

Welcome to the Child Health Plan, *Plus* (CHP+), where our mission is to improve the health of the children we serve. You have enrolled in a quality health benefit program that pays for many health care services, including physician and outpatient care, emergency care and hospital inpatient care.

This benefits booklet, sometimes referred to as the Evidence of Coverage, is a guide to your child's coverage. Please review this document, as well as any enclosures, to become familiar with benefits, including their limitations and exclusions. Please keep this benefits booklet in a convenient place for quick reference. By learning how coverage works, you can help make the best use of your child's health care coverage.

For questions about coverage, call HMO Colorado's Dedicated Services Department between the hours of 7:30 a.m. and 5:30 p.m., Monday through Friday. The local and toll-free Dedicated Services Department numbers are conveniently printed at the bottom of every page of this benefits booklet.

Thank you for selecting CHP+ for your child's health care coverage. We wish your family good health.



William P. Heller  
Acting Director, Child Health Plan, *Plus*

## **Attention CHP+ Members**

The information contained in this benefits booklet explains the administration of benefits for Child Health Plan *Plus* (CHP+). Information regarding the administration of CHP+ benefits can also be obtained through the CHP+ Customer Service Department. In the event of a conflict between the terms and conditions of this benefits booklet and any other materials provided by CHP+, the terms and conditions of this benefits booklet shall control.

No employee of CHP+ may change this benefits booklet by giving incomplete or incorrect information, or by contradicting the terms of this benefits booklet. Any such situation will not prevent CHP+ from administering this benefits booklet in strict accordance with its terms.

Your CHP+ plan is brought to you by CHP+ and HMO Colorado, a subsidiary of Anthem Blue Cross and Blue Shield. HMO Colorado is the Managed Care Network and is the contractor and Third Party Administrator for the State of Colorado Department of Health Care Policy and Finance. HMO Colorado is responsible for claims processing, referrals, authorizations, case management and utilization review only, and does not assume any financial risk or obligation with respect to claims.

□ **Important Addresses and Phone Numbers**

**Child Health Plan Plus**

P O Box 929  
Denver, CO 80201-0929  
800.359.1991

**CHP+ HMO Customer Service (Benefits and Primary Care)**

1.877.523.8171

**Anthem Behavioral (One Nation)**

800.424.4014

**CHP+/HMO Colorado Claims**

P O Box 5747  
Denver, CO 80217-5747  
877.523.8171

**Family Healthline**

303.692.2229 or 800.688.7777

**Rocky Mountain Poison Control Center**

800.332.3073

**Anthem Prescription Management**

Direct Member Reimbursement  
PO Box 145433  
Cincinnati, OH 45250-5433

**Anthem Prescription Management Direct Mail Order**

800.962.8192 (Placing refill orders and checking mail-order status)

**Delta Dental**

800.610.0201

□ **Important Web Site Addresses**

**[www.cchp.org](http://www.cchp.org)**

This web site offers information on plan benefits, how to apply for CHP+, and other information specific to CHP+ members and families.

**[www.chpplusprovider.com](http://www.chpplusprovider.com)**

This web site offers a Provider directory search for participating Primary Care Physicians and Specialists available in your area.

# Table of Contents

<b>1: MEMBER RIGHTS AND RESPONSIBILITIES.....</b>	<b>1</b>
<b>2: ABOUT YOUR HEALTH CARE COVERAGE .....</b>	<b>2</b>
Primary Care Physicians.....	2
Selecting PCP .....	3
Visiting a PCP .....	3
Changing PCPs.....	3
Referrals.....	3
<b>3: MANAGED CARE FEATURES .....</b>	<b>5</b>
Transition of Care.....	5
CHP+'s Process to Determine if Services are Covered.....	5
Medically Necessary Health Care Services.....	6
Appropriate Place and Pre-Authorization .....	6
Appropriate Length of Stay .....	7
Ongoing Care Needs.....	8
Case Management.....	8
<b>4: COST-SHARING REQUIREMENTS .....</b>	<b>10</b>
Co-Payment and Enrollment Fee.....	10
Out-of-Pocket Annual Maximum.....	11
<b>5: MEMBERSHIP .....</b>	<b>12</b>
Dependents and Newborn Enrollment.....	12
Enrollment Process.....	12
Termination .....	12
<b>6: MEMBER BENEFITS.....</b>	<b>14</b>
Preventative Care Services.....	15
Family Planning.....	16
Maternity and Newborn Care .....	18
Physician Office Services.....	19
Inpatient Facility Services.....	21
<b>Skilled Nursing</b> .....	23
Outpatient Facility Services.....	24
Emergency Care and Urgent Care.....	26
Ambulance and Transportation Services.....	28
<b>Outpatient Therapies</b> .....	29
Home Health Care/Home IV Therapy.....	30
Hospice Care.....	31
Human Organ and Tissue transplant Services .....	32
Medical Supplies and Equipment .....	36
Dental-Related Services.....	38
<b>Cleft Palate/Cleft Lip</b> .....	39
Food and Nutrition.....	41
Mental Health and Substance Abuse Care.....	42

---

Prescription Drugs .....	45
Audiology Services.....	49
Vision Services .....	49
<b>7: GENERAL EXCLUSIONS .....</b>	<b>50</b>
<b>8: ADMINISTRATIVE INFORMATION .....</b>	<b>58</b>
Enrollment Fees and Co-payments.....	58
How to File Claims.....	59
General Provisions.....	60
<b>9: COORDINATION OF BENEFITS AND SUBROGATION.....</b>	<b>63</b>
Workers Compensation .....	63
Automobile Insurance Provisions.....	63
Third Party Liability: Subrogation.....	64
<b>10: COMPLAINTS, APPEALS AND GRIEVANCES .....</b>	<b>66</b>
Complaints.....	66
Appeals.....	66
Grievances .....	68
Binding Arbitration .....	69
Legal action .....	69
<b>11: GLOSSARY .....</b>	<b>70</b>

## **1: Member Rights and Responsibilities**

### **As the parent or guardian of a member, you have the right to:**

- Receive information regarding terms and conditions of your child's health care benefits
- Be treated respectfully and with consideration
- Receive all the benefits to which your child is entitled under the benefits booklet
- Obtain complete information from a provider regarding your child's diagnosis, treatment and prognosis, in terms you can reasonably understand
- Receive quality health care through providers in a timely manner and in a medically appropriate setting
- Have a candid discussion, with providers, of appropriate or medically necessary treatment options for your child's condition, regardless of cost or benefit coverage
- Participate with your child's physician (s) in decision-making about health care treatment
- Refuse treatment for your child and be informed by a physician (s) of the medical consequences
- Receive wellness information to help your child maintain a healthy lifestyle
- Express concerns and complaints to HMO Colorado and CHP+ about the care and services provided by physicians and other providers, and to have HMO Colorado and CHP+ investigate and take appropriate action
- File a complaint or appeal a decision with HMO Colorado as outlined in COMPLAINTS, APPEALS AND GRIEVANCES section without fear of reprisal
- Expect that your child's personal health information will be maintained in a confidential manner
- Make recommendations regarding your child's rights and responsibilities policies
- Receive information about the managed care organization, its services, the practitioners and providers delivering care, and the rights and responsibilities of members.

### **As a parent or guardian of a member, you have the responsibility to:**

- Use providers who will provide or coordinate your child's total health care needs, and to maintain an ongoing patient-physician relationship
- Provide complete and honest information about your child's health care status and history
- Follow the treatment plan recommended by providers
- Understand how to access care in non-emergency and emergency situations, and to know your child's health care benefits as they relate to out-of-network coverage and co-payments
- Notify the provider or HMO Colorado about concerns you have regarding the services or medical care your child receives
- Be considerate of the rights of other members, providers, HMO Colorado and CHP+ staff.
- Read and understand your benefits booklet.
- Pay all member payment requirements in a timely manner
- Provide HMO Colorado and CHP+ with complete and accurate information about other health care coverage and/or benefits you may carry.
- Participate in understanding your child's health problems and developing mutually agreed upon treatment goals with the provider

## 2: About Your Health Care Coverage

CHP+ has coordinated and contracted with a network of physicians, hospitals, and support services (e.g., laboratory, x-ray, pharmacy, and physical therapy) to arrange for or provide comprehensive health care services to members based on a pre-determined annual enrollment fee and any applicable co-payments. Learning how CHP+ works can help ensure members make the best use of their health care benefits.

CHP+ strives to maintain reasonable health care costs by working with physicians, hospitals, other providers and members in unity. When family members and primary care physicians work together to obtain referrals to specialists and to obtain pre-authorizations for services, it can help ensure care that is medically necessary, performed in the appropriate setting, and is otherwise a covered service. A result of this collaboration is lower cost of health care.

### Identification Card

Your child's membership card shows that your child is a member of CHP+; a program administered as a partnership between state government and private business. This membership card provides you with the information needed when your child requires services. Always carry your child's membership card; any provider may ask to see it. Have your child's membership card ready when you call for an appointment and show it to the receptionist when you sign in for your child's appointment. If your child needs a prescription, show the card to the pharmacy where it is filled. If you have not received your card or need a replacement card, please contact CHP+ HMO Customer Service at 877.523.8171.

### Changing Your Information

If your child's membership information changes in any way, such as your address, call CHP+ Customer Service at 800.359.1991. If the change cannot be made over the phone, CHP+ will send you the forms needed to make the change.

### Primary Care Physicians

A key feature of CHP+ is that one doctor will be primarily responsible for delivering and coordinating all of a member's care. That physician is called a primary care physician (PCP). PCPs are pediatricians, family physicians, or general practitioners for children. As the member's first point of contact, the PCP provides a wide range of health care services, including initial diagnosis and treatment, health supervision, management of chronic conditions, preventive care, referrals to specialists, when appropriate, and ensuring continuity of patient care. If CHP+ does not have a contracted provider for a covered service, CHP+ will arrange for a referral with a provider with the necessary expertise.

Benefits are only provided for covered services, even if performed by the member's PCP or as a result of a PCP's referral, regardless of medical necessity. A referral service is any covered service that cannot be performed by the member's PCP and for which the PCP has given the member a referral to any other provider, usually a specialist. However, if the referral service requires pre-authorization before it can be performed, the approval of a referral alone does not guarantee or imply coverage for the services or procedures to be performed by the specialist.

**Selecting a PCP**

At the time of enrollment, a PCP selection is not required to receive covered services. However, to find a PCP for your child to visit in your area, you can call 1.877.523.8171 or search for a PCP on the Internet at [www.chpplusprovider.com](http://www.chpplusprovider.com). Some providers are listed as accepting existing patients only. However, CHP+ may not have notice of new limitations of this kind. Therefore, even if the listing for the selected PCP does not indicate patient limitations, the parent or guardian should call the PCP to confirm that the provider is still accepting new patients (unless the member is already an existing patient of the PCP).

**Visiting a PCP**

To visit a PCP, an appointment must be made with the PCP's office. To avoid possible delays when scheduling an office visit over the phone, please identify your child as a CHP+ HMO Colorado member. The PCP's office will instruct you on next steps in a non-emergency situation. The PCP's office should be notified at least 24 hours before a scheduled appointment if the appointment needs to be cancelled. You should check with the PCP's office to determine how far in advance a cancellation must be received. A fee may be charged by the PCP's office for a missed appointment. CHP+ will not pay for or reimburse for such a fee. You should notify the PCP's office if your child is going to be late for an appointment. The PCP may ask that the appointment be rescheduled.

Parents or guardians of members should call the PCP for instructions to receive medical care after the PCP's normal business hours, on weekends and holidays, or to receive non-emergency care within the service area for a condition that is not life threatening but that requires prompt medical attention. In case of emergency, the parent or guardian should call 911 or go directly to the nearest emergency room.

**Changing PCPs**

You may select a new PCP for your child at any time during your child's eligibility period without notifying CHP+.

To have medical records transferred from one physician to another, contact your child's former PCP. You are responsible for any charges related to transferring your child's medical records.

**Referrals**

A PCP provides members with basic health and medical services including routine and preventive care. Sometimes it is necessary for or desired by the member to visit a specialist or other provider. The member's PCP will recommend and coordinate any care provided by other health care providers. This is accomplished through a referral. A referral is the formal recommendation by a physician for a member to receive care from a specialist or a different physician or facility. The PCP will ensure that all appropriate referral information is communicated to the specialist. The member and PCP will be notified if the referral request has been denied.

A referral from the PCP must first be obtained when a family wants or needs the CHP+ member to visit a physician or health care provider other than the member's PCP. The PCP will call HMO Colorado at 800.832.7850 or 303.831.4115 for referrals.

A member **does not** need a referral from the PCP for:

- An emergent or urgent situation
- Care from an in-network OB/GYN physician or certified nurse midwife for obstetric or gynecologic care
- Care from an in-network optometrist or ophthalmologist for a routine eye exam.
- Mental health services – One Nation also known as, Anthem Behavioral must authorize all non-emergency services for mental health (whether biologically based or non-biologically based) or substance abuse before the member receives services. One Nation (Anthem Behavioral) can be reached at 800.424.4014.

For emergency services for mental health (whether biologically based or non- biologically based) or substance abuse, the member's family is responsible for ensuring that CHP+ has been notified of the emergency admission.

If a member visits any other provider, including a CHP+ in-network provider, without first obtaining a referral, his or her parent or guardian is responsible for all charges. Referrals can be made for a certain number of visits to specialists and a specific time period in which the member must receive the care. A second appointment with a specialist should not be scheduled if only one visit is authorized. The family is responsible for all charges related to visits in excess of those authorized. A standing referral for medically necessary treatment may be authorized for ongoing care. If a referral is not obtained for non-emergency care, CHP+ will not cover those services. Always review the services the PCP recommends for your child and make sure they are covered under CHP+ as explained in this benefits booklet. A PCP's referral does not always mean the service is covered.

### **Other Insurance**

CHP+ enrollment is contingent upon absence of other insurance coverage excluding Indigent Care and the Health Care Program for Children with Special Needs (HCP). If the subscriber is covered by any other valid coverage, including Medicaid and individual non-group coverage, she or he is not eligible for CHP+.

If the subscriber obtains other coverage, you must notify CHP+ at 800.359.1991. If the CHP+ member is found to have other insurance, coverage under this program is termed or in some cases retro-termed for the time period the other insurance was effective. The exceptions to double coverage are Medicare and Dental.

### **Newborn Enrollment**

This plan provides for initial newborn care. The member must enroll her newborn child for coverage by calling the CHP+ Customer Service Department at 800.359.1991 if the child is not eligible for Medicaid. After you have your baby, please contact CHP+ Customer Service at 800.359.1991 to notify CHP+ of the baby's name, date of birth and the social security number if available. Your newborn will be enrolled as of their date of birth.

### 3: Managed Care Features

Managed care is a system of health care delivery with the goal of giving members access to quality, cost-effective health care while optimizing utilization and cost of services by measuring provider and coverage performance.

CHP+ uses a variety of administrative processes and tools, such as pre-authorization for health care services, case management, concurrent hospital review and disease management to help determine the most appropriate use of the health care services available to members. This section of the benefits booklet explains how these managed care features are used and guides members through the necessary steps for obtaining care. For more information about how a member should proceed in case of an emergency, please see the MEMBER BENEFITS section.

#### **Transition of Care**

A new CHP+ member may be receiving ongoing care for a medical condition. Examples of ongoing care include prenatal/obstetrical care, home health care or hospice care. CHP+ strives to avoid disruption of a new member's care with its transition of care policy. To facilitate the transition of care, the member's family or the provider must review the reference sheet, complete a Transition of Care form and submit them to the HMO Colorado Medical Management and Utilization Department for review. After completing the forms, the member should schedule a visit with the new PCP. The member's family or the provider may request a reference sheet and Transition of Care form by calling HMO Colorado's Medical Management Department at 303.831.3238 or 800.797.7758. These completed forms should be faxed to HMO Colorado at 303.764.7030 or mailed to:

HMO Colorado  
Medical Management Department  
700 Broadway  
5<sup>th</sup> Floor  
Denver, Co 80273

#### **CHP+'s Process to Determine if Services are Covered**

To determine if a health service is a covered benefit, CHP+ considers whether the service is medically necessary and whether the service is experimental/investigational, cosmetic or otherwise excluded under this coverage. CHP+ uses numerous resources, including current peer-reviewed medical literature, CHP+'s adopted medical policies and practice guidelines, guidelines obtained from recognized national organizations and professional associations and consultations with physician specialists when determining if a particular service is covered. CHP+ will assist the member's family by determining what services are covered and what services are excluded from coverage. CHP+ does not promote or otherwise provide an incentive to its employees or provider reviewers for withholding a benefit approval for medically necessary services to which the member is entitled.

#### **Medically Necessary Health Care Services**

CHP+ determines if services, procedures, supplies or visits are medically necessary. Only medically necessary services (except as otherwise provided in this Benefits Booklet), procedures, supplies or

visits are covered services. CHP+ uses medical policy, medical practice guidelines, professional standards and outside medical peer review to determine medical necessity. CHP+'s medical policy reflects current standards of practice and evaluates medical equipment, treatment and interventions according to an evidence-based review of scientific literature. Medical technology is constantly changing, and CHP+ reserves the right to periodically review and update medical policies. The benefits, exclusions and limitations of a member's coverage take precedence over medical policy.

Most procedures, diagnostic tests, durable medical equipment, home health services, home IV services and medications require pre-authorization. It is the provider's responsibility to pre-authorize the test, equipment, service or procedure.

### **Experimental/Investigational and/or Cosmetic Procedures**

CHP+ will not pay for any services, procedures, surgeries or supplies that it considers experimental/investigational and/or cosmetic. CHP+ will not pay for complications arising from any services, procedures, surgeries or supplies that it considers experimental/investigational and/or cosmetic.

### **Appropriate Place and Pre-authorization**

Health care services may be provided in an inpatient or outpatient setting, depending on the severity of the medical condition and the services necessary to manage the condition in a given circumstance. CHP+ covers care received in both environments, provided the care received is appropriate to the setting and is medically necessary. Examples of inpatient settings include hospitals, skilled nursing facilities and hospice care. Examples of outpatient settings include physicians' offices and ambulatory surgery centers, home health and home hospice settings. Pre-authorization is a process CHP+ uses to determine if a requested service or supply is a covered benefit and that a member's care is provided in the most medically appropriate setting. The pre-authorization process may set limits on coverage available under this certificate. Pre-authorization is required before admission to a hospital or before receiving certain procedures or services. Some drugs also require pre-authorization. The physician who schedules an admission or orders the procedures or service is responsible for obtaining pre-authorization. To determine which services require pre-authorization and/or to be sure that pre-authorization has been obtained, the member may contact HMO Colorado.

### **Inpatient Admissions**

Admissions for all inpatient stays require pre-authorization and concurrent reviews. The member's health care provider must call the number for Provider Authorization on the member's health benefit ID card to request pre-authorization. HMO Colorado will review the request for pre-authorization. If the inpatient stay is approved, all benefits available under the member's coverage are provided. HMO Colorado initially authorizes a specified number of days for the inpatient stay and reevaluates such authorization if the health care provider requests additional days. This process facilitates timely discharge or transfer of the member to the appropriate level of care.

If HMO Colorado does not grant pre-authorization, the member's family will be held financially responsible for all charges related to that inpatient stay. The member's family may appeal the HMO Colorado pre-authorization decision by following the procedure outlined in the COMPLAINTS, APPEALS AND GRIEVANCES section.

**Scheduled Inpatient Admissions**

The health care provider must receive pre-authorization from HMO Colorado for all scheduled inpatient admissions, as well as concurrent reviews for continued stays that exceed the number of days CHP+ has authorized. Pre-authorization must be requested from HMO Colorado at least seven days before the member's admission. HMO Colorado will send written confirmation of their decision to the member and the health care provider within two business days of receipt of all necessary information.

