on an outpatient basis or in another facility. This could mean an ambulatory surgery center.

Some procedures performed in an outpatient setting must be pre-approved (preauthorized). Your health care provider must call and ask for a preauthorization. If a preauthorization is required for a procedure, your provider must contact us to ask for the authorization before the procedure is

scheduled. We may ask your provider for more details. This is to decide if the service is medically necessary.

A preauthorization is good only for an exact place and during exact dates. You can only get the approved service at the exact place and during the exact dates listed in the preauthorization. If you do not get the service during the specific dates, or if you need more services, your provider must contact us again to ask for another authorization.

Concurrent Hospital Review

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

RETROSPECTIVE CLAIM REVIEW

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

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

We may look at your medical records to help make payment decisions. If we decide that services are not covered, we will not pay for the charges. If the provider is in our network and we decide the claim should not have been paid, the provider cannot bill you.

ONGOING CARE NEEDS

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

Utilization Management

We made our utilization management program after studying nationally recognized guidelines. Utilization management is used to decide if you are getting the right care, at the right time, in the right place. We do not make covered service determinations or utilization review determinations based on moral grounds or religious beliefs.

If a provider refuses to give you a covered service based on moral or religious beliefs, please contact us. We will help you find a different provider who will provide the covered services you need.

To better understand how the utilization management team decides if a service is medically necessary, please call us. Call 800-511-5010 (toll-free) (State Relay 711). If you disagree with a decision and would like to file an appeal, please see the *Appeals* section.

Care coordination and disease management

Our care coordination and disease management teams are made up of health care professionals with a wide variety of backgrounds, experience, and knowledge. This allows our team to support your unique health care needs. This ensures that barriers and gaps are identified. And that you are connected to the right resources to best manage your health conditions.

Care coordination is a way we help you manage chronic health conditions and coordinate care across providers. We can also support you if you are experiencing a transition of care, educate you about your health and help to navigate the health care system. Having a point person to work with often makes things a lot easier to manage. In a case like this, a care manager may work with you to coordinate or facilitate medical care.

The care coordination program works to find members who could benefit from care coordination as early as possible. The care coordinator works to create a care plan for you. They will also help put the care plan into action and make sure it's working. They make sure you are getting the right care, at the right time, in the right place. They also help make sure your providers talk to each other. Care coordination interventions and care plan goals are designed to meet your unique needs.

Getting Care Coordination

There are several ways for you to request care coordination.

- We may contact you by phone or mail if we think you could benefit from care coordination.
- Providers may refer you.
- Call us at 800-511-5010 (toll-free) (State Relay 711).

ADVANCE MEDICAL DIRECTIVES

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

- Protect your right to make medical decisions and choices about your health care.
- Help family members make decision if you can't.

You can learn more about the state laws that apply to advance medical directives at coaccess.com/members/services.

OMBUDSMAN

The Health First Colorado Ombudsman is a neutral party that can help you with complaints and appeals. You can reach them at 877-435-7123 (State Relay 711) or help123@maximus.com.

For behavioral health services, you can also contact the Behavioral Health Ombudsman of Colorado, which is a neutral party to help members and health care providers with issues related to behavioral health access to care. You can reach them at 303-866-2789 or ombuds@bhoco.org.

CHP+ is subject to the Mental Health Parity and Addiction Equity Act (MHPAEA).

A denial, restriction, or withholding of benefits for behavioral health services that are covered could be a potential violation of MHPAEA. If you have or are experiencing a behavioral health access to care issue, contact the Behavioral Health Ombudsman.

8: Coordination of Benefits and Subrogation

You cannot have other health coverage to qualify for CHP+. This includes Health First Colorado and private insurance, including individual non-group coverage. The exceptions to this rule are standalone dental or vision plans and Medicare. You can also get CHP+ coverage during the transition from COBRA coverage.

If you get other coverage, you must call CHP+ customer service at 800-359-1991. Or call us at 800-511-5010 (toll-free) (State Relay 711). Failure to comply with obligations in this section may result in termination of coverage under this handbook.

If you are found to have other insurance, CHP+ coverage will be terminated (ended). In some cases, coverage will retroactively terminate for the time period the other insurance was in effect. We will go back and end your coverage on the date that your other insurance went into effect (started). You may be responsible to pay for any medical services you had during that time.

