State Managed Care Network and CHP+ Prenatal Care Program

CHP+ Member Benefits Booklet

Welcome!

Welcome to the Child Health Plan *Plus* (CHP+) State Managed Care Network, where our mission is to improve the health outcomes of the people we serve.

You have enrolled in a quality health benefit program that pays for many health care services, including outpatient care, emergency care and hospital inpatient care.

This CHP+ Member Benefits Booklet is a guide to your CHP+ benefits. Please review this document, as well as any enclosures, to become familiar with benefits, including their limitations and exclusions. Please keep this benefit booklet in a convenient place for quick reference. By learning how coverage works, you can help make the best use of your health care coverage.

This benefit booklet is also a guide to the CHP+ Prenatal Care Program which offers many benefits both during and after pregnancy. The CHP+ Prenatal Care Program is more than just prenatal care. We offer other medical care including visits to a doctor when you are sick, prescriptions, vision and mental health services. The coverage is good through 60 days after the end of your pregnancy. If you get other insurance, become covered by Medicaid or move out of Colorado, you are no longer eligible for CHP+ or the CHP+ Prenatal Care Program.

For questions about coverage, call the CHP+ Customer Service Department between the hours of 8:00 a.m. and 6:00 p.m. Monday through Friday. The local and toll-free Customer Service Department numbers are 303- 751-9051 or toll free 1-800-414-6198. These numbers are also conveniently printed at the bottom of every page of this CHP+ Member Benefits Booklet.

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

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

Attention State Managed Care Network Members

This benefit booklet gives you information about the State Managed Care Network and the CHP+ Prenatal Care Program including information about benefits and how the State Managed Care Network and CHP+ Prenatal Care Programs work. If you would like more information or have any questions please call the Customer Service Department at 303-751-9051 or 1-800-414-6198.

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

No employee of CHP+ or Colorado Access may change this CHP+ Member Benefits Booklet by giving incomplete or incorrect information, or by contradicting the terms of this CHP+ Member Benefits Booklet.

Please contact the State Managed Care Network (also referred to as the Plan) at 303-751-9051 or 1-800-414-6198 if you have any questions about your health care benefits.

Contact Information

Important Addresses

State Managed Care Network Customer Service
PO Box 17580
Denver, CO 80217-0580
303-751-9051
1-800-414-6198

Colorado Access TTY for the Hearing Impaired
720-744-5126 or 1-888-803-4494

Child Health Plan Plus
P O Box 929
Denver, CO 80201-0929
1-800-359-1991

Family Healthline
303-692-2229 or 1-800-688-7777

Rocky Mountain Poison Control Center
1-800-332-3073

Delta Dental
1-800-610-0201

Important Web Site Addresses

www.chpplusproviders.com
This Web site offers information on providers that are in-network with the State Managed Care Network.

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

www.coaccess.com
This site offers information on the State Managed Care Network, plan benefits, a provider directory, how to apply for CHP+, and other information about your health plan.

Si necesita información en español, llamenos al 303-751-9051 or 1-800-414-6198.

Important Things to Know About the State Managed Care Network Administered by Colorado Access

What is Colorado Access?
Colorado Access is a Colorado-based, non-profit health plan. While you are enrolled in the State Managed Care Network, Colorado Access is responsible for claims processing, referrals, authorizations, care management and utilization review. Colorado Access has a friendly staff to help you when you have questions about how to get health care. Please contact Colorado Access at 303-751-9051 or 1-800-414-6198 if you have any questions about your health care benefits.

Member ID card
All State Managed Care Network members receive a State Managed Care Network ID card. Bring this ID card with you when you get medical care. Tell all your health care providers that you have the State Managed Care Network. This includes all pharmacies (when you get prescription drugs), doctors, hospitals, and any medical supplies. Call the State Managed Care Network at 303-751-9051 or 1-800-414-6198 if you do not have an ID card.

Primary Care Providers
Your Primary Care Provider (PCP) is responsible for delivering and coordinating all of your care. A PCP can be a Family Medicine doctor, an Internal Medicine doctor or a General Practitioner. Your 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.