**Emergency (Unscheduled) Admissions**

HMO Colorado requires notification of an emergency admission within one business day after the admission. The member's family is responsible for ensuring that HMO Colorado has been notified of the emergency admission, unless unable to do so. Examples of emergency admissions include admissions involving accidents or the onset of labor in pregnancy. Failure to notify HMO Colorado may result in a reduction or denial of coverage. Inpatient admissions include admissions to acute care facilities (hospitals), rehabilitation facilities, long-term acute care facilities, sub-acute facilities, skilled nursing facilities and inpatient hospice facilities.

**Outpatient Procedures**

Most procedures performed on an outpatient basis must be pre-authorized. The member's health care provider must contact HMO Colorado's Preauthorization Department at 800.832.7850 or 303.831.4115 for pre-authorization. These services may be performed in a hospital on an outpatient basis or in a freestanding facility, such as an ambulatory surgery center. Upon receipt of a pre-authorization request, CHP+ may require additional information to determine the medical necessity of the procedure. Written confirmation of the HMO Colorado decision will be sent to the member's family and the health care provider within two business days of their receipt of all necessary information. The pre-authorization will be valid only for a specific place and period of time. The member must obtain the requested service within the time allotted in the pre-authorization and at the place authorized. If the pre-authorization period expires, or if additional services are requested, the provider must contact HMO Colorado to request another authorization.

A pre-authorization that a requested service meets medical necessity criteria does not guarantee that payment will be allowed. Fraud or abuse may cause a denial of payment. When HMO Colorado receives the member's claim(s), HMO Colorado will review them against the terms of this Benefits Booklet.

**Appropriate Length of Stay**

HMO Colorado, in conjunction with the member's providers, uses medical policies and medical care guidelines, such as inpatient and surgical care optimal recovery guidelines to determine the appropriate length of an inpatient hospital stay for which benefits will be paid for the member. By using these guidelines and encouraging member education, the member is more likely to receive the appropriate level of care and achieve favorable outcomes.

**Concurrent Review**

While a member is in the hospital, HMO Colorado will review the member's medical care to determine if the member is receiving appropriate and medically necessary hospital services. If the member has an unscheduled admission to the hospital for any reason, including a medical

emergency, maternity care, alcoholism or substance detoxification, HMO Colorado requires notification within one business day of the admission to assist with management of the hospital benefits and planning for covered medical services during hospitalization and after discharge. At some point during hospitalization, HMO Colorado may determine that further hospitalization is not medically necessary. HMO Colorado will advise the attending physician and the hospital of this determination. The hospital will give the member's family timely notice of such a determination. If the family elects for the member to remain in the hospital after notification that continued hospitalization is not medically necessary, HMO Colorado will not pay for services after the recommended date of discharge. HMO Colorado will also send written notification of the decision to the member's family, the attending physician and the hospital. The member's family will be responsible for all charges incurred after the recommended day of discharge. If a member's family or provider disagrees with a concurrent hospital review decision, the member's family may appeal by following the procedure outlined in the COMPLAINTS, APPEALS AND GRIEVANCES section.

**Retrospective Claim Review**

Retrospective claim review consists of reviewing services after the services have been provided to determine if the services were provided as pre-authorized, to evaluate claim charges, and to review appropriateness of services billed based on available benefits, medical policy and medical necessity. HMO Colorado may request and review medical records to assist in payment decisions. If HMO Colorado determines that benefits are not available, HMO Colorado will not pay those claims.

**Ongoing Care Needs**

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

**Utilization Management**

Utilization management is used to determine if a service is medically necessary, delivered in the right setting and for the appropriate length of time. Care is compared to nationally recognized guidelines. This review may be used to determine payment for covered services. However, the decision to obtain the service is made solely by the member's family and the provider, regardless of the decision by HMO Colorado about reimbursement.

**Case Management**

Case management is used when illnesses or injuries are so complex that individualized coordination of care is helpful. Examples include the medical management of a transplant candidate or of a patient with a spinal cord injury. In such cases, a case manager may work with the member's family to help coordinate and facilitate the administration of medical care. A case manager may also help organize a safe transition from hospital to home care. The case management program is designed to identify patients as early as possible in their course of medical treatment who may benefit from case management and to see that issues pertinent to the case are assessed and addressed, documented, and resolved in a consistent and timely manner.

Depending on the level of case management the member may need, a case manager may be assigned to the member. HMO Colorado employs nurses and other medical staff with special training in the coordination of care in complex cases. The member's family may or may not have

direct contact with an HMO Colorado case manager. This depends on the availability of a liaison at the facility where the member is admitted. If a case manager is assigned, the case manager's telephone number is provided to the member's family so they may contact the case manager with any questions. An assigned case manager works with the providers and the member's family to create a plan of care, implement that plan, monitor the use and effectiveness of services, and determine if the member is receiving services in a timely manner and in the most appropriate setting. HMO Colorado has full discretion as to which members it offers case management. HMO Colorado may not offer case management to all members with similar conditions. The HMO Colorado case management program is tailored to the individual. In certain extraordinary circumstances involving intensive case management, CHP+ may, at its sole discretion, provide benefits for care that are not listed as a covered services. CHP+ may also extend covered services beyond the contractual benefit limits of this coverage. CHP+ will make these decisions on a case-by-case basis. A decision in one case to provide extended benefits or approve care not listed as a covered service does not obligate CHP+ to provide the same benefits again to that member or to any other member. CHP+ reserves the right, at any time, to alter or cease providing extended benefits or approving care not listed as a covered service. In such cases, CHP+ will notify the member's family in writing.

**Participation in Ongoing Needs Programs**

There are several ways for eligible members to become involved in HMO Colorado's case management program. HMO Colorado can identify members that may benefit from the programs, or physicians may refer their CHP+ patients to us. A member's family may also contact HMO Colorado directly by calling the HMO Colorado Dedicated Services Department at 877-523-8171.

## 4: Cost Sharing Requirements

Cost sharing refers to how CHP+ and its members share the cost of health care services. It defines what CHP+ is responsible for paying and what the member's family is responsible for paying. Members satisfy the cost-sharing requirements through the payment of co-payments (as described below).

CHP+ works with physicians, hospitals, pharmacies and other health care providers to control health care costs. As part of this effort, most providers who contract with CHP+ agree to control costs by giving discounts to CHP+. The discounts range from paying a fixed amount per day for a hospital admission to paying a provider a fixed amount per month for each member whose family selected that provider as his or her PCP. Members benefit from provider discounts by allowing CHP+ to offer more extensive benefit plans with lower co-payments and make it possible for CHP+ to offer a lower-cost benefit plan to members.

The contracts between CHP+ and its providers include a "hold harmless clause" which provides that a member cannot be liable to the provider for moneys owed by CHP+ for health care services provided under this benefits booklet.

Services from non-participating providers are covered only under limited circumstances; non-emergency services from non-participating providers are **not covered** unless specifically authorized by the plan. Co-payments for authorized covered services received from a non-participating provider are the same as for covered services received from a CHP+ participating provider.

A member's family is always liable for a provider's full-billed charge for any non-covered service and for services that are received without a PCP's referral and/or the authorization by HMO Colorado. Benefits provided under this benefits booklet do not regulate the amounts charged by providers of medical care.

### **Co-payment and Enrollment Fees**

Co-payments are the member's cost-sharing requirements of this coverage. A co-payment is a predetermined, fixed-dollar amount a member must pay to receive a specific service. Co-payments are paid directly to the provider at the time that your child sees a doctor or when you get prescription drugs.

CHP+ co-payments range from \$0 to \$5 per visit for non-emergent or urgent care. Please see your membership card for the amount of your co-payment for emergency care. You are responsible for paying the co-payment to your child's health provider or pharmacy at the time of service. There are no co-payments for well-child care, health maintenance visits, or immunizations received from your child's PCP or from a local nursing service. In addition, there are no co-payments for family planning services.

Some families may pay an annual fee of \$25 to enroll one child and \$35 to enroll two or more children. This enrollment fee is based on family size and income. Most families will not have to pay an annual enrollment fee or make co-payments.

**Out-of-Pocket Annual Maximum**

The out-of-pocket annual maximum is designed to protect members' families from catastrophic health care expenses. Your family should not spend more than five percent (5%) of your adjusted gross income per year for the sum of all of your family's co-payments. It is your responsibility to keep track of all the money you spend for your child's covered health care services delivered through CHP+.

In order to meet the out-of-pocket annual maximum, you must save your co-payment receipts every time you obtain covered medical care and covered pharmaceuticals. When you have reached your "out-of-pocket limit," you must contact CHP+ Customer Service at 800.359.1991 and provide adequate evidence (receipts) that the co-payments paid for your child's health services during any member's benefit period equal or exceed the amount provided to the member by CHP+. Once the out-of-pocket annual maximum has been reached, no additional cost sharing (co-payments) shall be required from the member for the remainder of the member's benefit period.

## 5: Membership

### Newborn Enrollment

If the member's newborn child is not eligible for Medicaid, the Customer Service Department at CHP+ must be contacted at 800.359.1991 to continue coverage for the newborn. Most babies born to teen mothers are eligible for Medicaid. The new mother or her family should tell hospital personnel at the time of the delivery that the newborn might be eligible for Medicaid.

### Enrollment Process

For an eligible child to obtain coverage the family must follow the CHP+ enrollment process, which details who is eligible and what forms are required for enrollment. Coverage under this certificate begins as of the effective date stated on the member's health benefit ID card. No services received before the effective date is covered. Notification to CHP+ Customer Service does not guarantee member enrollment.

### Termination/Active Policy Termination

Member coverage ends on the first occurrence of one of the following events:

- When the member attains his or her 19<sup>th</sup> birthday.
- Upon the member's death.
- When the parent or guardian has committed fraud or intentional misrepresentation of material fact.
- When the member establishes permanent residence outside of Colorado.
- When CHP+ receives a written notification to cancel coverage for any member, coverage will end at the end of the month following the written notification period.
- In accordance with Refusal to Follow Recommended Treatment under the heading GENERAL PROVISIONS in the ADMINISTRATIVE INFORMATION section, when the member is unable to establish a positive patient-physician relationship with a PCP.
- When the member acts in a disruptive manner that prevents the orderly business operation of any CHP+ participating provider or is dishonestly attempting to gain a financial or material advantage.
- When the member obtains other insurance or is found to have other insurance, the member is no longer eligible for CHP+ for the time period the other insurance was effective.

### Certificate of Creditable Coverage

When a member's coverage with CHP+ terminates, CHP+ will send the subscriber a Certificate of Creditable Coverage, which will identify the length of the member's creditable coverage with CHP+. The member may need this letter as proof of prior coverage when the member enrolls with other health care benefits coverage.

### What CHP+ Will Pay for After Termination

Except as provided below, CHP+ will not pay for any services provided after the member's coverage ends, even if CHP+ pre-authorized the service, unless the provider verified the member's eligibility within two business days before each service was received. Benefits cease on the date the member's coverage ends as described above. A member's family may be responsible for benefit payments made by CHP+ on behalf of the member for services provided after the member's coverage has terminated. When a member's coverage is terminated for any reason other than for

fraud or abuse, CHP+ shall provide for the member's continued care, if the member is being treated at an inpatient facility, until the member is discharged or transferred to another level of care, subject to the terms of this benefits booklet. The discharge date is considered the first date on which the member is discharged from the facility or transferred to another level of care. When coverage has been terminated and a member receives additional facility care after the discharge date, CHP+ will not cover additional services received.

## 6: Member Benefits

This section describes covered services and supplies. Covered services and supplies are only benefits if they are medically necessary or preventive, not otherwise excluded under this benefits booklet as determined by CHP+, and obtained in the manner required by this benefits booklet. The member must obtain care by or through the member's PCP. Additionally, all services must be standard medical practice where they are received for the illness, injury or condition being treated, and must be legal in the United States. The fact that a provider may prescribe, order, recommend or approve a service, treatment or supply does not make it medically necessary or a covered service and does not guarantee payment from CHP+.

A PCP provides basic health services and other medical services to members. Sometimes the PCP determines that it is necessary, or a member's family requests, to see a specialist or other provider. The member's PCP must recommend and coordinate any care provided by other health care providers. This is accomplished through a referral. A referral is the formal recommendation, made by the PCP or other physician, that the member receives care from a specialist or a different provider. The PCP will submit a referral to HMO Colorado. Services received without a referral are not covered and a member's family may be liable for all costs incurred when a referral is not obtained. For referral guidelines, please see the REFERRALS heading in the ABOUT YOUR HEALTH CARE COVERAGE section.

HMO Colorado bases its decisions about referrals, pre-authorization, medical necessity, experimental/investigational and new technology on medical policy developed by HMO Colorado. HMO Colorado will also consider published peer-reviewed medical literature, opinions of experts, and the recommendations of nationally recognized public and private organizations that review the medical effectiveness of health care services and technology. A referral is not complete until HMO Colorado has approved the referral. The member and requesting provider will receive notification of approval of a referral. The member may also contact the PCP or customer service to receive verification that a referral has been approved.

All covered services are subject to the exclusions listed in this section in addition to the exclusions set forth elsewhere in this benefits booklet including those in the GENERAL EXCLUSIONS section. All covered services are subject to other conditions and limitations of this benefits booklet.

**Preventive Care Services**

This section describes covered services and exclusions for preventive care.

**Well baby or health maintenance visits**

Your child should receive medically necessary preventive care services so his or her PCP can look for early signs of illness or medical abnormalities. You should also use your child's preventive care visits to make sure she or he receives all necessary immunizations.

Your child's primary care provider (PCP) is the most important person involved in your child's health care. Your child's PCP will provide much of your child's care, including routine examinations, immunizations, health education and counseling. The PCP will provide continuing care for your child to help prevent illness and treat your child if he or she gets sick. Your child's PCP is also responsible for referring your child to a specialist when necessary and for authorizing care ordered by the specialist. You must receive a referral in order to receive benefits for non-emergency care provided by anyone other than your child's PCP. Limited exceptions are made for specified early examination and testing services listed below. You and your child's PCP must work together to keep your child healthy.

**Physical Exams and Early Detection Services**

Preventive care services (except reproductive health services) are covered only if your child's PCP delivers the service. Your child's PCP can do a well-child exam or give your child an immunization even if your child is at the doctor's office for a different reason. All infants, children, and adolescents should be seen by their PCP for regular immunizations and check-ups. The member's PCP determines frequency guidelines for well-child visits. CHP+ encourages parents and providers to follow the well-child visit schedule recommended by the American Academy of Pediatrics.

Infancy	Early Childhood	Middle Childhood	Adolescence
Prenatal	1 Year	5 Years	11 Years
Newborn	15 Months	6 Years	12 Years
First Week	18 Months	8 Years	13 Years
1 Month	2 Years	10 Years	14 Years
2 Months	3 Years		15 Years
4 Months	4 Years		16 Years
6 Months			17 Years
9 Months			18 Years

Additional services provided by your child's PCP are also covered and include:

- Annual gynecological examination - breast and pelvic examinations, and annual Pap tests (see Family Planning) Your child may receive such services from his or her PCP or go directly to an OB/GYN provider who participates in the CHP+ network without a referral. To visit an OB/GYN or reproductive health provider outside of the CHP+ network, an authorization must be requested prior to services rendered. If authorization is not received, benefits will be denied.
- Pediatric and adult immunizations
- Age-appropriate vision and hearing screening exams

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

- Immunizations required for international travel
- Services related to routine physical or screening exams and immunizations given primarily for insurance, licensing, employment, weight reduction programs, or for any non-preventive purpose.
- Services provided by an OB/GYN physician for primary care (for example, cold or flu symptoms, or abdominal pain) without a PCP referral
- Any services not medically necessary

### **Health Education**

Health education provided by your child's PCP is covered. This may include information on achieving and maintaining physical and mental health and preventing illness and injury. If your child has been diagnosed as diabetic, he or she may receive coverage for diabetic education classes attended within the first six months after diagnosis. Your child's doctor may ask a series of age-appropriate questions during your child's health maintenance visit. This will help the PCP decide on topics to talk about during your child's health education discussion. These questions will follow the recommendations made by the American Academy of Pediatrics.

### **Immunizations**

Pediatric and adolescent immunizations are covered as recommended by the American Academy of Pediatrics.

### **Family Planning**

Once a young person has selected a reproductive health provider, whether the provider is his or her PCP or an OB/GYN provider, he or she needs to see that provider for all of his or her reproductive health services. If your child uses the same provider, he or she will have a better chance of receiving good care.

Covered reproductive health services include:

- Injection of Depo-Provera for birth control purposes
- Fitting of a diaphragm or cervical cap
- Surgical implantation and removal of a NORPLANT device
- Fitting, inserting, or removing IUDs
- The purchase of IUDs, diaphragms, NORPLANT devices, and cervical caps provided by a physician in his or her office (if such devices are not provided by a physician, see PRESCRIPTION DRUGS,
- Tests to diagnose a possible genetic illness
- STD/HIV testing and treatment

**Note:** Birth control pills are also covered; see PRESCRIPTION DRUGS, page

The following services **are not covered**:

- Surgical sterilization (for example, tubal ligation or vasectomy) and related services
- Reversals of sterilization procedures
- Over-the-counter contraceptive products such as condoms and spermicide

- Preconception, paternity, or court-ordered genetic counseling and testing (for example, tests or discussion of family history or test results to determine the sex or physical characteristics of an unborn child)
- Elective termination of pregnancy, unless the elective termination is to save the life of the mother or if the pregnancy is the result of an act of rape or incest

**Maternity and Newborn Care**

This section describes covered services and exclusions for maternity and newborn care. Benefits are provided for maternity and newborn childcare, including diagnosis, care during pregnancy and delivery services. The member may self-refer to a prenatal medical provider from the list of CHP+ participating OB/GYN providers. The member must see the same prenatal medical care provider through the entire length of her pregnancy and for delivery.

**Benefits are provided for the following:**

- Inpatient, outpatient and physician office services (including prenatal care, such as prenatal vitamins) for vaginal delivery, cesarean section and complications of pregnancy.
- Anesthesia services.
- Routine nursery care for a covered newborn including physician services.
- For newborns, all medically necessary care and treatment of injury and sickness including medically diagnosed congenital defects and birth abnormalities.
- Tests to diagnose possible genetic illness.
- Circumcision of a covered newborn male.
- Laboratory services related to prenatal care, postnatal care or termination of a pregnancy
- Spontaneous termination of pregnancy prior to full term.
- Elective termination of pregnancy, only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.
- One routine ultrasound per pregnancy, additional ultrasounds are based on medical necessity and require pre-authorization.

This plan provides for initial newborn care. The member must enroll her newborn child for coverage by calling the CHP+ Customer Service Department at 800.359.1991 if the child is not eligible for Medicaid. Most babies born to teen mothers are eligible for Medicaid. Hospital personnel should be told at the time of delivery that the newborn may be eligible for Medicaid.

CHP+ will not limit coverage for a hospital stay in connection with childbirth for the mother and newborn child to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. If the delivery occurs between 8:00 p.m. and 8:00 a.m., coverage will continue until 8:00 a.m. on the morning following the 48-hour or 96-hour coverage period. The mother's attending physician, after consulting with the mother, may discharge the mother and newborn child earlier if appropriate.

**Maternity and Newborn Care Exclusions**

The following services, supplies and care are not covered:

- Maternity care and/or deliveries outside the service area within five weeks of the anticipated delivery date, except in an emergency
- Services including, but not limited to, preconception counseling, paternity testing, and genetic counseling and testing, or testing for inherited disorders, screening for disorders, and discussion of family history or test results to determine the sex or physical characteristics of an unborn child
- Storage costs for umbilical blood

**Home Deliveries**

CHP+ covers services performed by a certified mid-wife or a direct-entry midwife. The following services are covered benefits:

- Advising, attending, or assisting of a woman during pregnancy, labor and natural childbirth at home, and during the postpartum period in accordance with C.R.S. 12-37-101 et. al. seq. that includes one(1) metabolic screening, one (1) postpartum visit, and (1) prescreening visit, and (1) the actual delivery and labor.