COORDINATION OF BENEFITS

We will coordinate benefits for CHP+ members who have Medicare as their primary insurance coverage, temporary coverage through COBRA, or a standalone dental or vision plan. In these cases, the other insurance is primary and CHP+ is secondary.

WORKERS' COMPENSATION

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

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

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

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

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

- 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 your work-related illness or injury expenses.
- You fail to comply with any other provisions of the Worker's Compensation Act.

AUTOMOBILE INSURANCE PROVISIONS

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

HOW CHP+ COORDINATES BENEFITS WITH COMPLYING POLICIES

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

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

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

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

If You Do Not Have Another Policy

We will pay benefits for any injuries you get while riding in or operating a motor vehicle 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 handbook for any injuries if you are a non-owner operator,

passenger, or pedestrian involved in a motor vehicle accident, and if your injuries are not covered by a complying policy. In that event, we may exercise the rights in this section.

THIRD-PARTY LIABILITY: SUBROGATION

Third-party liability means someone other than you may be legally responsible for your condition or injury. We do not pay for covered services or supplies when a third party is liable. However, we may cover services under these conditions:

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

Our 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. Colorado Access has 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. This includes 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+, the following must occur:

- You must promptly notify us, in writing, of your claim against the third party.
- You and your attorney must provide for the amount of benefits paid by CHP+ in any settlement with the third party of the third party's insurance carrier.
- If you get money for the claim by suit, settlement, or otherwise, you must fully reimburse us for the amount of benefits given to you under this certificate. You may not exclude recovery for CHP+ 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 get non-emergency services.

9: Complaints (Grievances)

Please tell us if you are not happy with CHP+, our providers, or your services. You have the right to express a concern about anything you are not happy with. This is a complaint (also called a grievance).

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

Call us if you need help to file a complaint. We can help you. Call 800-511-5010 (toll-free) (State Relay 711).

Some examples of complaints are:

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

GET HELP WITH YOUR COMPLAINT

You may have someone help you and represent you when you file a complaint. This is a designated client representative. This is someone you choose to talk for you when you have a concern or appeal. It could be a provider, an advocate, a lawyer, a family member, or any other person you trust.

If you make someone your representative, you must do so in writing. Please include their name, address and phone number. This is so we can contact them during the investigation process.

We also have a form you can use.

They will not see your medical records or get information about your situation. You must sign the form if you want them to have information about you. Call us to get the form. Or find it at coaccess.com/members/services/forms.

How to File a Complaint with CHP+

We can help you file your complaint. Please call us if you need help to file your complaint.

You or your representative can call or write to us at any time.

Colorado Access

Member Grievances
P.O. Box 17950
Denver, Colorado 80217-0950
Phone: 800-511-5010 (toll-free)

Include your name, address, phone number, and State Identification (ID) number. This is on your CHP+ member ID card.

You can also use the member complaint form on our website at coaccess.com/members/services/forms.

What Happens When I File a Complaint?

- After we get your phone call or letter, we will send you a letter. This will be within two business days. The letter will say we got your complaint.
- We will review your complaint. We may talk with you or your representative. We may talk to the people who were part of the situation. We may also look at your medical records.
- Someone who was not part of the situation that you are concerned about, and who has the right experience, will review your complaint.
- Within 15 business days after we get your complaint, we will send you another letter. This letter will say what we found and how we fixed it. Or it will let you know that we need more time. You will get a letter from us after we finish the review. If you don't agree that we need more time, you may file a complaint about the extended time period to solve the complaint.
- 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.

To Contact the Department of Health Care Policy & Financing

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

Department of Health Care Policy & Financing CHP+ MCO Contract Manager
P.O. Box 17548
Denver, CO 80217Phone: 800-359-1991
Email: hcpf_chpplus@state.co.us

Let them know that you are a CHP+ member. Tell them what the problem is and how you want it fixed. HCPF will review your complaint and will work with you to find a solution. You will get a letter from HCPF explaining the results of the review. This decision is final.

10: Appeals

You may file an appeal if you disagree when we deny a service or decline to pay for services.

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 approved before.
- 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 give you notifications.
- If you live in a rural area and we deny your request to seek care outside of our network. You will not lose your CHP+ benefits if you express a concern or file an appeal.

GET HELP WITH YOUR APPEAL

If you have questions about how to file an appeal, call us at 800-511-5010 (State Relay 711).

You may have a designated representative to help you and represent you when you file an appeal. This is someone you choose to talk for you when you have an appeal. It could be a provider, an advocate, a lawyer, a family member, or any other person you trust.