**Physician Office Services**

This section describes covered services and exclusions for physician office-based services. For the member to receive these benefits, the member must receive the medical care and services in a physician's office by a physician or other professional provider. If the office visit is with a physician other than the PCP, a referral must have been approved prior to the visit unless the member is receiving medical care and/or services from a (1) in-network OB/GYN physician or certified nurse midwife for obstetrical or gynecologic or (2) a in-network ophthalmologist or optometrist for routine eye care.

For preventive care, see the PREVENTIVE CARE SERVICES heading in this section.

For family planning services, including maternity care, see the FAMILY PLANNING heading in this section.

For the treatment of alcoholism, substance abuse, or mental illness, see CHEMICAL DEPENDENCY TREATMENTS or MENTAL ILLNESS TREATMENTS headings in this section for those services covered by CHP+.

For information about receiving after-hours office services, call the PCP's office and request Instructions, see the EMERGENCY CARE AND URGENT CARE heading in this section.

For visits related to home health or hospice care, see HOME HEALTH CARE or HOSPICE CARE in this section.

For coverage of inpatient physician visits, see HOSPITAL/OTHER FACILITY SERVICES. For services related to a dental accident, oral surgery, or TMJ disorders, see DENTAL-RELATED SERVICES, SURGICAL SERVICES: ORAL SURGERY or TMJ SERVICES, in this section.

Benefits are provided for medical care, consultations and second opinions to examine, diagnose and treat an illness or injury when received in a physician's or other professional provider's office. A physician may also provide medication management for medical conditions or mental health disorders. Consultations and second opinions may be provided by another physician at the request of the physician or the member with an appropriate referral from the member's PCP. In certain cases, HMO Colorado may request a second opinion.

Benefits are provided for office-based surgery and surgical services, which includes anesthesia and supplies. Such surgical fees include local anesthesia and normal post-operative care. Office-based surgical services are subject to pre-authorization guidelines. See the MANAGED CARE FEATURES heading in the ABOUT YOUR HEALTH CARE COVERAGE section for information about pre-authorization guidelines.

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

- X-ray and other radiology services

- Laboratory and pathology services
- Ultrasound services for non-pregnancy related conditions. For pregnancy-related ultrasounds, see the MATERNITY AND NEWBORN CARE heading in this section for information
- Allergy tests - coverage is available for the following allergy care services:
  - Direct skin (percutaneous and intradermal) and patch allergy tests and RAST (radioallergosorbent testing).
  - Allergy medications administered by injection in a provider's office.
  - Charges for allergy serum.
- Audiometric (hearing) and vision tests required for the diagnosis and/or treatment of an accidental injury or an illness

### **Physician Office Services Exclusions**

The following services, supplies and care are not covered:

- Expenses for obtaining medical reports or transfer of files
- Treatment for hair loss, even if caused by a medical condition, except for alopecia areata
- Routine foot care, such as care for corns, toenails or calluses (except for members with diabetes)
- Telephone or Internet consultations
- Treatment for sexual dysfunction
- Infertility Services
- Genetic counseling
- Separate reimbursement for anesthesia and post-operative care when services are provided by the same physician in the physician's office
- Peripheral Bone Density Scans

### **Inpatient Facility Services**

This section describes covered services and exclusions for acute inpatient care such as hospital care and ancillary and professional services. Acute inpatient services may be obtained from an acute care hospital, long-term acute care hospital, rehabilitation hospital or other covered inpatient facility. All acute inpatient hospital admissions must be at an in-network facility. CHP+ will not provide coverage or reimbursement for acute inpatient care at an out-of-network facility unless services are for emergency care. All inpatient services are subject to pre-authorization by CHP+ or unscheduled admission notification guidelines. See the MANAGED CARE FEATURES heading in the ABOUT YOUR HEALTH CARE COVERAGE section for information about pre-authorization guidelines. See the MENTAL HEALTH AND SUBSTANCE ABUSE CARE heading in this section for services, including acute medical detoxification, covered by CHP+. For accident or emergency medical care, see the EMERGENCY CARE AND URGENT CARE heading in this section. For dental services, see the DENTAL RELATED SERVICES heading in this section.

### **Facility services**

Broad spectrums of health care services are provided in the inpatient hospital environment. Such covered services include, but are not limited to the following examples:

- Charges for a semi-private room (with two or more beds), board and general nursing services benefits are provided for the treatment of medical conditions and rehabilitation care, which is part of an acute care hospital stay
- Use of an operating room, recovery room and related equipment

- Medical and surgical dressings, supplies, surgical trays, casts and splints when supplied by the facility as part of an inpatient admission
- Prescribed drugs and medicines administered as part of an inpatient admission
- A room in a special care unit approved by HMO Colorado. The unit must have facilities, equipment and supportive services for the intensive care of critically ill patients
- Inpatient rehabilitation for non-acute hospital admissions for medically necessary care to restore and/or improve lost functions following an injury or illness. These inpatient rehabilitation benefits are limited to 30 days per the member's calendar year. These services must be received within six months from the date on which the illness or injury occurred.

### **Ancillary Services**

Numerous medical professionals and paraprofessionals work together in the inpatient hospital environment to provide comprehensive care to patients. Such covered ancillary services include, but are not limited to, the following examples:

- Diagnostic services such as laboratory and X-ray tests (e.g., CT scan, MRI).
- Chemotherapy and radiation therapy.
- Dialysis treatment.
- Respiratory therapy.
- Physical occupational and/or speech therapy.
- Charges for processing, transportation, handling and administration of blood.

### **Professional Services**

Professional services are those services provided by a physician for surgical and medical care during the inpatient admission. Such covered professional services include, but are not limited to, the following examples:

- Physician services for the medical condition(s) while the member is admitted at the inpatient facility
- Surgical services, which include normal post-operative care
- Anesthesia, anesthesia supplies and services for a covered surgery
- Intensive medical care for constant attendance and treatment when the member's condition requires it for a prolonged period of time
- Surgical assistants or assistant surgeons as determined by HMO Colorado's medical policy. HMO Colorado does not pay for a surgical assistant for all surgical procedures. The list of procedures for which HMO Colorado allows a surgical assistant or assistant surgeon, is available to the member's provider
- Surgical services for the treatment of morbid obesity, which are subject to meeting the criteria included in HMO Colorado's medical policy. The hospital performing the morbid obesity surgery must be designated and approved by HMO Colorado's to perform specific covered services provided under this benefit
- Reconstruction of a breast on which a mastectomy has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. Benefits are provided for physical complications for all stages of mastectomy, including lymphoedemas. If a member chooses not to have surgical reconstruction after a mastectomy, CHP+ will provide coverage for an external prosthesis.
- Consultations (including second opinions).
- Medical care by two or more physicians at the same time because of multiple illnesses.

- Medical care for an eligible newborn (also see MATERNITY AND NEWBORN CARE in this section).

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

- Consultations or visits related to any non-covered service.
- Inpatient physician services received on a day for which facility charges were denied.
- Telephone consultations.

### **Long-Term Acute Care Facility**

Long-term acute care facilities are institutions that provide an array of long-term critical care services to members with serious illnesses or injuries. Long-term acute care is provided for members with complex medical needs, including members with high-risk pulmonary disease with ventilator or tracheostomy needs, members who are medically unstable, members needing extensive wound care or who have post-operative surgery wounds and members with closed head or brain injuries. Long-term acute care facilities do not provide care for low-intensity member needs. HMO Colorado requires authorization for admission and for continued stay. See the MANAGED CARE FEATURES heading in the ABOUT YOUR HEALTH CARE COVERAGE section for information about pre-authorization guidelines.

### **Skilled Nursing Facility**

Skilled nursing facilities typically provide skilled nursing care, therapies, and protective supervision for patients who have uncontrolled, unstable, or chronic conditions. Skilled nursing care is provided under medical supervision to carry out non-surgical treatment of chronic conditions or care during convalescent stages of acute diseases or injuries. Skilled nursing facility coverage does not include care for members with significant medical needs.

When skilled nursing care is pre-authorized by HMO Colorado, benefits are available for up to 30 days per the member's eligibility in a given calendar year or until maximum medical improvement is achieved and no further significant measurable improvement can be anticipated as determined by HMO Colorado and their utilization process. 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. Authorization for admission and for continued stay is required by HMO Colorado. See the MANAGED CARE FEATURES heading in the ABOUT YOUR HEALTH CARE COVERAGE section for information on pre-authorization guidelines.

### **Inpatient Services Exclusions**

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

- Private room expenses, unless your child's medical condition requires isolation to protect him or her from exposure to dangerous bacteria and diseases (conditions that require isolation include, but are not limited to, severe burns and conditions that require isolation according to public health laws).
- Admissions related to non-covered services or procedures (see DENTAL-RELATED SERVICES in this section for exception).
- Room and board and related services in a nursing home.
- Custodial care facility admissions or admissions to similar institutions

- Charges related to the non-compliance of care if the member leaves a hospital or other facility against the medical advice of the physician
- Facility room and board charges for the day of discharge
- Surgical benefits for subsequent procedures to correct further injury or illness resulting from a member's noncompliance with prescribed medical treatment. An example of a non-covered subsequent procedure is the removal of infected tissue directly caused by a member not taking prescribed medication following a tonsillectomy
- Procedures solely cosmetic in nature
- Custodial and/or maintenance care
- Any services or care for the treatment of sexual dysfunction
- Sex change operations, preparation for a sex change operation or complications arising from a sex change operation
- Personal comfort and convenience items, such as televisions, telephones, guest meals, articles for personal hygiene and other similar services and supplies
- Surgical services for refractive keratoplasty, including radial keratotomy or lasik, or any procedure to correct visual refractive defect
- Additional procedures not routinely performed during the course of the main surgery
- Inpatient substance abuse treatment

### **Outpatient Facility Services**

This section describes covered services and exclusions for outpatient facility care services. Outpatient facility services may be obtained at a facility such as an acute hospital outpatient department, ambulatory surgery center, radiology center, dialysis center and outpatient hospital clinics.

All outpatient facility services must be at an in-network facility. CHP+ will not provide coverage or reimbursement for outpatient facility services at an out-of-network facility unless services are for an emergency. Some outpatient facility services are subject to pre-authorization guidelines. See the MANAGED CARE FEATURES heading in the ABOUT YOUR HEALTH CARE COVERAGE section for information about pre-authorization guidelines.

See the MENTAL HEALTH AND SUBSTANCE ABUSE CARE heading in this section for services covered by CHP+. For emergency care, see the EMERGENCY CARE AND URGENT CARE heading in this section.

For dental services covered by CHP+, see the DENTAL RELATED SERVICES heading in this section.

### **Facility Services**

A broad spectrum of health care services is provided in an outpatient facility environment. Such covered services include, but are not limited to, the following:

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

**Ancillary Services**

Numerous medical professionals and paraprofessionals work together to provide comprehensive care to members in an outpatient facility. Such covered ancillary services include, but are not limited to, the following:

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

Note: Therapeutic dialysis services are covered only when your child is not eligible for Medicare or the child is covered by Medicare but does not have a Medicare supplemental insurance policy (see COORDINATION OF BENEFITS AND SUBROGATION), and when services are performed by a participating dialysis provider. Your child may receive dialysis services in your home if the services are authorized by HMO Colorado before your child receives the care.

Covered dialysis services include:

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

**Professional Services**

Professional services are those provided by a physician for surgical and medical care during the outpatient visit. Such covered professional services include, but are not limited to, the following examples:

- Physician services for the medical condition(s) while the member is in the outpatient facility.
- Surgical services. The surgical fee includes normal post-operative care.
- Anesthesia, anesthesia supplies and services for a covered surgery.
- Surgical assistants or assistant surgeons as determined by HMO Colorado's medical policy HMO Colorado does not pay for a surgical assistant for all surgical procedures. The list of procedures for which HMO Colorado allows a surgical assistant or assistant surgeon is available to the member's provider.
- Consultation by another physician when requested by the member's physician. Staff consultations required by facility rules are not covered.

**Outpatient Services Exclusions**

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

- Surgical benefits will not be provided for subsequent procedures to correct further injury or illness resulting from the member's noncompliance with prescribed medical treatment. An example of a non-covered subsequent procedure is the removal of infected tissue directly caused by a member not taking prescribed medication following a tonsillectomy.
- Procedures solely cosmetic in nature.
- Any services or care for the treatment of sexual dysfunction.

- Sex change operations, preparation for a sex change operation or complications arising from a sex change operation.
- Personal comfort and convenience items such as televisions, telephones, guest meals, articles for personal hygiene and other similar services and supplies.
- Surgical services for refractive keratoplasty, including radial keratotomy or lasik, or any procedure to correct visual refractive defect.
- Additional procedures routinely performed during the course of the main surgery.
- Peripheral bone density scans.

### **Emergency Care and Urgent Care**

This section describes covered services and exclusions for emergency and urgent care. Emergency care is the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

Urgent care means situations that are not life threatening but require prompt medical attention to prevent serious deterioration in a member's health.

CHP+ covers emergency services necessary to screen and stabilize a member without pre-authorization, if a prudent layperson having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life- or limb-threatening emergency existed. Follow-up care, including but not limited to, removal of stitches and dressing changes, received in an emergency department or urgent care center is not considered emergency care. The member must receive follow up care from their PCP. By choosing an urgent care center, when appropriate, instead of an emergency room, the member's out-of-pocket expenses may be reduced.

### **Emergency Care**

Medically necessary emergency care includes emergency accident care and emergency medical care received at a hospital or other facility. Benefits are provided regardless of whether the care is received from a network provider or non-network provider. No prior authorization is necessary. A member should call 911 in the case of a life-or limb-threatening emergency.

If, because of the severity of your child's medical problem, you are unable to reach a participating hospital, go to the nearest medical facility. Unless your child's condition makes it impossible to do so, you should notify your child's PCP within 48 hours of receiving care. Do not use an emergency center for non-emergency services. It is not covered.

Whenever a member is admitted to a facility directly from a hospital emergency room, the emergency room co-payment will be waived. When a member is admitted to a facility following emergency care, the member must contact HMO Colorado within **one** business day of admission, for authorization for continued care after the emergency admission. When HMO Colorado is contacted for authorization for an inpatient stay, the provider and member are notified of the number of days approved for the inpatient stay, e.g., the number of days considered medically necessary as determined by HMO Colorado's medical policy and guidelines. If your child is treated at a nonparticipating hospital, send itemized bill from the hospital to:

CHP+/HMO Colorado Claims  
P.O. Box 5747  
Denver, CO. 80217-5747

If the nonparticipating hospital accepts assignment then the hospital is reimbursed directly. You will be responsible for the co-payment only. CHP+ requires proof of payment (for example, a receipt) to reimburse you directly.

Once the member is stabilized, ongoing care and treatment is not emergency care. Continuation of care from an out-of-network provider beyond what is needed to evaluate and/or stabilize the member's condition will be denied unless HMO Colorado authorizes continued inpatient care by the out-of-network provider. A case manager may facilitate a transfer to a network facility once a member is determined to be medically stable.

### **Urgent Care**

Benefits are provided for accident or medical care received from an urgent care center or other facility, such as a physician's office. Urgent care is not considered a life-or limb-threatening emergency and does not require the use of an emergency room.

### **Urgent/After-Hours Care Within or Outside of the CHP+ Service Area**

Urgent and after-hours care received within the CHP+ service area is covered only when it is provided by your child's PCP or by a provider or urgent care center when the PCP has referred your child. When your child is temporarily absent from the CHP+ service area, urgent/after-hours care is covered only if you receive a referral from his or her PCP.

CHP+ will not cover urgent/after-hours care provided more than 50 miles from CHP+'s service area if you knew your child might need care before you left, or if your child could have traveled to the PCP's office without medically harmful results. If your child is sick, take him or her to the PCP before you leave town. If your child receives care away from home, call your doctor within 48 hours.

### **Travel Outside the Country**

In an emergency only care situation the member should go to the nearest medical facility. The member will be required to pay the bill in full at the time of service. The member is encouraged to pay with a credit card because the credit card company will automatically transfer the foreign currency into American dollars. When the member returns home, the member should complete a claim form, which is available by contacting HMO Colorado's Dedicated Services Department at 877.523.8171. The member must submit the claim form, along with the receipts, to the address on the claim form. The amount submitted must be in American dollars. HMO Colorado may require medical records for the services received. The member is responsible for providing such medical records and it may be necessary for the member to provide an English translation of the medical records.

### **Emergency Care and Urgent Care Exclusions**

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

- Services received outside the member's service area if the need for this care could have been foreseen before leaving the service area.
- Follow-up care received in an emergency department or urgent care center, including but not limited to, removal of stitches and dressing changes.
- Maternity care and/or deliveries outside the service area within five weeks of the anticipated delivery date, except in an emergency.
- Non-emergency continued care after the member's condition has stabilized.

### **Ambulance and Transportation Services**

This section describes covered services and exclusions for ambulance services. Benefits are provided for local transportation by a vehicle designed, equipped and used only to transport the sick and injured. The vehicle must be operated by trained personnel and licensed as an ambulance to take your child:

- From the member's home or the scene of an accident or medical emergency to the closest hospital with appropriate emergency facilities.
- From one hospital to another for medically necessary transport by ambulance for continuing inpatient or outpatient care.

### **Air Ambulance**

Ground ambulance is usually CHP+'s approved method of transportation. Air ambulance is only a covered benefit when terrain, distance, or the member's physical condition requires the services of an air ambulance. HMO Colorado will determine on a case-by-case basis if transport by air ambulance is a covered benefit. If HMO Colorado determines that ground ambulance could have been used, the level of benefits will be limited to those for transport by ground ambulance. The member's family will be responsible for the remainder of the bill.

### **Ambulance and Transportation Services Exclusions**

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

- Commercial transport (air or ground), private aviation or air taxi services.
- Transportation by private automobile, commercial or public transportation or wheelchair ambulance (ambu-cab).
- Ambulance transportation if the member could have been transported by automobile or commercial or public transportation without endangering the member's health and/or safety.

If the member elects not to receive transport to an emergency facility after an ambulance has been called then the member is responsible for any charges.

- Ambulance transportation from an emergency facility to the member's residence.

## Outpatient Therapies

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

Physical therapy may involve a wide variety of evaluation and treatment techniques. Examples include manual therapy, hydrotherapy and heat, and the application of physical agents and biomechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, prevent disability following illness, injury or loss of a body part, or prevent disability due to congenital defect or birth abnormality. All care must be received from a licensed physical therapist.

Speech therapy is for the correction of speech impairment resulting from illness, injury or surgery. Speech therapists are also involved in the medical management of swallowing disorders. All care must be received from a licensed speech therapist.

Occupational therapy is the use of constructive activities designed to promote the restoration of a member's ability to satisfactorily accomplish the ordinary tasks of daily living. All care must be received from a licensed occupational therapist.

Up to the member's 5<sup>th</sup> birthday, benefits are provided for 20 outpatient visits each for physical, speech and occupational therapies. For outpatient physical rehabilitation (physical, occupational, and/or speech therapy) coverage is limited to 30 visits per diagnosis per year. The services must be received six months from the date the injury or illness occurred.

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

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

For a cleft palate or cleft lip condition, speech therapy benefits are unlimited, as long as medical necessity has been demonstrated. Such speech therapy visits reduce the maximum visits as described above but are not limited to the maximum visits.

## Therapies Exclusions

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

- Formula for any medical condition that does not meet the above requirements
- Cardiac rehabilitation programs unless following a major cardiac event
- Maintenance therapy or care provided after the patient has reached his or her rehabilitative potential as determined by HMO Colorado
- Home programs for on-going conditioning and maintenance
- Therapies for learning disorders, developmental delays, stuttering, voice disorders, or rhythm disorders. However, up until the member's 5th birthday, this exclusion shall not apply to therapies for the care and treatment of congenital defects or birth abnormalities.
- Non-specific diagnoses relating to developmental delay and learning-related disorders

- Therapeutic exercise equipment such as treadmills and/or weights prescribed for home use
- Membership at health spas or fitness centers
- Convenience items as determined by CHP+
- 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, stress management and weight-loss programs
- Transactional analysis, encounter groups and transcendental meditation (TM)
- Sensitivity, anger management and assertiveness training
- Rolfing, Pilates, myotherapy and prolotherapy
- Holistic medicine and other wellness programs
- Educational programs such as behavior modification or arthritis classes, except as otherwise specifically provided for under this certificate
- Services for sensory integration disorder
- Occupational therapies for diversional, recreational or vocational therapies (e.g., hobbies, arts and crafts)
- Acupuncture care

### **Home Health Care/Home IV Therapy**

This section describes covered services and exclusions for home health and home infusion therapy (IV therapy) care. Benefits are provided for services performed by a home health agency engaged in arranging and providing nursing services, home health aide services and other therapeutic services. Home health services are covered only when such services are necessary as alternatives to hospitalization. Prior hospitalization is not required. Home health services must be rendered pursuant to a physician's written order, under a plan of care established by the physician in collaboration with a home health agency. Registered nurses must coordinate the services on behalf of the home health agency and your child's PCP. HMO Colorado must pre-authorize all services and reserves the right to review treatment plans at periodic intervals.

Covered services include the following:

- Professional-nursing services performed by a registered nurse (R.N.) or a licensed practical nurse (L.P.N) on a defined schedule of visits.
- Certified nurse aide services if under the supervision of a registered nurse or a qualified therapist with professional nursing services.
- Physical therapy provided by a licensed physical therapist.
- Occupational therapy provided by a licensed occupational therapist or certified occupational therapy assistant.
- Respiratory and inhalation therapy services.
- Speech and hearing therapy and audiology services.
- Medical/social services.
- Medical supplies (including respiratory supplies), durable medical equipment (rental or purchase), oxygen, appliances, prostheses and orthopedic appliances.

- Formulas for metabolic disorders, total parental nutrition, enteral nutrition and nutrition products, and formulas for gastrostomy tubes are covered for documented medical needs including attainment of normal growth and development.
- Intravenous medications and other prescription drugs ordinarily not available through a retail pharmacy.
- Nutritional counseling by a nutritionist or dietitian.

**Home Infusion/Injection Therapy**

Benefits for home infusion therapy (IV therapy) include a combination of nursing, durable medical equipment and pharmaceutical services in the home. Home IV therapy includes but is not limited to antibiotic therapy, hydration therapy and chemotherapy. Intra-muscular, subcutaneous and continuous subcutaneous injections are also covered services. See the FOOD AND NUTRITION heading in this section for information about Total Parenteral Nutrition (TPN) and enteral nutrition.

**Home Health Care and IV Therapy Exclusions**

The following services, supplies and care are not covered:

- Custodial care.
- Care that is provided by a nurse who ordinarily lives in the member's home or is an immediate family member of the patient.
- Services provided by a mental health social worker. See the MENTAL HEALTH AND SUBSTANCE ABUSE CARE heading in this section for the services covered by CHP+.
- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements, other than listed above, or dietary counseling, even if the food, meal, formula or supplement is the sole source of nutrition.
- Religious or spiritual counseling.

**Hospice Care**

This section describes covered services and exclusions for hospice care. Hospice care includes medical, physical, social, psychological and spiritual services that stress palliative care for patients. Covered hospice care may be provided in the member's home or in an inpatient facility. Hospice services must be received through a hospice program that participates with CHP+ and HMO Colorado must authorize inpatient or home hospice services for a terminally ill child before care is received.

To be eligible for home or inpatient hospice benefits, the member must have a life expectancy of six months or less, as certified by the attending physician. HMO Colorado initially approves hospice care for a period of three months. Benefits may continue for up to two additional three-month periods. After the exhaustion of each three month period, HMO Colorado will work with the physician and the hospice provider to determine the appropriateness of continuing hospice care. HMO Colorado reserves the right to review treatment plans at periodic intervals.

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

- Physician visits by hospice physicians.
- Skilled nursing services of a registered nurse (RN) or licensed practical nurse (LPN).
- Medical supplies and equipment used during a covered visit (if supplies are not provided by the hospice agency, see SUPPLIES, EQUIPMENT, AND APPLIANCES, section).

- Drugs and medications for a terminally ill child (if drugs are not provided by the hospice agency, see PRESCRIPTION DRUGS, section).
- Respite care provides a brief break for the family and provides total care to a terminally ill child. The patient may be placed in respite care for a period not to exceed five continuous days for every 60 days of hospice care. A child may not be placed in respite care for more than two respite care stays during the 60 day period of hospice care.
- Services from a licensed or certified therapist for physical, occupational, respiratory, and speech therapy.
- Medical social services provided by a qualified individual with a degree in social work, psychology, or counseling, or the documented equivalent in a combination of education, training, and experience (such services must be provided at the recommendation of a physician for purposes of assisting you or your child in coping with a specified medical condition).
- Services of a home health aid under the supervision of a registered nurse and in conjunction with skilled nursing care.
- Nutrition assessment, counseling and support, such as intravenous feeding, hyperalimentation and enteral feeding.

Benefits are also available for inpatient hospice accommodations and services.

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

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

### **Human Organ and Tissue Transplant Services**

This section describes covered services and exclusions for organ and tissue transplants.

Coverage is available for transplant services that are medically necessary services, and which are deemed **not** to be experimental procedures, and are performed at designated transplant facilities. Services are covered based on criteria established by the medical community and HMO Colorado and are provided only upon referral by a member's PCP. In addition, the member must follow all provisions in this benefit program.

A member is eligible for the covered services contained in this section if the following guidelines are met:

- All human organ and tissue transplants must be performed at a hospital designated and approved by HMO Colorado for each specific covered service provided under this section.
- HMO Colorado 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 pre-authorized based on the clinical criteria and guidelines established, adopted or endorsed by HMO Colorado or its designee at the sole discretion of HMO Colorado. Approval for such covered services will be at the sole discretion of HMO Colorado.

- If a hospital admission is not due to a medical emergency, it is subject to pre-authorization by HMO Colorado. If the services must be performed based on a medical emergency, HMO Colorado must be notified within one business day after admission.

Benefits are provided, when pre-authorized by HMO Colorado, for services directly related to the following transplants:

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

The following hospital, surgical, medical and other services are covered services if they are pre-authorized by HMO Colorado. See the MANAGED CARE FEATURES heading in the ABOUT YOUR HEALTH CARE COVERAGE section for information on pre-authorization requirements.

### **Hospital Covered Services**

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

### **Medical Covered Services**

- Inpatient and/or outpatient professional services.
- Intensive medical care rendered to a member whose condition requires a physician's constant attendance and treatment for a prolonged period of time.
- Medical care by a physician other than the operating surgeon rendered concurrently during the hospital stay for treatment of a medical condition separate from the condition for which the surgery was performed.
- Medical care by two or more physicians rendered concurrently during the hospital stay when the nature or severity of the member's condition requires the skills of separate physicians.

- Consultation services rendered by another physician at the request of the attending physician, other than staff consultations required by hospital rules and regulations.
- Home, office and other outpatient medical care visits for examination and treatment of the member.

### **Surgical Covered Services**

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

### **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. These drugs are covered only if the member's coverage includes an outpatient prescription drug benefit.
- 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 to accompany the recipient child. If a member must temporarily relocate outside of his or her city of residence to receive a covered organ transplant, coverage is available for travel to the city where the transplant will be performed, and for reasonable lodging expenditures for the member and one adult. Travel and lodging expenses for the member and the accompanying adult are limited to a lifetime maximum benefit of \$10,000 per transplant - which is part of the maximum lifetime benefit for organ transplants under this "Organ Transplant" provision. Lodging expenses are further limited to \$100 per day. Travel expenses incurred by a donor are not applied to a member's lifetime travel and lodging expenses, but are applied to the maximum lifetime benefit for these transplants. Coverage is **not** available for travel costs associated with a pre-transplant evaluation if the travel occurs more than five (5) days prior to the actual transplant.

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

- When both the recipient and the donor are CHP+ members, each is entitled to the covered services specified in this section
- When only the recipient is CHP+ member, both the donor and the recipient are entitled to the covered services specified in this section
- The donor benefits are limited to those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, grants, foundations and government programs.
- If the donor is a CHP+ member, and the recipient is not a CHP+ member, benefits will not be provided for the donor or recipient expenses

Donor expenses are paid only after a member's initial claims for the transplant have been processed. No coverage is available to the donor after he or she has been discharged from the transplant facility.

No benefits will be provided for procurement of a donor organ or organ tissue which is not used in a covered transplant procedure, unless the transplant is cancelled due to the member's medical condition or death and the organ cannot be transplanted to another person. No benefits will be provided for procurement of a donor organ or organ tissue that has been sold rather than donated.

### **Human Organ and Tissue Transplant Exclusions**

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

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

### **Maximum Lifetime Benefit for Organ Transplants**

Coverage for all covered organ transplants and all transplant-related services, including travel, lodging, and donor expenses or organ procurement is limited to a maximum lifetime benefit for major organ transplants of \$1,000,000 per member.

Amounts applied toward the maximum lifetime benefit for organ transplants include all covered charges for transplant-related services, such as hospitalizations and medical services related to the transplant, and any subsequent hospitalizations and medical services related to the transplant. The travel, lodging, and donor expenses coverage apply toward the maximum lifetime benefit for organ transplants.

A service or supply is considered transplant-related if it directly relates to a transplant covered under this benefits booklet, and is received during the transplant benefit period (up to five days before, or within one year following, the transplant). *Exception:* A pre-transplant evaluation may be received more than five days before a transplant and may be considered transplant-related (this

exception does not extend to travel required to receive a transplant evaluation). Covered services received during the evaluation will be subject to the maximum lifetime benefit for organ transplants and subject to the limitations of this "Organ Transplant" benefit.

If a member receives a covered transplant under CHP+ (for example, heart transplant) and later requires another transplant of the same type (for example, another heart transplant), the covered charges for the new transplant are applied to the remaining (if any) maximum lifetime benefit available per member.

Payments under this "Organ Transplant" benefit are not applied to other specified benefit maximums. Expenses for covered transplant-related services in excess of the maximum lifetime benefit for organ transplants are not payable under this provision or any other portion of this benefits booklet.

### **Medical Supplies and Equipment**

This section describes covered services and exclusions for medical supplies, durable medical equipment, oxygen and its equipment, and orthopedic and prosthetic devices. Supplies are subject to pre-authorization requirements. See the MANAGED CARE FEATURES heading in the ABOUT YOUR HEALTH CARE COVERAGE section for information about pre-authorization requirements. The supplies, equipment and appliances described in this section are covered benefits only if supplied by an in-network provider and if they meet HMO Colorado's medical policy criteria. Benefits described in this section are allowed up to the maximum benefit payment except for medical and surgical supplies, which are not subject to the maximum payment.

#### **Medical Supplies**

Disposable items received from a CHP+ in-network provider and required for the treatment of an illness or injury on an inpatient or outpatient basis are covered. Benefits are provided for syringes, needles, surgical dressings, splints and other similar items that treat a medical condition. For information about supplies received from a pharmacy see the PRESCRIPTION DRUGS heading in this section.

#### **Oxygen and Equipment**

Benefits are provided for oxygen and the rental of the equipment needed to administer oxygen (one stationary and one portable unit per member). Pre-authorization is required from HMO Colorado at 800.832.7850 or 300.831.4115.

#### **Durable Medical Equipment**

Durable medical equipment, including such things as crutches, wheelchairs, breathing equipment and hospital beds, is covered if it is medically necessary and prescribed by an in-network physician. Durable medical equipment generally can withstand repeated use and must serve a medical purpose. Durable medical equipment will be rented or purchased at HMO Colorado's option. Rental costs must not be more than the purchase price and will be applied to the purchase price. Medical equipment repair, maintenance and adjustment due to normal usage are covered if HMO Colorado purchased the equipment or if it would have been approved by HMO Colorado. HMO Colorado will review other situations on a case-by-case basis. During repair or maintenance of durable medical equipment CHP + will provide coverage for replacement rental equipment. Durable medical

equipment used as part of an inpatient admission is covered as part of the inpatient hospital admission.

### **Orthopedic Appliances**

An orthopedic appliance is a rigid or semi-rigid supportive device that helps to increase the use of a malfunctioning body part, limb or extremity, limiting or stopping the motion of a weak or poorly functioning body part. A knee brace is an example of an orthopedic appliance. Benefits are provided for the purchase, fitting and repairs of and the needed adjustments to orthopedic appliances. Covered benefits are limited to the most appropriate model that adequately meets the medical needs of the member.

### **Prosthetic Devices**

A prosthetic device replaces all or part of a missing body part or extremity (leg or arm) to increase the member's ability to function. Benefits are provided for the purchase, fitting, repair and replacement of and the needed adjustments to prosthetic devices. Prosthetic devices reduce the maximum benefit as described in the benefits booklet and are not limited to the maximum benefit.

### **Other Appliances**

Benefits for other appliances include the following:

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

### **Durable Medical Equipment Payment Limit**

If the PCP has ordered the following medically necessary items, these items will **not** be subject to the durable medical equipment payment limit of \$2,000:

- Durable medical equipment owned by the facility and medical supplies used during a covered admission or during a covered outpatient visit.
- Medical supplies (including casts, dressings, and splints used in lieu of casts) used during covered outpatient visits.
- Surgically implanted prosthetics or devices authorized by CHP+ before your child receives the device.
- Insulin pumps and related supplies.

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

- Oxygen and oxygen equipment
- Orthopedic appliances (this does not include orthotic shoe inserts, whether functional or otherwise)
- Crutches
- Glucometers
- The rental, or if approved by CHP+, the purchase of durable medical equipment, including repairs, when prescribed by a physician or other professional provider and required for therapeutic use (for example, wheelchairs and walkers)

- Prostheses and orthopedic appliances or devices (for example, neck brace); their fitting, adjustment, repairs, or replacement because of wear or a change in your child's condition which causes your child to need a new appliance

### **Medical Supplies and Equipment Exclusions**

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

- Comfort, luxury or convenience item supplies, equipment and appliances (e.g., wheelchair sidecars or a cryocuff unit). Equipment or appliance requested by the member that include more features than needed for the medical condition are considered luxury, deluxe and convenience items (e.g., motorized equipment, such as electric wheelchairs or electric scooters, when manually operated equipment can be used).
- Any items available without a prescription, such as over-the-counter items and items usually stocked in the home for general use, including, but not limited to, bandages, gauze, tape, cotton swabs, dressing, thermometers, heating pads and petroleum jelly.
- Air conditioners, purifiers, humidifiers, dehumidifiers, special lighting or other environmental modifiers, surgical supports and corsets or other articles of clothing, whirlpools, hot tubs, saunas, flotation mattresses and biofeedback equipment.
- Self-help devices that are not medical in nature, regardless of the relief or safety they may provide for a medical condition, including, but not limited to, bath accessories (including bathtub lifts), telephone arms, home modifications to accommodate wheelchairs, wheel chair convenience items, wheel chair lifts and vehicle modifications.
- Dental prostheses, hair/cranial prostheses, penile prostheses or other prosthesis for cosmetic purposes.
- Orthotics (except for members with diabetes), whether functional or otherwise, regardless of the relief they provide.
- 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**

Delta Dental provides coverage to CHP+ members for non accident-related dental services. Contact Delta Dental at 303.741.9300 or 800.610.0201

This section describes covered services and exclusions for accident-related dental services, anesthesia for children, inpatient services for dental-related services, and cleft palate and cleft lip conditions. Dental services are not covered except under the specific circumstances described below. This Benefits Booklet provides coverage for health conditions and should not be considered as the member's dental coverage. All dental services and supplies are subject to pre-authorization guidelines. See the MANAGED CARE FEATURES heading in the ABOUT YOUR HEALTH CARE COVERAGE section for information about pre-authorization guidelines. Accident-Related Dental Services Benefits are provided for accident-related dental repairs to sound natural teeth or related body tissue within 72 hours of an accident. Dental services to stabilize the teeth after an accident or injury are covered to stabilize the teeth and/or condition if received within 72 hours of the accident. Such dental services do not include dental restoration.

All dental services received after 72 hours following the accident, including follow up care, are not covered under the medical benefit.

**Dental Anesthesia**

Benefits are provided for general anesthesia when provided in a hospital, outpatient surgical facility or other facility, and for associated hospital or facility charges for dental care if the care is provided to a covered dependent child who **1)** has a physical, mental or medically compromising condition; **2)** has dental needs for which local anesthesia is not effective due to acute infection, anatomic variation or allergy; **3)** is extremely uncooperative, unmanageable, uncommunicative, or anxious and whose dental needs are deemed sufficiently important that dental care cannot be deferred; or **4)** has sustained extensive orofacial and dental trauma.

**Inpatient Admission for Dental Care**

Benefits are provided for inpatient facility services including room and board, but do not include charges for the dental services, only if the member has a non-dental related physical condition, such as a bleeding disorder or heart condition that make the hospitalization medically necessary.

**Cleft Palate and Cleft Lip Conditions**

Benefits are allowed for inpatient care and medical services, including orofacial surgery, surgical management and follow-up care by plastic surgeons and oral surgeons, orthodontics, prosthetic treatment such as obturators, speech appliances, and prosthodontic and surgical reconstruction for the treatment of cleft palate and/or cleft lip as indicated below.

Pursuant to statute 10-16-104 (c) **(I)** Except as provided for cleft lip and cleft palate coverage in sub-subparagraph (A) of subparagraph (II) of this paragraph (c) and for inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and for which medically standard methods of diagnosis, treatment, and monitoring exist pursuant to sub-subparagraph (A) of subparagraph (III) of this paragraph (c), the benefits available to newborn children shall consist of coverage of injury or sickness, including all medically necessary care and treatment of medically diagnosed congenital defects and birth abnormalities for the first thirty-one days of the newborn's life, notwithstanding policy limitations and exclusions applicable to other conditions or procedures covered by the policy. Except as provided in sub-subparagraph (C) of subparagraph (II) of this paragraph (c), such coverage shall be subject to copayment, deductible, and aggregate dollar policy maximums that are no higher than are generally applicable under the policy to all other sicknesses, diseases, and conditions otherwise covered under the policy.

**(II) (A)** With regard to newborn children born with cleft lip or cleft palate or both, there shall be no age limit on benefits for such conditions, and care and treatment shall include to the extent medically necessary: Oral and facial surgery, surgical management, and follow-up care by plastic surgeons and 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; and audiological assessments and treatment.

(B) Cleft lip, cleft palate, or any condition or illness which is related to or developed as a result of the cleft lip or cleft palate shall be considered to be compensable for coverage under the provisions of sub-subparagraph (A) of this subparagraph (II).

(C) If a dental insurance policy, a contract for dental insurance, or an enrollee coverage contract issued pursuant to this article is in effect at the time of the birth, or is purchased after the birth, of a child with cleft lip or cleft palate or both, it shall provide fully for any orthodontics or dental care needed as a result of the cleft lip or cleft palate or both. Such policy or contract may contain the same copayment provisions for the coverage of cleft lip or cleft palate or both as apply to other conditions or procedures covered by the policy or contract.