If you make someone your representative, you must do so in writing. Please include their name, address and phone number so we can contact them during the investigation process.

They will not see your medical records or get information about your situation. You must sign a form if you want them to have information about you. Call us to get the form. Or find it at coaccess.com/members/services/forms.

HOW TO ASK FOR AN APPEAL

We can help you file your appeal. Please call us if you need help.

- You or your representative must ask for an appeal within 60 calendar days from the date on the letter that says what action we took, or plan to take.
- **To start your appeal, call us**. You or your representative can call our appeals department. Tell them you are a CHP+ member. Tell them you want to file an appeal.

- You or your representative can ask for a "rush" or expedited appeal if you are in the hospital. Or if you feel that waiting for a regular appeal would threaten your life or health.
- You can ask for an appeal by phone, mail, fax, or email:
  Colorado Access Appeals Department
  PO Box 17950
  Denver, CO 80217-0950
  Phone: 844-683-1072
  Fax: 844-683-1071
  Email: clinicalappeals@coaccess.com
- If you send a letter instead of calling, it must be signed by you or your representative. We can help you with the letter.
- 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. You or your representative can also ask for the criteria or information we used to make our decision. You or your representative can look at our records that have to do with your appeal. If the decision or action you appeal is about a denial or change of services, a doctor will review your medical records and other information. This doctor will not be the same doctor who made the first decision.

After You File an Appeal

After we get your phone call or letter, we will send you a letter. This will be within two business days. This letter will tell you that we got your request for an appeal.

We will make a decision. We will let you know within 10 business days from the day we get your request. This is unless it is expedited (rushed). We will send you a letter that tells you the decision. We will also tell you 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. This will be for no more than 14 calendar days. If you do not agree with the extended review, you may file a complaint.

EXPEDITED ("RUSH") APPEALS

If you feel that waiting for an appeal would seriously affect your life or mental health, you may need a fast decision from us. You or your representative can ask for an expedited (rush) appeal. For a rush appeal, a decision is made within 72 hours instead of the usual 10 business days for a regular appeal. During your appeal, your services will stay the same.

We will make our decision on an expedited appeal within three business days. You have only a short period of time to give us information. You can give us information in person or in writing.

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 under the regular timeframe.

You will get a letter that tells you the decision of the appeal and the reason. If you are not happy with the outcome of the expedited appeal, or any appeal, you have the right to request a State Review.

HOW TO REQUEST A STATE REVIEW

A State Review is also called a State Fair Hearing. It means that a state administrative law judge (ALJ) will review our decision or action. You can ask for a state fair hearing:

- After you complete our appeal process; or
- If you are not happy with our decision about your appeal; or
- We did not send you a letter about our decision or we did not meet the timeframes to address your appeal.

The request must be made within 120 days of the date on our appeal decision letter (adverse benefit determination).

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

To ask the Office of Administrative Courts for a state fair hearing, please write, call, fax, or email:
Office of Administrative Courts
1525 Sherman St., 4th Floor
Denver, CO 80203
Phone: 303-866-2000
Fax: 303-866-5909 (10 pages or fewer)
Email: oac-gs@state.co.us

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

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

For help with state fair hearings, please call us at 800-511-5010 (State Relay 711).

11: Other Legal Information

CATASTROPHIC EVENTS

In case of fire, flood, war, civil disturbance, court order, strike, an act of terrorism, or other causes beyond our control, we may not be able to process claims on a timely basis. No legal action or lawsuit may be taken against us due to delay caused by any of these events.

CHANGES TO THE CHP+ MEMBER BENEFITS BOOKLET

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

PREVENTING FRAUD

You can help prevent fraud by doing the following:

- Be careful of mobile health testing labs. Ask what insurance company will be charged for the test first.
- Always read and get familiar with this CHP+ member benefits booklet. If there are any differences between what is in the CHP+ member benefits booklet and the treatment you are offered or bills you are sent, call us. Call 800-511-5010 (toll-free) (State Relay 711).
- Be cautious about giving any information about your CHP+ insurance coverage over the phone to anyone other than us or your provider.

You may be a victim of medical identity theft or fraud if you:

- Get a bill for a medical service you didn’t get.
- 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.
- Have been promised free goods, such as medical equipment or gift cards, for giving your medical identification to someone.