### **Dental Services Exclusions**

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

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

**Food and Nutrition**

This section describes covered services and exclusions for nutrition therapy. Benefits for enteral therapy and Total Parenteral Nutrition (TPN) include a combination of nursing, durable medical equipment and pharmaceutical services. Durable medical equipment and supplies are subject to any medical benefit limitation as listed on the Health Plan Description Form. An in-network licensed therapist or home health agency must provide the nutrition services. All services must be pre-authorized. See the MANAGED CARE FEATURES heading in the ABOUT YOUR HEALTH CARE COVERAGE section for information about pre-authorization guidelines.

**Enteral Therapy and Parenteral Nutrition (TPN)**

Enteral nutrition is delivery of nutrients by a tube into the gastrointestinal tract.

TPN is the delivery of nutrients through an intravenous line directly into the bloodstream.

Nursing visits to assist with enteral nutrition are covered when they are medically necessary and not custodial care under the home health benefits. These services are frequently provided through a home health agency. For more information, see the HOME HEALTH CARE/HOME IV THERAPY and HOSPICE CARE headings in this section.

Benefits are provided for medical foods for home use for metabolic disorders. These medical foods may be taken either orally or enterally. A provider must have prescribed the medical foods that are appropriate for inherited enzymatic disorders involved in the metabolism of amino, organic and fatty acids. Such disorders include phenylketonuria, maternal phenylketonuria, maple syrup urine disease, tyrosinemia, homocystinuria, histidinemia, urea cycle disorders, hyperlysinemia, glutaric acidemias, methylmalonic acidemia and propionic acidemia. This benefit **does not include** medical foods for members with lactose or soy-intolerance. All covered medical foods must be obtained through a participating pharmacy and are subject to the pharmacy co-payment.

TPN received in the home is a covered benefit for the first 21 days following a hospital discharge when it is determined to be medically necessary. Additional days may be allowed up to a maximum of 42 days per the member's eligibility during a given calendar year as determined to be medically necessary and when pre-authorized by HMO Colorado.

**Other Medical Nutrition**

The following are also covered services:

- Diagnosis of diabetes - inpatient nutrition counseling, outpatient nutrition and self-management training and follow-up visits for members diagnosed as diabetic.
- Hospice care - nutrition assessment, counseling and support, such as intravenous feeding, hyperalimentation and enteral feeding.
- Formulas for metabolic disorders, total parental nutrition, enteral nutrition and nutrition products, and formulas for gastrostomy tubes are covered for documented medical needs including attainment of normal growth and development. Enteral formula is covered under the Home Healthcare benefit. Payment for formula must be authorized before your child receives the formula and will be considered only if there is a gastrointestinal disorder (including of the oral cavity), malabsorption syndrome, or a condition that affects growth pattern or the normal absorption of nutrition. Cost of pumps, tubing and other supplies for administration of formulas administered by tube or vein are included.

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

### **Food and Nutrition Exclusions**

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

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

### **Mental Health and Substance Abuse Care**

This section describes covered services and exclusions for biologically based and non-biologically based mental health care. This section describes covered services and exclusions for mental health care and substance abuse care.

Biologically based mental illness conditions are covered and are not subject to the limitations of the mental health benefit. They are covered according to the same guidelines listed in this Benefit's Booklet as any other physical illness, and they are described in the appropriate sections of the Benefit's Booklet, depending on the type of care received. Services are subject to the medical benefits specialist co-payment. Biologically based mental illnesses are schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, obsessive-compulsive disorder and panic disorder.

Coverage described in this section is also for non-biologically based conditions (including substance abuse detoxification conditions) identified as a mental disorder in the most current

version of the International Classification of Diseases, in the chapter titled “Mental Disorders.” Mental health conditions are those conditions with a psychiatric diagnosis or that require specific psychotherapeutic treatment, regardless of the underlying condition.

Autism is covered under the member’s medical benefit.

Services for attention deficit disorder (ADD) and attention deficit hyperactivity disorder (ADHD) are covered as mental health conditions, if a licensed in-network therapist provides the services. Benefits are then paid under the mental health benefit.

Outpatient substance abuse treatment is considered a mental health condition for the purpose of this benefit. Services for medical detoxification are described below.

**Covered substance abuse services described in this section are for acute medical detoxification, which takes place during an acute substance abuse episode.** Substance abuse is a condition that develops when an individual uses alcohol and/or other drugs in such a manner that the member’s health is impaired and/or the member’s ability to control actions is lost. The primary purpose of medical detoxification for this condition is to rid the body of toxins, monitor heart rate, blood pressure and other vital signs, manage withdrawal symptoms, and administer medications as needed. Following medical stabilization, any further rehabilitation services or treatment must be transitioned to the behavioral health benefit. Substance abuse detoxification benefits are provided for inpatient treatment for detoxification purposes only. See the Pre-authorization/Pre-certifications heading in this section for information about notification requirements when the member has an unscheduled emergency admission.

Benefits are provided for medically necessary inpatient care, outpatient care, and provider office services for the treatment of mental health disorders. Benefits include the diagnosis of, crisis intervention for and treatment of mental health conditions. Inpatient services must be provided by a licensed hospital, psychiatric hospital or substance abuse treatment center for acute stabilization. A physician, licensed clinical psychologist or other professional provider who is properly licensed or certified to practice psychotherapy, and is an in-network provider must perform outpatient facility and provider office services.

Benefits are provided for medication management of mental health conditions by the member’s medical provider, psychiatrist or prescriptive nurse. If medication management is provided by the member’s medical provider or if the condition is a biologically-based mental illness, coverage is provided under the medical benefit. If medication management is provided by a psychiatrist or a prescriptive nurse, coverage is provided under the mental health benefit.

### **Pre-authorizations/Pre-certifications**

To obtain mental health care, the member does **not** need a referral from the member’s PCP. However, the member must contact CHP+’s behavioral health administrator, One Nation also known as Anthem Behavioral at 800.424.4014 to determine medical necessity, the appropriate treatment level and the appropriate setting for mental health and substance abuse services. When the member does not obtain the required pre-authorization from One Nation or does not receive services from the provider designated by that pre-authorization, services are not covered.

If a member is receiving services from a mental health professional at the time his or her enrollment becomes effective, One Nation (Anthem Behavioral) must be called at 800.424.4014 to receive authorization for additional services. If a nonparticipating mental health professional is selected, the member or parent or guardian must contact One Nation (Anthem Behavioral) to make arrangements and to receive authorization to see the nonparticipating mental health professional.

One Nation also known as Anthem Behavioral must be notified about all emergency admissions, including those that occur on weekends or holidays, by the next business day.

### **Inpatient Mental Health Services**

Inpatient services to treat mental health conditions are subject to medical policy and medical necessity. Treatment for inpatient mental health conditions is limited to a combination equaling a total of 45 inpatient days or 90 partial hospitalization days during the member's contract year. Provider visits received during a covered admission are also covered. Covered services include but are not limited to:

- Inpatient semi-private room and ancillary services.
- Individual psychotherapy.
- Group psychotherapy.
- Psychological testing.
- Family counseling with family members to assist in the member's diagnosis and treatment.
- Medication management.
- Provider visits during a covered admission.

### **Partial Hospitalization Services**

The same services covered for inpatient services are also covered for partial hospitalization. One inpatient day is defined as an admission to a facility for more than 12 hours of treatment. One-partial treatment day is defined as no less than three and no more than 12 hours of treatment per day. Partial day treatment is covered only when the member receives care through a day treatment program. Every two partial day treatments count as one full inpatient day and will be applied against the 45-day maximum inpatient benefit. The maximum number of partial hospitalization days available is 90 days per a member's eligibility during a given calendar year.

### **Outpatient Mental Health Services**

Covered outpatient and intensive outpatient program services for mental health and substance abuse conditions (except room, board, general nursing and ancillary services) are the same as the covered inpatient services listed previously in this section, if such services are for less than three hours per day.

Benefits are limited to the maximum payment amount based on the member's eligibility during a given calendar year. (not including biologically based mental illnesses and autism). Coverage for outpatient services is limited to 20 visits per enrollment year. Services rendered by psychiatrists, psychologists, licensed family therapists, and social workers are included in the 20-visit maximum treatment of neurobiologically based mental illness is not subject to the 20-visit outpatient limit. These illnesses are covered the same as a general condition. However, One Nation, otherwise known, as Anthem Behavioral must authorize services or the services will not be covered.

**Mental Health and Substance Abuse Care Exclusions**

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

- Inpatient treatment for substance abuse.
- Services or care provided or billed by a residential treatment center, school, halfway house, custodial care facility for the developmentally disabled, residential programs for substance abuse which are not specifically in the CHP+ network, or outward bound programs, even if therapy is included.
- Private room expenses.
- Biofeedback.
- Psychoanalysis or psychotherapy that a member may use as credit toward earning a degree or furthering the member's education.
- Hypnotherapy.
- Religious, marital and social counseling.
- The cost of any damages to a treatment facility caused by the member.
- Recreational, sex, primal scream, sleep and Z therapies.
- Self-help, stress management and weight-loss programs.
- Transactional analysis, encounter groups and transcendental meditation.
- Sensitivity training and assertiveness training.
- Behavior modification programs.
- Rebirthing therapy.
- Custodial care.
- Domiciliary care.
- Court or police-ordered treatment that would not otherwise be covered.
- Services not authorized by One Nation (Anthem Behavioral).

**Residential treatment center service**

The same services covered as inpatient services are also covered for residential treatment center services. Residential treatment center services are services in a licensed residential treatment facility that can provide day services and 24-hour supervision after day program. Residential treatment center services may be substituted for inpatient services. Every two residential treatment days count as one inpatient day and will be applied against the 45-day maximum inpatient benefit. The maximum number of partial residential treatment days available is 90 days per the member's eligibility in a given calendar year. Residential treatment is approved only if the charges are equal to or less than partial hospitalization.

**Prescription Drugs**

This section describes covered services and exclusions for outpatient pharmacy prescription drugs and medications. CHP+ allows inpatient pharmacy benefits during a covered inpatient stay when the drugs are billed by a hospital or other facility. See the INPATIENT FACILITY SERVICES heading in this section for information about inpatient care. For benefit information about special foods and formulas for metabolic and nutritional needs, see the FOOD AND NUTRITION heading in this section for information. See the HOME HEALTH CARE/HOME IV THERAPY heading in this section for benefit information about home intravenous (IV) therapy.

The outpatient pharmacy benefits available under this certificate are managed by CHP+'s affiliate, Anthem Prescription Management (APM), a pharmacy benefits management company. As part of its formulary management services to CHP+, APM offers a nationwide network of retail pharmacies, a mail-service pharmacy and clinical services. APM, in consultation with CHP+ also promotes and enforces the appropriate use of medications by reviewing for improper dosage, potential drug-to-drug interactions or drug-pregnancy interactions. The current formulary is available at [www.anthem.com](http://www.anthem.com), under "Search the national drug formulary." The formulary is subject to periodic review and amendment. Inclusion of a drug or related item on the formulary is not a guarantee of coverage.

For certain prescription drugs, the prescribing physician may be asked to provide additional information before APM will determine medical necessity. APM may, at its sole discretion, establish quantity limits for specific prescription drugs. Covered services will be limited based on medical necessity, quantity limits established by APM or utilization guidelines.

Certain prescription drugs (or the prescribed quantity of a particular drug) may require pre-authorization. Pre-authorization helps promote appropriate utilization and enforcement of guidelines for prescription drug benefit coverage. When the member has a prescription filled, the network pharmacist is informed of the pre-authorization requirement through the pharmacy's computer system, and the pharmacist is instructed to contact APM at 800.665.0210. APM uses pre-approved criteria reviewed and adopted by CHP+. If additional information is required, APM may contact the prescribing physician to determine if pre-authorization should be granted. For a list of current drugs requiring pre-authorization, visit [www.anthem.com](http://www.anthem.com) or call HMO Colorado's Dedicated Services Department at 877.523.8171. If pre-authorization is denied, the member may appeal the decision by following the instructions in the CLAIMS, GRIEVANCES AND APPEALS section. The provider or network pharmacist may check with APM at 800.338.6180 to verify formulary drugs, quantity limits, pre-authorization requirements, and appropriate brand name or generic drugs covered under this plan.

Outpatient pharmacy benefits include a therapeutic drug substitution program approved by CHP+ and managed by APM. This is a voluntary program designed to inform members and physicians about formulary or generic alternatives to non-formulary or formulary brand drugs. APM may contact the member and the prescribing physician to make the member aware of the formulary or generic drug substitution options. Therapeutic substitutions may also be initiated at the time the prescription is dispensed. Only the member and the physician together can determine if the therapeutic substitute is appropriate for the member.

Outpatient pharmacy benefits are limited to the following, which must be obtained from a network pharmacy:

- Prescription drugs, including self-administered injectable drugs.
- Injectable insulin and syringes used for administration of insulin.
- Oral contraceptive drugs and contraceptive devices.
- Certain supplies, equipment and appliances (such as those for diabetes and asthma). Contact HMO Colorado's Dedicated Services Department to determine approved covered supplies when obtained through a network pharmacy.

If the member does not obtain certain supplies, equipment and appliances through the mail-order service or from a network pharmacy, they may be covered as medical supplies or durable medical equipment and appliances instead of prescription drug benefits and would be covered under the other headings of this benefits booklet and may require pre-authorization.

Each prescription order is subject to a co-payment. If the prescription order includes more than one covered drug or supply, a separate co-payment is required for each covered drug or supply. The co-payment will be the lesser of the member's co-payment, amount or the retail price charged for the prescription by the pharmacy or mail order service that fills the prescription. The co-payment will not be reduced by any discounts, rebates or other funds that APM receives from drug manufacturers or similar vendors and/or funds CHP+ receives from APM. CHP+ will make no payment for any covered drug or supply unless the APM negotiated rate exceeds any applicable co-payment for which the member is responsible.

The member is limited to a 34-day supply of a prescription drug if it is obtained at a network pharmacy, or up to a 90-day supply if the drug is obtained through the mail order service. For oral contraceptives, members are limited to one pill pack (normally 28 days) at a network pharmacy, or three pill packs by mail order service. When medically necessary a one-month vacation override is available if the member is traveling out of the CHP+ service area.

The amount of benefits paid is based upon whether the member obtains covered drugs and supplies from a network pharmacy or mail service program. It is also based on whether the member obtains a generic or brand name prescription drug and whether formulary or non-formulary prescription legend drugs were dispensed. A prescription drug must be a legend drug to be eligible for benefits.

### **How to Obtain Outpatient Prescription Drug Benefits**

How the member obtains benefits depends on whether they use a retail pharmacy or the mail-order service.

- **Network Pharmacy** The member presents the written prescription order from the physician and the member's health benefit ID card to the pharmacist at a network pharmacy. The pharmacy will file the claim for the member. The member is charged at the point of purchase for applicable co-payment amounts.

If the member does not present the health benefit ID card at a network pharmacy, the member must pay the full cost of the prescription. When the member pays the full charge for the prescription, the member should obtain an itemized receipt from the pharmacist and submit it to APM with a written request for reimbursement. The address to send the receipts to is:

Anthem Prescription Management  
Direct Member Reimbursement  
PO Box 145433  
Cincinnati, OH 45250-5433

The member will be reimbursed based on the charge for the covered drug, less the network pharmacy discount payable after review and approval of the claim, less the applicable co-payment. Prescription drugs dispensed in excess of a 34-day supply are not reimbursable.

- **Mail-Order Service** Mail-order service offers a convenient option for obtaining maintenance prescription drugs if the member takes prescription drugs on a regular basis. Covered prescription drugs are ordered directly from the licensed pharmacy mail-order service that has entered into a reimbursement agreement with APM, and the drugs are sent directly to the member's home. Maintenance prescription drugs are those drugs used on a continuing basis for the treatment of a chronic illness such as heart disease, high blood pressure, arthritis or diabetes. The member must complete the Order and Patient Profile Form, which is available at [www.anthem.com](http://www.anthem.com) or by calling Anthem Prescription Management Direct Mail at 800.962.8192. The member must complete the patient profile information only once. The member may mail written prescriptions from the physician or have the physician fax the prescription to APM's mail-order service. The member's physician may also phone in the prescription to APM's mail-order service. The member is required to submit the applicable co-payment amounts to the APM mail-order service when the member requests a prescription or refill. Class II prescription drugs (e.g., narcotics) will only be dispensed in a 34-day supply.

### **Prescription Drugs Exclusions**

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

- Prescription drugs and supplies received from a non-network pharmacy
- Drugs prescribed for weight control or appetite suppression
- Medications or preparation used for cosmetic purposes to promote or prevent hair growth, or growth or medicated cosmetics, including, but not limited to, Rogaine®, Viniqa® and Tretinoin (sold under such brand names as Retin-A®)
- Any drug, product or technology within six months of the Food and Drug Administration (FDA) approval. APM may at its sole discretion, waive this exclusion in whole or in part for a specific new FDA-approved drug product or technology.
- Any medications used to treat infertility.
- Special formulas, food or food supplements (unless for metabolic disorders); see the FOOD AND NUTRITION heading in this section for benefit information), vitamins, or minerals, except for legend prenatal vitamins.
- Delivery charges for prescriptions.
- Charges for the administration of any drug, unless it is dispensed in the physician's office or through home health care.
- Drugs provided as samples to the provider.
- Antibacterial soap/detergent, toothpaste/gel, shampoo or mouthwash/rinse.
- Hypodermic needles, syringes or similar devices, except when they are used for administration of a covered drug when prescribed in accordance with the terms of this section.
- Therapeutic devices or appliances, including support garments and other non-medicinal supplies (regardless of intended use).
- Non-prescription and over-the-counter drugs, including herbal or homeopathic preparations; prescription drugs with an over-the-counter bioequivalent, even if it is written as a prescription; and drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not federal law), except for injectable insulin. Some prescription drugs may not be covered even if the member receives a prescription order from the physician.
- Prescription drugs dispensed in quantities that exceed the applicable limits, which are established by us at our sole discretion.

- Refills that exceed the quantity prescribed by the provider or that are refilled more than one year from the date of such order.
- Prescription drugs intended for the treatment of sexual dysfunction or inadequacy, regardless of origin or cause (including drugs, such as Viagra®, for the treatment of erectile dysfunction).
- Appetite suppressants.
- Nicorette, nicotine patches, or other drugs containing nicotine or other smoking deterrent medications.
- Prescription drugs dispensed for the purpose of international travel.

### **Audiology Services**

The following audiology services are covered:

- Age appropriate hearing screenings for preventive care.
- Newborn hearing screening and follow-up for a failed screen.
- Hearing aides for congenital and traumatic injuries up to a maximum of \$800 per calendar year.

A member's PCP and, if available, a pediatric audiologist, will direct follow-up tests and appropriate care if a member appears to need hearing services at birth. Many times, a newborn will be referred to other appropriate community agencies for additional care.

### **Vision Services**

Covered vision services include:

- Age appropriate vision screening and routine eye exam.
- One routine eye exam per calendar year.
- A \$50 credit per member per calendar year towards the purchase of lenses, frames, and/or contacts. CHP+ members must obtain services for the eye exam from a CHP+ participating provider. The lenses, frames, and/or contacts can be purchased from a participating or nonparticipating provider.
- Specialty vision services with a preauthorization from your child's PCP.
- An eye screening with a participating ophthalmologist or optometrist to diagnose a medical condition or illness. This service does not require a preauthorization.

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

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

## 7: General Exclusions and Limitations

These general exclusions apply to all benefits described in this Benefits Booklet. The following list of exclusions is not a complete list of all services, supplies, conditions or situations that are not covered services. In addition to these general exclusions, specific limitations, conditions and exclusions apply to specific covered services, which may be found in the MEMBER BENEFITS section and elsewhere in this benefits booklet.

Even if the member receives a service or a referral from the PCP, benefits will not be provided if such service is an exclusion. If a service is not covered, then all services performed in conjunction with that service are not covered. CHP+ is the final authority for determining if services and supplies are medically necessary for the purpose of payment. CHP+ will not cover any services not obtained from the member's PCP except as set forth in the MEMBER BENEFITS section.

**CHP+ will not allow benefits for any of the following services, supplies, situations or related expenses:**

### **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 in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aromatherapy, massage therapy, reiki therapy, herbal medicine, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergetic synchronization technique (BEST), colonics, or iridology.

### **Alcoholism**

No coverage for inpatient treatment. See the Substance Abuse entry in this section for information.

### **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.

### **Before effective date**

This coverage does not cover any service received before the member's effective date of coverage.

### **Biofeedback**

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

### **Chelating agents**

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

**Chemical dependency**

No coverage for inpatient treatment. See the Substance Abuse entry in this section for information.

**Chiropractic services**

This coverage does not cover any services or supplies for chiropractic care unless care is for spinal manipulation.

**Clinical research**

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

**Complications of non-covered services**

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

**Convalescent care**

Except as otherwise specifically provided, this coverage does not cover convalescent care following a period of illness, an injury or surgery, unless the convalescent care is normally received for a specific condition, as determined by CHP+'s medical policy. Convalescent care includes the physician'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 (e.g., wheelchair sidecars, fashion eyeglass frames or a cryocuff unit). Equipment or appliances requested by the member include more features than needed for the medical condition are considered luxury, deluxe and convenience items (e.g., motorized equipment, such as electric wheelchairs or electric scooters, when manually operated equipment can be used) and are not covered.

**Cosmetic services**

This coverage does not cover cosmetic procedures, services, equipment or supplies provided for psychiatric or psychological reasons, to change family characteristics or to improve appearance. This coverage does not cover services required as a result of a complication or outcome of a non-covered cosmetic service. Face lifts, botox injections, breast augmentation, rhinoplasty and scar revisions are examples of cosmetic procedures.

**Court-ordered services**

This coverage does not cover services rendered under court order, parole or probation, unless those services would otherwise be covered under this benefits booklet.

**Custodial care**

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

- Assistance with walking, bathing or dressing
- Transferring or positioning in bed
- Administration of self-administered or self-injectable medicine
- Meal preparation
- Assistance with feeding
- Oral hygiene
- Routine skin and nail care
- Suctioning
- Toileting
- Supervision of medical equipment or its use

**Dental services**

This coverage does not cover dental services, except as provided under the DENTAL RELATED SERVICES heading in the MEMBER BENEFITS section. CHP+ members are eligible for dental coverage provided by Delta Dental.

**Discharge (services received beyond approved discharge date)**

This coverage does not cover any services after the date that HMO Colorado determines discharge is appropriate based on managed care guidelines.

**Discharge against medical advice**

This coverage does not cover hospital or other facility services if the member leaves a hospital or other facility against the medical advice of the physician.

**Discharge day expense**

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

**Domiciliary care**

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

**Double Coverage**

It is not acceptable for the subscriber to have double coverage except for Dental or Medicare.

**Drug abuse**

No coverage for inpatient treatment. See the Substance Abuse entry in this section for information.

**Elective termination of pregnancy**

Therapeutic or elective termination of pregnancy unless the elective termination is to save the life of the mother or if the pregnancy is the result of rape or incest.

**Experimental/investigative procedures**

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

**Genetic testing/counseling**

This coverage does not cover services including, but not limited to, preconception testing, paternity testing, court-ordered genetic counseling and testing, or 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 HMO Colorado's medical policy, review and criteria and after appropriate pre-authorization has been obtained.

**Government operated facility**

This coverage does not cover services and supplies for all disabilities connected to military service that are furnished by a military medical facility operated by, for or at the expense of federal, state, or local governments or their agencies, including a veterans administration facility, unless CHP+ authorizes 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, drugs, wigs, hairpieces, artificial hairpieces, hair or cranial prosthesis, hair transplants, or implants, even if there is a physician prescription, and a medical reason for the hair loss.

**Hypnosis**

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

**Illegal conduct**

This coverage does not cover any loss to which a contributing cause was the member's commission of or attempt to commit a felony or to which a contributing cause was the member's being engaged in an illegal occupation.

**Infant formula**

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

**Learning deficiencies**

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

**Maintenance therapy**

This coverage does not cover any treatment that does not significantly enhance or increase the member's functioning or productivity, or care provided after the member has reached the member's maximum medical improvement as determined by HMO Colorado, except as provided in the MEMBER BENEFITS section.

**Medical necessity**

This coverage does not cover expenses for services and supplies that are not medically necessary. Services may be denied before or after payment, unless the services were pre-authorized. A decision by HMO Colorado as to whether a service or supply is medically necessary is based on medical policy, and peer-reviewed medical literature as to what is approved and generally accepted medical or surgical practice. The fact that a provider may prescribe, order, recommend or approve a service does not, of itself, make the service medically necessary.

**Medical Nutritional Therapy**

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

**Missed appointments**

This coverage does not cover charges for the member's failure to keep scheduled appointments. The member is solely responsible for the charges.

**Neuropsychiatric testing**

This coverage does not cover evaluation and treatment for neuropsychiatric testing, unless allowed by HMO Colorado's medical policy.

**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 certificate. These non-covered providers or facilities include, but are not limited to, the following:

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

- Services provided to the member by the member, by a family member or by a person who ordinarily resides in the member's household.

**Non-medical expenses**

This coverage does not cover nonmedical expenses, including, but not limited to, the following:

- Adoption or surrogate expenses.
- Educational classes and supplies not provided by the member's provider, unless specifically allowed as a benefit listed in this Benefit Booklet.
- Vocational training services and supplies.
- Mailing and/or shipping and handling expenses.
- Interest expenses and delinquent payment fees.
- Modifications to home, vehicle or workplace, regardless of medical condition or disability.
- Membership fees for spas, health clubs, or other such facilities, or fees for personal trainers, even if medically recommended and regardless of any therapeutic value.
- Personal convenience items such as air conditioners, humidifiers or exercise equipment.
- Personal services such as haircuts, shampoos, guest meals, and radios or televisions.
- Voice synthesizers or other communication devices, except as specifically allowed by CHP+ medical orthognathic surgery. This coverage does not cover upper or lower jaw augmentation or reductions (orthognathic surgery), even if the condition is due to a genetic congenital or acquired characteristic; except as provided under the heading DENTAL SURGERY in the MEMBER BENEFITS section and as mandated by state law.

**Orthotics**

Orthotics (except for members with diabetes), whether functional or otherwise, regardless of the relief they provide.

**Other Insurance**

The subscriber cannot be eligible or covered by another insurance except for Dental and Medicare while enrolled with CHP+.

**Over-the-counter products**

This coverage does not cover any items available without a prescription, such as over-the-counter items and other items usually stocked in the home for general use, including, but not limited to, bandages, gauze, tape, cotton swabs, dressing, thermometers, heating pads and petroleum jelly. This coverage does not cover laboratory test kits for home use, including, but are not limited to, home pregnancy tests and home HIV tests.

**Post-termination benefits**

This coverage does not cover benefits for care received after coverage is terminated, except as provided in the MEMEBERSHIP section. Follow up care is not covered even if the inpatient facility admission was allowed.

**Private duty nursing service**

This coverage does not cover private-duty nursing services.

**Private room expenses**

This coverage does not cover services related to a private room, except as provided in the MEMBER BENEFITS section.

**Professional or courtesy discount**

This coverage does not cover charges for services and supplies when the member has received a professional or courtesy discount from a provider. This coverage does not cover any services for which the member's portion of the payment is waived due to a professional courtesy or discount.

**Radiology services**

This coverage does not cover Ultrafast CT scan and peripheral bone density testing. This coverage does not cover whole body CT scan, routine screening, or more than one routine ultrasound per pregnancy, except as described by medical policy for screening.

**Reduction Mammoplasty**

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

**Report preparations**

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

**Sex-change operations**

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

**Sexual dysfunction**

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

**Substance abuse**

This coverage does not cover outpatient services, supplies and laboratory or X-ray care related to substance abuse. This coverage does not cover inpatient services or supplies related to substance abuse except for medical detoxification. Outpatient treatment for alcohol or drug abuse is covered under the mental health benefit.

**Taxes**

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

**Temporomandibular joint (TMJ) surgery or therapy/orthognathic surgery**

This coverage does not cover services related to temporomandibular joint surgery, except for temporomandibular joint surgery with a medical basis.

**Third-party liability (subrogation)**

This coverage does not cover services and supplies that may be reimbursed by a third party. See the ADMINISTRATIVE INFORMATION section for information.

**Travel expenses**

This coverage does not cover travel or lodging expenses for the member, the member's family or the physician, except as provided under the HUMAN ORGAN AND TISSUE TRANSPLANT SERVICES heading in the MEMBER BENEFITS section.

**Tubal Ligation**

This coverage does not cover tubal ligations.

**Vasectomies**

This coverage does not cover vasectomies.

**Vision**

This coverage does not cover any surgical, medical or hospital service and/or supply rendered in connection with any procedure designed to correct farsightedness, nearsightedness or astigmatism. This coverage does not cover vision therapy, including, but not limited to, treatment 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 services related to weight loss, except as provided in the MEMBER BENEFITS section.

**Workers' compensation**

This coverage does not cover services and supplies for a work-related accident or illness. See the ADMINISTRATIVE INFORMATION section for information.

## 8: Administrative Information

This section describes plan maintenance for members or parents and guardians while enrolled in the CHP+ Plan.

### **Enrollment Fee**

Some families may pay an annual enrollment fee of \$25 to enroll one child and \$35 to enroll two or more children in CHP+. The enrollment fee is based on family size and income and is established by the Colorado General Assembly. Most families will **not** have to pay an annual enrollment fee or make co-payments.

The enrollment fee, if one is required, must be paid on or before the effective date of coverage under this certificate. Members will not be covered until CHP+ receives payment. Coverage will be effective at 12:01 a.m. on the effective date as stated on the member's health benefit ID card. At the end of the member's eligibility in a given calendar year, CHP+ will notify the parent or guardian that a new application form must be completed and an enrollment fee, if any, paid for the next eligibility period.

### **Co-payments (cost-sharing)**

Co-payments are paid at the time that a member sees a doctor or when prescription drugs are purchased. CHP+ co-payments range from \$0 to \$5 per visit. Please see the member's health care ID membership card for the amount of his or her co-payment including emergent and urgent care. The parent or guardian is responsible for paying the co-payment to the member's child's health provider or pharmacy at the time of service. There are no co-payments for well-child care, health maintenance visits, or immunizations received from a member's PCP or from a local nursing service. In addition, there are no co-payments for family planning services.

### **Membership Card**

A health care membership ID card shows that your child is a member of this plan and provides the information needed when your child requires services. Always carry your child's membership card; any provider may ask to see it. Have it handy when you call for an appointment and show it to the receptionist when you sign your child in for an appointment. Also, show your card to the pharmacist whenever you have a prescription filled.

### **Changing Member Information**

If your child's membership information changes in any way, such as his or her address or PCP, call the CHP+ Customer Service Department at 800.359.1991. If the change cannot be made over the phone, Customer Service will send you the forms needed to make the change.

### **Change of Residence**

A member's parent or guardian must notify CHP+ of an address change within 31 days after moving to a new residence by submitting an Enrollment Application and Change Form by calling the CHP+ Customer Service Department. Failure to receive a renewal notice due to an unreported address change (or any other reason) does not relieve the member from the responsibility to submit an application for renewal by the date.

If your family moves to a location that is not convenient (within 20 miles) to your child's current PCP office, you may choose a new PCP nearer to your new residence. You must notify CHP+ within 31 days after you move to a new residence by calling or writing the CHP+ Customer Service Department. CHP+ will make the PCP change effective for the 1st of the month if notified before the 21<sup>st</sup>. If notification is received after the 21<sup>st</sup> of the month then the PCP change will take place the 1<sup>st</sup> of the following month.

**How to File Claims**

When an in-network provider bills HMO Colorado for covered services, HMO Colorado will pay the appropriate charges for the benefit directly to the provider. The member or his or her parent or guardian is responsible for providing the in-network provider with all information necessary for the provider to submit a claim. The member pays the applicable co-payment to the provider when the covered service is received.

Services performed by a nonparticipating provider (one who is not contracted to provide services for CHP+) will be covered only in an emergency as described under EMERGENCY AND URGENT/AFTER-HOURS CARE or when approved in advance by CHP+.

If a nonparticipating provider does not bill CHP+ directly, the member must file the claim. To obtain claim forms, contact HMO Colorado at 877.523.8171. The member must complete the claim form and attach the itemized bill from the provider. Balance due statements, cash register receipts and cancelled checks are not accepted. All information on the claim form and itemized bill must be readable. When traveling outside the country, the member should obtain itemized bills translated to English. Charges for covered services should be stated in terms of United States currency. To determine the United State currency amount, use the exchange rate as it was on the date the member received care. If information is missing on the claim form or is not readable, the form will be returned to the member's family. The information contained on the itemized bills will be used to determine benefits, so it must support information reported on the submitted claim form. The claim form contains detailed instructions on how to complete the form and what information is necessary.

CHP+ is not required to honor an assignment of benefits to nonparticipating providers. CHP+ may honor an assignment of benefits to nonparticipating providers at CHP+'s sole discretion. If CHP+ pays the member directly, the member is responsible for paying the out-of-network provider of services for all charges.

A separate claim form is required for each nonparticipating provider for which the member is requesting reimbursement. A separate claim form is required for each member when charges for more than one family member are being submitted.

**Where and When to Send Claims**

A claim must be filed within 120 days after the date of service. Any claims filed after this limit may be refused. Failure to file a claim within such time will not invalidate or reduce any claim if it is shown that it was not reasonably possible to give such notice and that notice was given as soon as reasonably possible. Claims will be processed in accordance with the timeframe as required by state law for prompt payment to the extent such laws are applicable. Members should make copies of the

bills for their own records and attach the original bills to the completed claim form. The bills and the claim form must be submitted to the following address:

HMO Colorado  
CHP+ Claims  
P.O. Box 5747  
Denver, CO 80217-5747

**Payment in Error**

If CHP+ makes an erroneous benefit payment, CHP+ may require the member, the provider of services or the ineligible person to refund the amount paid in error. CHP+ reserves the right to correct payments made in error by offsetting the amount paid in error against new claims. CHP+ also reserves the right to take legal action to correct payments made in error.

**Catastrophic Events**

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

**Changes to the Benefits Booklet**

No agent or employee of CHP+ may change this benefits booklet by giving incomplete or incorrect information, or by contradicting the terms of this certificate. Any such situation will not prevent CHP+ from administering this Benefits Booklet in strict accordance with its terms. Oral or written statements do not supercede the terms of this benefits booklet.

**Fraudulent Insurance Acts**

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

Insurance fraud results in cost increases for health care coverage. Members may help decrease these costs by doing the following:

- Be wary of offers to waive Co-payments. This practice is usually illegal.
- Be wary of mobile health testing labs. Ask what the insurance company will be charged for the tests.
- Always review the benefits booklet received from CHP+. If there are any discrepancies, call HMO Colorado at 877.523.8171.
- Be very cautious about giving the member's health insurance coverage information over the phone.

If fraud is suspected, a member's parent or guardian should contact HMO Colorado's Dedicated Services Department.

CHP+ reserves the right to recoup any benefit payments paid on behalf of a member if the member or his or her parent or guardian has committed fraud or material misrepresentation in applying for coverage or in receiving or filing for benefits.

### **Independent Contractors**

CHP+ has an independent contractor relationship with CHP+'s participating providers; physicians and other providers are not agents or employees of CHP+, and CHP employees are not employees or agents of any of CHP+'s participating providers. CHP+ has no control over any diagnosis, treatment, care or other service provided to a member by any facility or professional providers. CHP+ is not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the member while receiving care from any of CHP+ participating providers by reason of negligence or otherwise.

CHP+ may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include, but is not limited to, prescription drugs and mental health and substance abuse services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims payment or customer service duties on behalf of CHP+.

### **Notice of Privacy Practices**

HMO Colorado is committed to protecting the confidential nature of members' medical information to the fullest extent of the law. In addition to various laws governing member privacy, HMO Colorado has its own privacy policies and procedures in place designed to protect member information. HMO Colorado is required by law to provide individuals with notice of HMO Colorado's legal duties and privacy practices. To obtain a copy of this notice, visit [www.anthem.com](http://www.anthem.com) or contact HMO Colorado's Dedicated Services Department.

### **No Withholding of Coverage for Necessary Care**

CHP+ does not compensate, reward or incent, financially or otherwise, CHP+'s associates for inappropriate restrictions of care. CHP+ does not promote or otherwise provide an incentive to employees or physician reviewers for withholding benefit approval for medically necessary services to which the member is entitled. Utilization review and benefit coverage decision-making is based on appropriateness of care and service and the applicable terms of this certificate. CHP+ does not design, calculate, award or permit financial or other incentives based on the frequency of denials of authorization for coverage, reductions or limitations on hospital lengths of stay, medical services or charges, or telephone calls or other contacts with health care providers or members.

### **Paragraph Headings**

The headings used throughout this benefits booklet are for reference only and are not to be used by themselves for interpreting the provisions of the benefits booklet.

**Physical Examinations and Autopsies**

CHP+ has the right and opportunity, at CHP+'s 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, CHP+ may request an autopsy where it is not forbidden by law.

**Refusal to Follow Recommended Treatment**

If a member or his or her parent or guardian refuses treatment that has been recommended by CHP+ participating provider, the provider may decide that such refusal compromises the provider-patient relationship and obstructs the provision of proper medical care. Providers will try to render all necessary and appropriate professional services according to a member's or his or parent or guardian's wishes, when they are consistent with the provider's judgment. If a member or his or her parent or guardian refuses to follow the recommended treatment or procedure, the member is entitled to see another provider of the same specialty for a second opinion. The member can also pursue the appeal process. If the second provider's opinion upholds the first provider's opinion and the member or his or her parent or guardian still refuses to follow the recommended treatment, then the member's coverage may be terminated by CHP+ following a 30-day notice to the member's parent or guardian. If coverage is terminated, neither CHP+ nor any provider associated with CHP+ will have any further responsibility to provide care to the member. CHP+ may also cancel any member's coverage who acts in a disruptive manner that prevents the orderly operation of any CHP+ participating provider.

**Sending Notices**

All member notices are considered sent to and received by the member's parent or guardian when deposited in the United States mail with postage prepaid and addressed to the member or his or her parent or guardian at the latest address in CHP+'s membership records

**Time Limit on Certain Defenses**

After one year from the date of issue of this coverage, no misstatements, except fraudulent misstatements, made by the member or his or her parent or guardian in the application for coverage will be used to void the coverage or to deny a claim for a loss incurred or a disability (as defined in the policy) commencing after the expiration of such one-year period.

The foregoing policy provision shall not be so construed to affect any legal requirement for avoidance of a policy or denial of a claim during such initial one-year period, nor to limit the application of information in this provision in the event of misstatement with respect to age or occupation or other insurance. After this policy has been in force for a period of one year during the lifetime of the member (excluding any period during which the member is disabled), it shall become incontestable as to the statements contained in the Enrollment Application and Change Form.

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

## 9: Coordination of Benefits and Subrogation

### Coordination of Benefits (COB)

This plan does not coordinate benefits with any other coverage except Medicare in which CHP+ pays as secondary. Members with Medicare A are to be coordinated with Medicare A *and* B as primary over CHP+ even though they do not have Part B. It is not acceptable to have double coverage. Double coverage exceptions include; Indigent Care and the Health Care Program for Children with Special needs (HCP) in which CHP+ pays primary over. If the subscriber is covered by any other valid coverage, including Medicaid and individual non-group coverage, he or she is not eligible for CHP+. If your child has access to the State of Colorado Employee Benefits Plan, he or she is not eligible for CHP+.