If you suspect fraud by a provider or anyone else, call our compliance hotline at 877- 363-3065. You will not have to give your name or member number when you call the hotline number unless you want to.

INDEPENDENT CONTRACTORS

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

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

NO WITHHOLDING OF COVERAGE FOR NECESSARY CARE

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

PHYSICAL EXAMINATIONS AND AUTOPSIES

We have the right and opportunity, at our expense, to request an examination of a person covered by CHP+ 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 gotten by you when deposited in the United States Postal Service mail with postage prepaid and addressed to you at the latest address in our membership records.

TIME LIMIT ON CERTAIN DEFENSES

After one year from the beginning of your CHP+ coverage, no inaccurate statements made by you during the application process will be used to terminate the coverage or to deny a claim or a

disability. This is unless the statement is made fraudulently. Fraudulently made statements may impact coverage and claims.

Starting one year from the date of issue of this policy, no claim for a loss incurred or a disability, as defined in the 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 existed before the effective date of coverage of this policy.

12: Glossary

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

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

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

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

Admission – the period of time between the date a patient enters a facility as an inpatient and the date they are discharged as an inpatient.

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

Substance Use Disorders – conditions defined by patterns of usage that continue despite occupational, social, or physical problems. These conditions may have severe withdrawal symptoms if the use of alcohol or other substances stops.

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. Also when they are used as alternative instead of conventional treatments. Alternative medicine includes, but is not limited to, eastern medicines such as Chinese or Ayurvedic, herbal treatments, vitamin therapy, homeopathic medicine, naturopathy, faith healing, and other non-traditional remedies for treating diseases or conditions.

Ambulance – a specially designed and equipped vehicle used only for transporting the sick and injured. It must have customary safety and lifesaving equipment. These are things like first aid supplies and oxygen equipment. The vehicle must be operated by people trained to do so 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:

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

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

Audiology services – the testing for hearing disorders. This is 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. This is before applicable in-network provider discounts or adjustments.

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

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

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 personal coordination of care is helpful. Sometimes care management is also called case management.

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

Chemotherapy – medication therapy given 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 serves as a contract between us and our members.

CHP+ provider – also known as an in-network provider. This is a professional health care provider or facility (for example, a provider, a hospital, or a home health agency) that contracts with us to provide services to our members. Providers in our network agree to bill us directly for services they provide and to accept our payment amount (given in accordance with the provisions of the contract) and a member's copay 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 we may recommend a specific provider for specialized care as medically necessary for the member.

CHP+ service area – the geographic area where enrollment in CHP+ offered by Colorado Access 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 it has not responded to current available treatment methods. Chronic pain can continue for the rest of a person's life.

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

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

Congenital defect – a condition or anomaly that exists at or dates 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.

Copay – a dollar amount you pay in order to get a specific service, supply, or prescription medication. A copay is a predetermined, fixed amount paid at the time the service is rendered. The copay amount is printed on the member CHP+ ID card.

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

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

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

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

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

Custodial care – care offered primarily to meet the personal needs of the patient. This includes help to walk, bathe, or dress. 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.

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

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

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

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

Effective date – the date coverage with CHP+ begins.

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

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

Experimental or investigative procedures or services –

1. Any drug/medication, biologic device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which we determine, in our sole discretion, to be experimental or investigational. We will deem any drug/medication, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be experimental or investigational if we determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The drug/medication, biologic, device, diagnostic, product, equipment, procedures, treatment, service, or supply:

    - Cannot be legally marketed in the United State without the final approval of the Food and Drug Administration (FDA) or any other state or federal regulatory agency, and such final approval has not been granted.
    - The FDA has advised against the specific use.
    - Is given as part of a clinical research protocol or clinical trial. Or is given in any other way that is intended to evaluate the safety, toxicity, or efficacy of the drug/medication biologic, device, diagnostic, product, equipment, procedures, treatment, service, or supply, or is subject to review and approval of an institutional review board (IRB) or other body serving a similar function.
    - Is offered pursuant to informed consent documents that describe the drug/medication, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as experimental or investigational, or otherwise indicate that the safety, toxicity, or efficacy of the drug/medication, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.
2. Any service not deemed experimental or investigational based on the criteria in Subsection A may still be deemed to be experimental or investigational by CHP+. To

determine if a service is experimental or investigational, we will consider the information described in Subsection C and look at 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. This is under the usual conditions of medical practice outside clinical investigatory settings.