### Workers' Compensation

To recover benefits under workers' compensation insurance for a work-related illness or injury, the member or his or her parent or guardian must pursue the member's 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. CHP+ may pay conditional claims during the appeal process if the member or his or her parent or guardian signs a reimbursement agreement to reimburse CHP+ for up to 100 percent of benefits paid that duplicate benefits paid from another source.

Services and supplies resulting from work-related illness or injury are not a benefit under this benefits booklet, except for corporate officers who may opt out of workers' compensation coverage, pursuant to state or federal law.

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.

CHP+ **will not pay** benefits for services and supplies resulting from a work-related illness or injury even if other benefits are not paid **because**:

- The member or his or her parent or guardian fails to file a claim within the filing period allowed by the applicable law.
- The member obtains care that is not authorized by workers' compensation insurance.
- The member's employer fails to carry the required workers' compensation insurance. In this case, the employer becomes liable for any of the employee's work-related illness or injury expenses.
- The member or his or her parent or guardian fails to comply with any other provisions of the Workers' Compensation Act.

### Automobile Insurance Provisions

CHP+ will coordinate the benefits of this benefits booklet with the benefits of a complying automobile insurance policy. A complying automobile insurance policy is an insurance policy

approved by the Colorado Division of Insurance that provides at least the minimum coverage required by law, and one, which is subject to the Colorado Auto Accident Reparations Act or Colorado Revised Statutes §§ 10-4-601 through 10-4-633. Any state or federal law requiring similar benefits through legislation or regulation is also considered a complying policy.

### **How CHP+ Coordinates Benefits with Complying Policies**

Member benefits under this benefits booklet may be coordinated with the coverages afforded by complying policy. After any primary coverages offered by the complying policy are exhausted, CHP+ will pay benefits subject to the terms and conditions of this benefits booklet. If there is more than one complying policy that offers primary coverage, each will pay its maximum coverage before CHP+ is liable for any further payments.

A member or his or her parent or guardian must fully cooperate with CHP+ to make sure that the complying policy has paid all required benefits. CHP+ may require members to take a physical examination in disputed cases. If there is a complying policy in effect, and the member or his or her parent or guardian waives or fails to assert the member's rights to such benefits, this plan will not pay those benefits that could be available under a complying policy.

CHP+ may require proof that the complying policy has paid all primary benefits prior to making any payments to the member. Alternatively, CHP+ may but is not be required to pay benefits under this Benefits Booklet and later coordinate with or seek reimbursement under the complying policy. In all cases, upon payment, CHP+ is entitled to exercise its rights under this certificate and under applicable law against any and all potentially responsible parties or insurers. In that event, CHP+ may exercise the rights found in the ADMINISTRATIVE INFORMATION section, under the heading Third Party Liability: Subrogation.

### **What Happens If a Member Does Not Have Another Policy**

CHP+ will pay benefits for injuries received by the member while the member is riding in or operating a motor vehicle that the member or his or her parent or guardian owns if the vehicle is not covered by an automobile complying policy as required by law.

CHP+ will also pay benefits under the terms of the benefits booklet for injuries sustained by a member who is a non-owner-operator, passenger or pedestrian involved in a motor vehicle accident if that member's injuries are not covered by a complying policy. In that event, CHP+ may exercise the rights found in the ADMINISTRATIVE INFORMATION section, under the heading Third Party Liability: Subrogation.

### **Third-Party Liability: Subrogation**

Third-party liability exists when someone other than the member or his or her parent or guardian is legally responsible for the member's condition or injury. CHP+ will not pay for any services or supplies under this benefits booklet for which a third party is liable.

However, CHP+ may provide benefits under the following conditions:

- When it is established that a third-party liability does not exist.

- When the member or his or her parent or guardian guarantees in writing to reimburse CHP+ for any claims paid by CHP+ on the member's behalf if the third party later settles with the member for any amount, or if the member recovers any damages in court.

**CHP+'s Rights Under Third-Party Liability**

When a third party is or may be liable for the costs of any covered expenses payable to the member or on the member's behalf under this benefits booklet, CHP+ has subrogation rights. This means that CHP+ has the right, either as co-plaintiffs or by direct suit, to enforce the member's claim against a third party for the benefits paid to the member or on the member's behalf.

**Member Obligations Under Third-Party Liability**

The member or his or her parent or guardian has an obligation to cooperate in satisfying CHP+'s subrogation interest or to refrain from taking any action that may prejudice CHP+'s rights under this Benefits Booklet. If CHP+ must take legal action to uphold CHP+'s rights and if CHP+ prevails in that action, CHP+ will be entitled to receive, and the member or his or her parent or guardian will be required to pay, CHP+'s legal expenses, including attorneys' fees and court costs.

If a third party is or may be liable for any expenses payable to a member or on a member's behalf under this certificate, then the following must occur:

- The member or his or her parent or guardian must promptly notify CHP+ of the member's claim against the third party.
- The member or his or her parent or guardian and the member's attorney must provide for the amount of benefits paid by CHP+ in any settlement with the third party or the third party's insurance carrier.
- If the member receives money for the claim by suit, settlement or otherwise, the member or his or her parent or guardian must fully reimburse CHP+ for the amount of benefits provided to the member under this certificate. The member or his or her parent or guardian may not exclude recovery for CHP+'s health care benefits from any type of damages or settlement recovered by the member.
- The member or his or her parent or guardian must cooperate in every way necessary to help CHP+ enforce CHP+'s subrogation rights.

NOTE: Failure to comply with obligations in this section may result in termination of coverage under this benefits booklet.

## 10: Complaints, Appeals and Grievances

This section explains what to do if a member or his or her parent or guardian disagrees with HMO Colorado's denial, in whole or in part, of a claim or requested service or supply, and it includes instructions for initiating a complaint, filing an appeal or filing a grievance with HMO Colorado.

### Complaints

If a member or his or her parent or guardian has a complaint about any aspect of CHP+'s service or claims processing, the member or his or her parent or guardian should contact HMO Colorado at 877-811-3106. A trained representative will work to clear up any confusion and resolve the member's or his or her parent or guardian's concerns. A member or his or her parent or guardian may submit a written complaint to the address listed below. If the member or his or her parent or guardian is not satisfied with the resolution of the member's or his or her parent's or guardian's concerns by the customer service associate, an appeal may be filed on behalf of the member as explained under the Appeals heading in this section.

### Appeals

While CHP+ encourages members or their parents or guardians to file appeals within 60 days of an adverse benefit determination, a written appeal on behalf of the member must be received by CHP+ within 180 days of the adverse benefit determination. Appeals may be for pre-service denials or post-service denials. CHP+ will assign a customer advocate to assist the member or his or her parent or guardian in the appeal process.

Written complaints and appeals may be sent to the following address:

HMO Colorado  
Appeals Department  
P.O. Box 5425  
Denver, CO 80217-5425

An appeal may be filed with or without first submitting a complaint. In the appeal, the member or his or her parent or guardian must state plainly the reason(s) the claim or requested service or supply should not have been denied. The member or his or her parent or guardian should include any documents not originally submitted with the claim or request for the service or supply, and any information that may have a bearing on CHP+'s decision. For a thorough, unbiased review, the member or his or her parent or guardian may access two internal levels of appeal. In the case of a benefit denial based on utilization review, an independent external review appeal is also available to the member.

A member or this or her parent or guardian may designate a representative (e.g., the member's physician or anyone else of the member's or his or her parent or guardian's choosing) to file any level of appeal review with CHP+ on the member's behalf. The member or his or her parent or guardian must give this designation to CHP+ in writing.

**Level 1 Appeal**

At this appeal level, HMO Colorado appoints an internal person(s) not involved in the initial determination to review the denial of the claim or requested service or supply. A person who was previously involved with the denial may answer questions. The person(s) appointed to review a Level 1 Appeal involving utilization review shall consult with an appropriate clinical person(s) in the same specialty as would typically manage the case being reviewed. For pre-service and post-service utilization review issues, the member or his or her parent or guardian will receive a response to the Level 1 Appeal within 20 business days (or no later than 30 calendar days) of receipt of the appeal request. Non-utilization pre-service review appeals will typically be resolved within 30 calendar days. Non-utilization post-service appeals will be resolved in 60 calendar days.

**Level 2 Appeals**

This is a voluntary level of appeal of an adverse benefit determination that has not been resolved to the satisfaction of the member or his or her parent or guardian under the Level 1 Appeal process. The Level 2 Appeal must be requested within 60 calendar days after the member or his or her parent or guardian receives HMO Colorado's adverse determination from the Level 1 Appeal. The member or his or her parent or guardian may appear or be teleconferenced in to present testimony, introduce documentation the member or his or her parent or guardian believes supports the appeal and provide documentation requested by HMO Colorado at a hearing concerning the appeal.

The panel of reviewers shall include a minimum of three people and may be comprised of HMO Colorado associates who have appropriate professional expertise. A majority of the panel shall be persons who were not previously involved in the dispute; however, a person who was previously involved with the dispute may be a member of the panel or appear before the panel to present information or answer questions. In the case of utilization review appeals, the majority of the persons reviewing the appeal shall be health care professionals who have appropriate expertise. Such reviewing health care professionals shall meet the following criteria:

- They have not previously been involved in the member's care.
- They are not members of the health plan's board of directors.
- They have not previously been involved in the review process for the member.
- They do not have a direct financial interest in the case or in the outcome of the review.

HMO Colorado will issue a copy of the written decision to the member or his or her parent or guardian and to the provider who submits an appeal on the member's behalf, if any, within 50 business days of HMO Colorado's receipt of the Level 2 Appeal request. The appeal decision timeframes may be extended if the member or his or her parent or guardian requests or voluntarily agrees to the extension.

**Expedited Appeals**

A member or his or her parent or guardian or member's representative has the right to request an expedited appeal of a utilization review decision when the timeframes for a standard review would seriously jeopardize the member's life or health; jeopardize the member's ability to regain maximum function; or, for persons with a disability, create an imminent and substantial limitation on the member's existing ability to live independently. Typically the decision will be made as soon as possible, but no later than within 72 hours. Expedited appeals will be evaluated by an appropriate

clinical peer or peers who were not involved in the initial denial. HMO Colorado will not provide an expedited review for retrospective denials.

**Independent External Review Appeals**

Independent External Review Appeals are conducted by independent external review entities, which are selected by the Colorado Division of Insurance. Independent External Review Appeals are available only when claims or requested services or supplies were denied based on utilization review, and which have gone through HMO Colorado's Level 2 Appeal process. To request an Independent External Review Appeal, the member or his or her parent or guardian or member's representative must complete and submit a written request on the Request for Independent External Review of Carrier's Final Adverse Determination Form. This form is available through HMO Colorado's Dedicated Services Department. The request must be made within 60 calendar days after the date of receipt of notice of the Level 2 Appeal denial. The Division of Insurance will assign an independent external review entity to conduct the review. The independent reviewer's decision will be made within 30 business days after HMO Colorado receives a request for such a review. This timeframe may be extended up to 10 business days for the consideration of additional material if requested by the independent external review entity.

**Expedited Independent External Review Appeals**

Expedited Independent External Review Appeals reviews may be requested by a member or his or her parent or guardian or the member's representative if the member has a medical condition where the timeframe for a standard independent external review appeal would seriously jeopardize the member's life or health; jeopardize member's ability to regain maximum function; or, for persons with a disability, create an imminent and substantial limitation on the member's existing ability to live independently. The request must include a physician's certification that the member's medical condition meets the criteria for an Expedited Independent External Review Appeal. The request must be made on the form referenced in the previous paragraph. Determinations will be made by the independent external review entity within seven business days after HMO Colorado receives a request for an Expedited Independent External Review Appeal. This timeframe may be extended for an additional five business days for the consideration of additional information if requested by the independent external review entity. An Expedited Independent External Review Appeal may not be provided for retrospective denials.

A member may send a written grievance to the following address:

HMO Colorado  
PO Box 5747  
Denver, CO 80217-5747

Receipt of the member's grievance will be acknowledged by HMO Colorado's quality management department, which will investigate the grievance. HMO Colorado treats each grievance investigation in a strictly confidential manner.

**Binding Arbitration**

The binding arbitration provision under this benefits booklet is applicable to claims arising under all individual plans, governmental plans, church plans, plans or claims to which ERISA preemption does not apply, and plans maintained outside the United States. Any such arbitration will be governed by the procedures and rules established by the American Arbitration Association, provided, however, that no formal discovery shall be allowed, unless agreed to by the parties. Members or their parents or guardians may obtain a copy of the Rules of Arbitration by calling HMO Colorado's Dedicated Services Department. The law of the State of Colorado shall govern the dispute. The arbitration decision is binding on both the member or his or her parent or guardian and CHP+. Judgment on the award made in arbitration may be enforced in any court with proper jurisdiction. If any person subject to this arbitration clause initiates legal action of any kind, CHP+ may apply for a court of competent jurisdiction to enjoin, stay or dismiss any such action and direct the parties to arbitrate in accordance with this provision.

Damages, if any, are limited to the amount of the benefit payment in dispute, plus reasonable costs. CHP+ is not liable for punitive damages or attorney fees.

**Legal Action**

Before a member or his or parent or her guardian takes legal action on a claim decision, the process outlined under the Appeals heading in this section must first be followed and the member must meet all the requirements of this benefits booklet.

No action in law or in equity shall be brought to recover on this benefits booklet before the expiration of 60 calendar days after a claim has been filed in accordance with the requirements of this benefits booklet. No such action shall be brought at all unless brought within three years after a claim has been filed as required by the benefits booklet.

## 11: Glossary

This section defines words and terms used throughout the certificate to help members and their parents or guardians understand the content. Members or their parents or guardians should refer to this section to find out exactly how a word or term is used, for the purposes of this certificate.

**Accidental injuries** - unintentional internal or external injuries, e.g., strains, animal bites, burns, contusions and abrasions that result in trauma to the body. Accidental injuries are different from illness-related conditions and do not include disease or infection.

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

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

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

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

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

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

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

**Ancillary services** - services and supplies (in addition to room expenses) that hospitals, substance abuse treatment centers and other facilities bill for and regularly make available for the treatment of the member’s condition. Such services include, but are not limited to the following:

- Use of an operating room, recovery room, emergency room, treatment rooms and related equipment; intensive and coronary care units.

- Drugs and medicines, biologics (medicines made from living organisms and their products) and pharmaceuticals.
- Medical supplies (dressings and supplies, sterile trays, casts, and splints used instead of a cast).
- Durable medical equipment owned by the facility and used during a covered admission.
- Diagnostic and therapeutic services.
- Blood processing and transportation and blood handling costs and administration.

**Anesthesia** - the loss of normal sensation or feeling. There are two different types of anesthesia:

- General anesthesia, also known as total body anesthesia, causes the patient to become unconscious or put to sleep for a period of time.
  - Regional or Local anesthesia causes loss of feeling or numbness in a specific area without causing loss of consciousness and is usually injected with a local anesthetic drug such as Lidocaine.
- Anesthesia must be administered by a physician or certified registered nurse anesthetist (CRNA).

**Annual enrollment fee** - families may be charged an annual fee for children to be enrolled in CHP+. The enrollment fee, if any, will be calculated once CHP+ determines eligibility. CHP+ does NOT want families to send in payment with their application. The calculation will be based on family income and number of eligible children. The annual enrollment fee may be \$25 to enroll one child in the program and \$35 to enroll two or more children in the program for an entire year of coverage. Most families will **not** have to pay an annual enrollment fee.

**Appeal** - a process for reconsideration of CHP+'s decision regarding a member's claim.

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

**Authorization** - approval of benefits for a covered procedure or service. See also "Preauthorization".

**Benefits booklet** - this document (certificate) explains the benefits, limitations, exclusions, terms, and conditions of a member's health coverage. This document also serves as a contract between CHP+ and its members.

**Billed charges** - a provider's regular charges for services and supplies as offered to the public generally and without any adjustment for any applicable CHP+ participating provider or other discounts.

**Biologically based mental illnesses** - schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder and panic disorder.

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

**Calendar year** - a period of a year beginning and ending with the dates that are conventionally accepted as marking the beginning and end of a numbered year or a period of time equal in length to that of a year. In some cases, a member may receive less than 12 months coverage or gaps in coverage whereby the coverage spans add up to 12 months.

**Case management** - a plan of medically necessary and appropriate health care that is aimed at promoting more effective interventions to meet member needs and optimize care. Case management is also referred to as care management.

**Case manager** - a professional (e.g., nurse, doctor or social worker) who works with members and their parents or guardians, providers and CHP+ to coordinate services deemed medically necessary for the member. A case manager is also referred to as a care manager.

**Certificate** - this document (benefits booklet) explains the benefits, limitations, exclusions, terms and conditions of the health care coverage.

**Chemical dependency** - dependence on either alcohol and/or other substances; for example, drugs.

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

**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.

**CHP+ participating provider** - a professional health care provider or facility (i.e., a physician, hospital or home health agency) that contracts with CHP+ to provide services to CHP+ members. Participating providers agree to bill CHP+ directly for services provided and to accept this plan's payment amount (provided in accordance with the provisions of the contract) and a member's co-payment as payment in full for covered services. CHP+ pays the participating provider directly. CHP+ may add, change or delete specific providers at its discretion or recommend a specific provider for specialized care as medical necessity warrants.

**CHP+ service area** - the geographic area where CHP+ enrollment is available.

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

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

**Complaint** - an expression of dissatisfaction with CHP+'s services or the practices of a participating provider, whether medical or non-medical in nature.

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

**Consultation/second opinion** - a service provided by another physician at the request of the attending physician in charge of a specific case or the PCP who gives an opinion about the

treatment of the member's condition. The consulting physician often has specialized skills that are helpful in diagnosing or treating the illness or injury.

**Co-payment** - the amount that is a portion of a claim or medical expense that a member or his or her parent or guardian must pay out of pocket to a provider or a facility for each service. A co-payment is a predetermined fixed amount paid at the time the service is rendered. The co-payment amount is printed on each member's health care ID card.

**Cosmetic services** - beautification procedures, services or surgery performed on a physical characteristic to improve an individual's appearance.

**Cost sharing** - the general term used for out-of-pocket expenses paid by a member or his or her parent or guardian.

**Covered services** - services, supplies or treatments that are:

- Medically necessary or otherwise specifically included as a benefit under this certificate
- Within the scope of the license of the provider performing the service
- Rendered while coverage under this certificate is in force
- Not experimental/investigational or otherwise excluded or limited by the certificate, or by any amendment or rider thereto
- Authorized in advance by CHP+ if such pre-authorization is required by the certificate

**Cryocuff** - a water circulating pad with a pump that circulates fluid through a specially designed pad to provide continuous cold or heat therapy to a specific area.

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

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

**Detoxification** - acute treatment for withdrawal from the physical effects of alcohol or other substance.

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

**Dialysis** - the treatment of acute or chronic kidney ailment during which impurities are removed from the body with dialysis equipment.

**Discharge planning** - the evaluation of a member's medical needs and arrangement of appropriate care after discharge from a facility.

**Drug formulary** - a list of prescription drugs approved for use by CHP+. This list is subject to periodic review and modification by CHP+.

**Durable medical equipment** - 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 under this certificate begins.

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

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

**Experimental or investigative procedures or services -**

**(a)** Any drug, 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 CHP+ determines, in its sole discretion, to be experimental or investigational.