3. The information we consider or evaluate to determine if a drug/medication, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is experimental or investigational under Subsection A and B may include one or more items from the following list. This list is not all-inclusive:
    - Randomized, controlled, clinical trials published in an authoritative, peer-reviewed United States medical or scientific journal.
    - Evaluations of national medical associations, consensus panels and other technology evaluation bodies.
    - Documents issued by and/or filed with the FDA or other federal, state, or local agency with the authority to approve, regulate, or investigate the use of the drug/medication, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply.
    - Documents of an IRB or other similar body performing substantially the same function
    - Consent documentation(s) used by the treating providers, other medical professionals /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.
4. We have the sole authority and discretion to identify and weigh all information and figure out all questions that pertain 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 Colorado Access to a member after a claim has been filed and a decision has been made about the claim. The EOB includes things like the date of service, name of provider, amount covered, and what the patient owes.

Formulary list – a list of prescription medications approved for use by members of CHP+. 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. Brand name and generic medications must meet the same standards for safety, purity, strength, and quality. It is the law.

Healthy living initiatives – these are projects to promote healthy lifestyles. They also can help members avoid preventable diseases.

Hemodialysis – the treatment of an acute or chronic kidney ailment during which impurities are removed from the blood. This is done 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 given by a certified home health agency to eligible members who are under a plan of care, in their place of residence.

Hospice care – an alternative way to care 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 supports physical, social, psychological, and spiritual needs of the patient and the patient's family.

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

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

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

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

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

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

IUD – stands for intra-uterine device. This is 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 given for patients with complex medical needs. These include patients with high-risk pulmonary conditions who have ventilator or tracheotomy needs or who are medically unstable, patients with extensive wound care needs or post-operative surgery wound care needs, and patients with low-level, closed-head injuries. Long-term acute care facilities do not provide care for low-intensity patient needs.

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

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

- Normal vaginal delivery.
- Cesarean section delivery.
- Spontaneous termination of pregnancy before full term.
- Therapeutic or elective termination of pregnancy, regardless of reason.

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+. 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 given for the prevention, diagnosis, and treatment of illness, injury, and other general conditions.

Medically necessary – Those covered physical health, mental health, and/or substance use disorder services which are determined under the applicable utilization management program to be:

- Consistent with the symptom, diagnosis, and treatment of a member's medical condition.
- Widely accepted by the provider's peer group as effective and reasonably safe based on scientific evidence.
- Not experimental, investigational, unproven, unusual, or not customary.
- Not just for cosmetic purposes.
- Not just for the convenience of the member, subscriber, physician, or other provider.
- The most appropriate level of care that can be safely given to the member, and failure to provide the service would adversely affect the member's health.
- When applied to inpatient care – medically necessary services cannot be safely given in an ambulatory setting.
- Not otherwise subject to an exclusion under this booklet.

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

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

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

Member advisory council (MAC) – this is a group where member voices can be heard. This is a group of diverse people who have Health First Colorado (Colorado's Medicaid Program) or Child Health Plan *Plus* (CHP+). The MAC is a forum to talk about member ideas, topics, and concerns.

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

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

Nephritis – infection or inflammation of the kidney.

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

Nutrition assessment/counseling – medical nutrition therapy given by a qualified nutrition professional such as a registered dietitian with training in pediatric nutrition. Services given by a registered dietitian may require preauthorization from us. Medical nutrition therapy includes nutrition assessment, support, and counseling to decide 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) do such therapy.

Office of Member and Family Affairs – they can help you to understand the mental health system, how to advocate for yourself, answer any questions, concerns and complaints, understand what services you get, and know what your rights and responsibilities are.

Organ transplants – a surgical process that involves the removal of an organ from one person and placement of the organ into another person. Transplant can also mean removal of body

substances, such as stem cells or bone marrow. This is for the purpose of re-implanting the removed organ or tissue in the same person. Organ transplant benefits given to members of CHP+ may be subject to a lifetime maximum benefit.

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

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

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

Out-of-network provider – an appropriately licensed health care provider that has not contracted with us to provide services to our members. We may not cover services given by a provider who is not in our network, this is unless you get preauthorization. A member may be financially responsible for services done by a provider who is not in our network, this is 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 given to a member of CHP+ offered by Colorado Access when they are outside the service area. See also CHP+ service area.

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

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

Overweight/obesity – weight for height at greater than the 95th percentile or body mass index (BMI) greater than the 95th percentile. Obesity in children has long-term consequences that become major health issues later in life. Treatment plans are standard pediatric weight

management programs medically supervised by medical professionals seldom using surgical or pharmacological interventions due to the long-term side effects of these treatments.

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

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

Physical therapy – the use of physical agents to treat a disability that results 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 given.

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

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 set number of years. After the patent expires and FDA requirements are met, any manufacturer may produce the medication and sell the medication under its own brand name or under the medication's chemical (generic) name.

Formulary list: A list of pharmaceutical products developed in consult with providers and pharmacists and approved for their quality and cost-effectiveness.

Generic prescription drug: Medications determined by the FDA to be bioequivalent to brand-name medications and that are not manufactured or marketed under a registered trade name or trademark. A generic medication's active ingredients are the same as those of a brand-name medication. Generic medications must meet the same FDA specifications as brand-name medications for safety, purity, and potency. They must be dispensed in the same dosage form (tablet, capsule, cream) as the counterpart brand- name medication. On average, generic medications cost about half as much as the counterpart brand-name medication.

Legend drug: A medical substance dispensed for outpatient use, which, under the federal Food, Drug, and Cosmetic Act, is required to bear on its original packing label, "Caution:

Federal law prohibits dispensing without a prescription." Compound medications that contain at least one such medicinal substance are considered to be prescription legend drugs. Insulin is considered a prescription legend drug under this booklet.

Preventive care – comprehensive care that focuses on 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 given, for approval of benefits, length of stay, appropriate location, and medical necessity. For prescription medications, the designated CHP+ pharmacy and therapeutics committee defines the medications and criteria for coverage. This includes the need for preauthorization for certain medications.

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

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

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

Provider – a person or facility that is recognized by CHP+ 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 given to perform designated health care services. For benefits to be payable, services of a provider must be within the scope of the authority granted by the license and covered by this plan. Such services are subject to review by a medical authority appointed by us. Other professional providers include, among others, certified nurse midwives, dentists, optometrists, and certified registered nurse anesthetists. Services of such a provider must be among those covered by this certificate and are subject to review by a medical authority appointed by us.

Facility provider: an inpatient and outpatient facility provider, as defined below: **Inpatient facility provider** – a hospital, hospice facility, skilled nursing facility or other facility that we recognize as a health care provider. These facility providers may collectively be called a facility provider or separately as a substance use disorder treatment center provider.

Outpatient facility provider – a dialysis center, home health agency or other facility provider such as an ambulatory surgery center (but not a hospital, hospice facility, or skilled nursing facility)

recognized by CHP+ and licensed or certified to perform designated health care services by the state or jurisdiction where services are given. Services of such a provider must be among those covered by this plan and are subject to review by a medical authority appointed by us.

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

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

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

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

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

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

- Pays Colorado income tax.
- Is employed in Colorado. This is other than that normally given on a temporary basis to students.
- Owns 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 that do not require immediate attention. Also 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 a managed care organization to reduce unnecessary surgery by encouraging people 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 given under medical supervision to carry out non-surgical treatment of chronic diseases or convalescent stages of acute diseases or injuries. Skilled nursing facilities do not provide care for patients with high-intensive medical needs, or for patients who are medically unstable.

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

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

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

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

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

Substance use disorder treatment center – a withdrawal management and/or treatment facility licensed by the state to treat substance use disorders

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

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

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

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

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

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

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

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

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

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

Language Services and Disability Accommodations

If you speak another language, ask your doctor if they offer interpretation services. Colorado Access can also arrange interpretation services for your appointment in any language or ASL. You or your doctor must request interpretation at least four business days before your appointment. To arrange services, go to coaccess.com/InterpreterRequest/ or call us at 800-511-5010 (State Relay 711).

If you have a disability and need help finding a provider, call our care coordination team at 866-833-5717 (State Relay 711). We will help you find a provider who offers the access and support you need.

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.

If you believe that we have 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 complaint with:
Colorado Access ADA Coordinator
800-511-5010 (State Relay 711).
memberadacoordinator@coaccess.com

You can file a complaint in person or by mail, fax, or email. If you need help filing a complaint, the director of member affairs can help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. You can file electronically through the Office for Civil Rights Complaint Portal. You can file a complaint at 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
800-368-1019, 800-537-7697 (TDD)

Complaint process can be found at hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html.