CHP+ will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply to be experimental or investigational if it determines 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, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply:

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA) or any other state or federal regulatory agency, and such final approval has not been granted
- Has been determined by the FDA to be contraindicated for the specific use
- Is provided as part of a clinical research protocol or clinical trial, or is provided in any other manner that is intended to evaluate the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function
- Is provided pursuant to informed consent documents that describe the drug, 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, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is under evaluation

**(b)** Any service not deemed experimental or investigational based on the criteria in subsection (a) may still be deemed to be experimental or investigational by CHP+. In determining if a service is experimental or investigational, CHP+ will consider the information described in subsection (c) and assess all of the following:

- Whether the scientific evidence is conclusory concerning the effect of the service on health outcomes

- Whether the evidence demonstrates that the service improves the net health outcomes of the total population for whom the service might be proposed as any established alternatives
- Whether the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings

(c) The information CHP+ considers or evaluates to determine if a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is experimental or investigational under subsections (a) and (b) may include one or more items from the following list, which is not all-inclusive:

- Randomized, controlled, clinical trials published in an authoritative, peer-reviewed United States medical or scientific journal
- Evaluations of national medical associations, consensus panels and other technology evaluation bodies
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate or investigate the use of the drug, 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 physicians, other medical professionals or facilities, or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply
- The written protocol(s) used by the treating physicians, other medical professionals or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply
- Medical records
- The opinions of consulting providers and other experts in the field

(d) CHP+ has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is experimental or investigational.

**Explanation of Benefits** - also known as an EOB, a printed form sent by an insurance company to a member after a claim has been filed and adjudicated. The EOB includes such information as the date of service, name of provider, amount covered and patient balance. An explanation of Medicare benefits, or EOMB, is similar, except it is sent following submission of a Medicare claim.

**Formulas** - authorized formulas for metabolic disorders, total parenteral nutrition, enteral nutrition and nutrition products and formulas for gastrostomy tubes for documented medical need, include attainment of normal growth and development.

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

**Grievance** - a written complaint about the quality of care or service a member receives from a provider.

**Health benefit ID card** - the card CHP+ gives members with information such as the member's name, number, date issued, co-payment amount (if applicable).

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

**Holistic medicine** - various preventive and healing techniques that are theoretically 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 is primarily engaged in arranging and providing nursing services, home health aide services, and other therapeutic and related services.

**Home health care** - the general term for skilled nursing, occupational therapy and other health-related services provided at home by an accredited agency.

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

**Hospice agency** - an agency licensed by the Colorado Department of Public Health and Environment to provide hospice care in this state. A hospice is a centrally administered program of palliative, supportive and interdisciplinary team services providing physical, psychological, spiritual and sociological care for terminally ill individuals and their families, within a continuum of inpatient care, home health care and follow-up bereavement services available 24 hours a day, seven days a week.

**Hospice care** - an alternative way of caring for terminally ill individuals that stresses palliative care rather than curative or restorative 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 member. Hospice care addresses physical, social, psychological and spiritual needs of the member and the member's family.

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

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

**Intractable pain** - a pain state in which the cause of the pain cannot be removed and which in the generally accepted course of medical practice no relief or cure of the cause of the pain is possible,

or none has been found after reasonable efforts, including, but not limited to, evaluation by the attending physician and one or more physicians specializing in the treatment of the area, system or organ of the body perceived as the source of the pain.

**IUD** - an acronym for intra-uterine device, a birth control device inserted into the uterus to prevent pregnancy.

**Keratoconus** – cone-shaped protrusion of the cornea.

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

**Long-term Acute Care Facility** - an institution that provides an array of long-term critical care services to members with serious illnesses or injuries. Long-term acute care is provided for members with complex medical needs. These include members with high-risk pulmonary conditions who have ventilator or tracheotomy needs, members who are medically unstable, members with extensive wound care needs or post-operative surgery wound care needs, and members with low-level closed-head injuries. Long-term acute care facilities do not provide care for low-intensity patient needs.

**Nephritis** - infection or inflammation of the kidney.

**Managed care** - a system of health care delivery, the goals of which 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 member for the diagnosis and care of a pregnancy, complications of pregnancy and for delivery. Delivery services include the following:

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

**Maximum medical improvement** - a determination at CHP+'s sole discretion that no further medical care can reasonably be expected to measurably improve a member'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 this plan, however certain covered services have maximum benefit limits per admission, per member's eligibility in a given calendar year, or per diagnosis.

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

**Medically necessary** - an intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that CHP+ solely determines to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the condition, illness, disease or injury
- Obtained from a physician and/or licensed, certified or registered provider
- Provided in accordance with applicable medical and/or professional standards
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes
- The most appropriate supply, setting or level of service that can safely be provided to the member and which cannot be omitted, and is consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained as an outpatient)
- Cost-effective compared to alternative interventions, including no intervention (cost effective does not mean lowest cost)
- Not experimental/investigational
- Not primarily for the convenience of the member, the member's family or the provider
- Not otherwise subject to an exclusion under this certificate

The fact that a physician and/or 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 drugs) required for the treatment of an illness or injury.

**Member** - any child, age 18 and younger, who is enrolled for coverage under this plan.

**Mental health condition** - non-biologically based mental conditions that have a psychiatric diagnosis or that require specific psychotherapeutic treatment, regardless of the underlying condition (e.g., depression secondary to diabetes or primary depression). CHP+ defines mental illness 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.

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

**Neurobiologically-based mental illness** - schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive compulsive disorder, and panic disorder. These disorders are defined as general conditions (see Glossary) and are not subject to the 20-visit limit for other mental illnesses.

**Nonparticipating provider** - an appropriately licensed health care provider that has **not** contracted with CHP+. CHP+ will not cover services provided by a nonparticipating provider. A member's family is financially responsible for such services unless the member is referred to the provider by

his or her PCP, and then only if the referral is approved by CHP+ or if a service does not require a referral.

**Nutrition assessment/counseling** - medical nutrition therapy is provided by a qualified nutrition professional such as a Registered Dietitian with training in pediatric nutrition. A Registered Dietitian is a referral provider for CHP+. Medical nutrition therapy includes nutrition assessment, support and counseling to determine a treatment plan to increase nutritional intake to promote adequate growth, healing and improved health.

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

**OMT** - an acronym for Osteopathic Manipulative Therapy, a hands-on modality of evaluation, diagnosis, and treatment using palpation of the body's tissues and musculoskeletal system with a variety of therapeutic techniques involving fascia, muscles, and joints to help resolve both acute and chronic musculoskeletal injuries.

**Organ transplants** - a surgical process that involves the removal of an organ from one person and placement of the organ into another person. Transplant can also mean removal of body substances, such as stem cells or bone marrow, for the purpose of treatment and re-implanting the removed organ or tissue into the same person.

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

**Orthotic** - a support or brace for weak or ineffective joints or muscles.

**Out-of-area services** - covered services provided to a member when he or she is outside the CHP+ service area. See CHP+ service area, above.

**Out-of-pocket annual maximum** - the cost-sharing total for which a member may be responsible under this certificate for medical expenses under his/her policy during a specified period. The out-of-pocket annual maximum is designed to protect members from catastrophic health care expenses. For each member's benefit period, after the out-of-pocket annual maximum is reached, for most services, payment will be made at 100 percent of the allowable charge for the remainder of the member's benefit year.

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

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

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

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

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

**PCP** - an acronym for primary care physician, a physician who has contracted with CHP+ to supervise, coordinate and provide initial and basic care to members, initiate a referral for specialist care and maintain continuity of patient care.

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

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

**Pre-authorization** - a process during which requests for services are reviewed, before services are rendered, for approval of benefits, length of stay and appropriate location.

### **Prescription Drugs and Medicines -**

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

**Formulary** A list of pharmaceutical products developed in consultation with physicians and pharmacists and approved for their quality and cost-effectiveness.

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

**Legend drug** A medicinal substance, dispensed for outpatient use, which under the Federal Food, Drug and Cosmetic Act is required to bear on its original packing label, "Caution: Federal law prohibits dispensing without a prescription." Compounded medications that contain at least one

such medicinal substance are considered to be prescription legend drugs. Insulin is considered a prescription legend drug under this certificate.

**Pharmacy** - an establishment licensed to dispense prescription drugs and other medications through a licensed pharmacist upon an authorized health care professional's order. A pharmacy may be a CHP+ participating provider or a nonparticipating CHP+ provider. A participating pharmacy is contracted with CHP+ to provide covered drugs to members under the terms and conditions of this certificate. A nonparticipating pharmacy is not contracted with CHP+.

**Pre-authorization** - the process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. HMO Colorado's pharmacy and therapeutics committee define the drugs and criteria for coverage.

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

**Private-duty nursing services** - services that require the training, judgment and technical skills of an actively practicing registered nurse (R.N.) or licensed practical nurse (L.P.N.) Such services must be prescribed by the attending physician 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 physician or other professional provider who is licensed or otherwise authorized by the state or jurisdiction where services are provided to perform designated health care services. For benefits to be payable, services of a provider must be within the scope of the authority granted by the license and covered by this certificate. Such services are subject to review by a medical authority appointed by CHP+. 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 CHP+.

*Facility provider.* An inpatient and outpatient facility provider, as defined below:

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

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

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

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

**Referral** - authorization given to a member to visit another provider. The member's PCP generally initiates a referral.

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

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

- Payment of Colorado income tax
- Employment in Colorado, other than that normally provided on a temporary basis to students
- Ownership of residential real estate property in Colorado
- State identification card or driver's license
- Acceptance of future employment in the state of Colorado
- Vehicle registered in Colorado
- Voter registration in Colorado
- Phone bill or utility bill from Colorado

**Room expenses** - expenses that include the cost of the room, general nursing services and meal services for the member.

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

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

**Second surgical opinion** - a mechanism used by managed care organizations to reduce unnecessary surgery by encouraging individuals to seek a second opinion before specific elective surgeries. In some cases, the health coverage may require a second opinion before a specific elective surgery.

**Skilled nursing care facility** - an institution that provides skilled nursing care, e.g., therapies and protective supervision for members with uncontrolled, unstable or chronic conditions. Skilled

nursing care is provided under medical supervision to carry out non-surgical treatment of chronic diseases or convalescent stages of acute diseases or injuries. Skilled nursing facilities do not provide care for members with high intensity medical needs, or for members 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 physician, devoted to a specific disease, condition or body part. Example: orthopedist- a physician 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 member's condition is improving but the member is not ready for a skilled nursing facility or home health care.

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

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

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

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

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

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

**Utilization management** - a process of integrating review of medical services and care management in a cooperative effort with other parties, including patients, physicians, and other health care providers and payers.

**Utilization review** - a set of formal techniques 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 reviews to determine coverage.

This is based on whether a procedure or treatment is considered experimental/investigational in a given circumstance (except if it is specifically excluded under this certificate), 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 physician visit that includes the following components: an age-appropriate physical exam, history, anticipatory guidance, and education (e.g., examining family functioning and dynamics, injury prevention counseling, discussing dietary issues, reviewing age-appropriate behaviors, etc.), and assessment of growth and development. For older children, a well-child visit also includes safety and health education counseling.

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

# Index

## A

acupuncture ..... 29,49,69  
 after hours care ..... 26,58,69  
 allergy tests..... 20  
 ambulance and transportation..... 27,69  
 ancillary services ..... 20,21,24,42,43,69  
 Anthem Behavioral ..... iii, 4,42,43,44  
 appeals..... 1,7,9,45,65,66,67,68,69  
 appropriate length of stay ..... 8  
 audiology ..... 29,47,70,75  
 authorizations ..... 2,42  
 automobile insurance..... 62

## B

biofeedback ..... 29,43,49  
 biologically based mental illness..... 41,43,70

## C

cardiac rehabilitation ..... 29  
 case management..... 6,9,10,71  
 certificate of creditable coverage ..... 13  
 changing your information ..... 2  
 chemical dependency ..... 19,50,71  
 chiropractic services ..... 50,71  
 cleft lip..... 28,37,38,39,40  
 cleft palate ..... 28,37,38,39,71  
 complaints ..... 1,7,9,65  
 coordination of benefits (COB)..... 24,62  
 co-payments ..... 1,2,11,12,57,59  
 cosmetic..... 6,7,23,24,37,39,46,50,72,79,81  
 court-ordered services ..... 50  
 custodial care..... 22,30,39,43,51,72

## D

Delta Dental..... 37,51  
 dental related services ..... 20,23,38,51  
 detoxification..... 9,20,41,55,72,82  
 developmental delays ..... 28  
 diabetes..... 20,37,40,45,46,54,77  
 diagnostic services..... 19,21,24,32,72  
 dialysis..... 21,23,24,72,80

dietary counseling ..... 30  
 domiciliary care ..... 44,51  
 double coverage ..... 5,52,63  
 drug abuse ..... 51,55,82  
 drug formulary ..... 44,73  
 durable medical  
 equipment... 7,29,30,35,36,39,40,45,70,73  
     payment limit ..... 36

## E

elective termination of  
 pregnancy..... 17,18,51,76  
 emergency care ..... 3,5,11,16,19,20,23,25,26  
 enrollment fees..... 11  
 enteral formula ..... 41  
 enteral therapy..... 41  
 exclusions and limitations.....  
     .3,7,15,16,18,19,20,22,23,24,25,26,27,28,29,  
     30,31,34,35,37,38,39,40,41,42,43,44,46,49,50,  
     61,70,71,72  
 experimental/investigational  
     ..... 6,7,15,34,50,52,72,73,74,77,83

## F

family planning ..... 11,16,17,19,57,81  
 family size ..... 11,57  
 food and nutrition..... 30,41,44,47  
 food and nutrition exclusions..... 41  
 formula(s)..... 28,30,40,41,44,47,52,53,74  
 fraudulent insurance acts..... 59

## G

general exclusions/limitations..... 15,49  
 genetic counseling..... 17,18,20,52  
 genetic testing ..... 52  
 grievances ..... 1,7,9,45,65

## H

hearing aid(s) ..... 37,47  
 hemodialysis ..... 75  
 home health care ..6,19,29,30,39,44,47,75,82  
 home infusion/injection therapy ..... 30  
 home IV therapy ..... 29,30,39,44  
 hospice care..... 6,7,19,30,39,40,75

**I**

immunizations ..... 11,16,17,57,80,81  
 inpatient admissions ..... 7,8  
 inpatient mental health services ..... 42  
 IUD ..... 17,76

**J**

jaw augmentation ..... 39,54

**K**

keratoconus ..... 36,76  
 keratoplasty ..... 23,25,48  
 keratotomy ..... 23,25,48

**L**

laboratory services ..... 18  
 learning deficiencies ..... 52  
 learning disorders ..... 28  
 lifetime maximum ..... 33,76  
 limitations ..... 3,7,15,39,42,50,61,71,72  
 long-term acute care ..... 8,20,22,76

**M**

mammoplasty ..... 56,82  
 maternity care ..... 9,18,19,27  
 maximum benefit ..... 33,35,36,76  
 medical nutritional therapy ..... 53  
 medical records ..... 3,9,26,55,74  
 medical supplies .....  
 ..... 29,30,35,36,37,45,70,75,77  
 Medicaid ..... 13,18,62  
 Medicare ..... 24,62,74  
 medications ..... 7,20,29,30,40,41,44,46,47,80  
 membership card ..... 2,3,11,57  
 mental health .....  
 ..... 4,17,19,20,23,30,41,42,43,55,60,77  
 metabolic disorders ..... 39,40,44,47,74  
 missed appointments ..... 53  
 morbid obesity ..... 21

**N**

neurobiological based mental illness ....43,77  
 neuropsychiatric testing .....53  
 newborn care ..... 18,20,22  
 newborn enrollment ..... 13  
 nicotine patches .....47  
 non-emergency care ..... 1,3,4,5,11,16,25,27  
 non-medical expenses .....53  
 non-participating hospital .....25  
 non-participating mental health professional  
 .....42  
 non-participating provider 25,42,48,58,78,80  
 Norplant .....17  
 nutritional counseling.....29  
 nutritional therapy .....53

**O**

obesity .....21,40,41,79  
 occupational accidents .....62  
 occupational disease laws .....62  
 occupational therapy .....28,29,75,78  
 One Nation ..... iii, 4,42,43,44  
 oral surgery ..... 19  
 orthopedic appliance(s) .....29,36,78  
 orthotics .....37,54  
 other insurance .....5,33,55,61  
 out-of-pocket annual maximum ..... 12,78  
 outpatient care ..... i, 27,42  
 outpatient mental health services .....43  
 outpatient procedures .....8  
 outpatient services .....39,43,55  
 outpatient services exclusions .....24  
 oxygen .....29,35,36,69

**P**

palliative care .....30,75,79  
 paternity ..... 17,18,52  
 pathology services .....20,75,76,82  
 pediatric weight management .....40,79  
 physical exams ..... 16,80,81  
 physician office services ..... 18,19,20  
 physical therapy .....2,28,29,32,75,79  
 post termination benefits .....54  
 pre-authorization .....  
 2,6,7,8,15,18,19,20,22,23,25,31,32,35,37,39,4  
 1,42,44,45,52,72,79,80

pregnancy ..... 8,17,18,20,44,51,54,55,76  
 prenatal ..... 6,18,47  
 prescriptions ..... 46,47  
 preventive care ..... 2,4,16,19,47,80  
 primary care physicians (PCP) ..... 2  
     changing ..... 3  
     referrals ..... 4  
     selecting ..... 3  
     visiting ..... 3  
 private duty nursing ..... 31,54  
 prosthesis ..... 21,37,52,80  
 prosthetic devices ..... 35,36

**R**

radiation therapy ..... 21,24,81  
 radiology services ..... 19,54,83  
 reconstructive surgery ..... 81  
 referrals ..... ii, 2,3,4,15  
 refractive keratoplasty ..... 23,25,48  
 rehabilitation services ..... 41  
 reproductive health services ..... 16,17,81  
 respite care ..... 30  
 rhythm disorders ..... 28  
 Rocky Mountain Poison Control Center ..... iii  
 room expenses ..... 22,43,54,69,81  
 routine care ..... 81

**S**

second opinion ..... 19,21,61,72,81,83  
 second surgical opinion ..... 81  
 service area (CHP+) ..... 26,45,71,78  
 sex-change operations ..... 50,55  
 skilled nursing ..... 7,8,22,30,31,51,75,80,82  
 special care unit ..... 21,32,82  
 special change requests (PCP) ..... 4  
 special education ..... 52  
 specialist ..... 2,4,6,15,16,41,79,82  
 speech therapy ..... 21,28,31,38,75,82  
 stuttering ..... 28  
 subrogation ..... 24,55,62,63,64  
 substance abuse .....  
 4,19,20,23,30,41,42,43,49,50,51,55,60,69,80,  
 82  
 surgical assistants ..... 21,24  
 surgical services ..... 19,21,23,24,25,33,78,82

**T**

taxes ..... 55  
 temporomandibular joint surgery (TMJ) ... 55  
 terminally ill ..... 30,75  
 termination (active policy) ..... 13  
 termination of coverage ..... 64  
 termination (post-termination benefits) ..... 54  
 therapies  
     chemotherapy ..... 21,24,30,71  
     occupational ..... 21,28,29,31,75,78  
     physical ..... 2,28,29,32,75,79  
     radiation ..... 21,24,81  
     speech ..... 21,28,31,38,75,82  
 third party liability ..... 63  
 transition of care ..... 6  
 transplants ..... 31,33,34,35,52,78  
 transplant exclusions ..... 34  
 tubal ligation ..... 17,55

**U**

ultrasound ..... 18,20,55,79,82,83  
 urgent care ..... 11,19,20,23,25,26,27,57,69,82  
 urgent care exclusions ..... 26  
 utilization management ..... 9,83

**W**

weight loss/reduction programs .....  
 ..... 16,29,40,43,56  
 weight management ..... 40,79  
 well baby visits ..... 16  
 worker's compensation ..... 62

**X**

x-ray services ..... 2,19,21,24,55,81,83