Do you have a Primary Care Provider?
It is important for you to choose an in-network PCP. Call the State Managed Care Network at 303-751-9051 or 1-800-414-6198 to choose a PCP. To see a listing of network providers, ask for a State Managed Care Network Provider Directory, or visit the State Managed Care Network Web site at www.chpplusproviders.com.

Selecting a PCP
You must choose a PCP that participates in the State Managed Care Network. You can find a list of PCPs in the State Managed Care Network Provider Directory. If you need a Provider Directory, call Customer Service at 303-751-9051 or 1-800-414-6198. You can also find a provider directory online at www.chpplusproviders.com.

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

Once you choose a PCP from the Provider Directory, please call Customer Service at 303-751-9051 or 1-800-414-6198 and a new ID card will be sent.

Remember:

- Choose your PCP. Call the State Managed Care Network at 303-751-9051 or 1-800-414-6198 and tell us which network PCP you want.
- Show your State Managed Care Network ID card when you get health care. Tell all your health care providers that you have the State Managed Care Network. This includes all pharmacies (when you get prescription drugs), doctors, hospitals, and any medical supplies.
- Call the State Managed Care Network at 303-751-9051 or 1-800-414-6198 for questions. We want to help you with your health care needs.

Frequently Asked Questions and Special Concerns for CHP+ Prenatal Care Program Members

Do I need a referral for prenatal care?
No. You do not need a referral to see an in-network OB/GYN for any care related to your pregnancy. You can verify that your provider for prenatal care is in-network with CHP+ by calling Customer Service at 303-751-9051 or 1-800-414-6198.

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

What if I need care for medical issues not related to my pregnancy?
The CHP+ Prenatal Care Program is a comprehensive health care program for pregnant women. This means that the CHP+ Prenatal Care Program will cover medical needs unrelated to your pregnancy, as long as they are listed as covered benefits and considered medically necessary.

How will the CHP+ Prenatal Care Program know when I have had my baby?
After you have your baby, please contact CHP+ Eligibility and Enrollment at 1-800-359-1991 as soon as possible so that there are not any problems paying claims. If you are unable to call CHP+ Eligibility and Enrollment, a family member, or your provider can also call. Please tell them the baby's name, date of birth and the social security number, if available. Your newborn will be enrolled as of the date of birth.

What if I call Customer Service and they advise me that I am not eligible or I have problems filling a prescription?
Customer Service will work with you to help answer questions about eligibility. You can also contact CHP+ Eligibility and Enrollment at 1-800-359-1991. Please ask the representative if you are covered by the CHP+ Prenatal Care Program.

How long does the CHP+ Prenatal Care Program coverage last?
If you are eligible for the program, your coverage will start the date your completed application is submitted. Your coverage will continue for at least 60 days after your pregnancy ends. Coverage with the CHP+ Prenatal Care Program terminates 60 days after the last day of the month in which your pregnancy ended. For example, if you give birth on June 26, your coverage would end on August 30.

What doctors and clinics will care for me under the CHP+ Prenatal Care Program?
For prenatal care, you may visit any of the State Managed Care Network's in-network prenatal providers.

To get a list of prenatal providers in your area, please visit our Web site at www.chpplusproviders.com or call Customer Service at 303-751-9051 or 1-800-414-6198. For regular medical care, you must see a Primary Care Provider (PCP) from the State Managed Care Network. If you need help finding a PCP, please call Customer Service at 303-751-9051 or 1-800-414-6198 or visit our Web site at www.chpplusproviders.com.

Summary of State Managed Care Network Benefits	
Service	**Available Benefits**
Preventive Care	Covered in full when provided by your Primary Care Provider (PCP). Includes immunizations, well-child, well-teen and routine exams.
Reproductive Health Care Services	Covered in full when provided by an in-network provider. Includes well-woman check-ups.
Medical Office visit	Primary Care Provider (PCP) visits and specialty visits covered.
Inpatient Hospital Stay	Covered in full.
Lab, X-ray & Diagnostic Services	Covered in full.
Outpatient Prescription Drugs	Covered in full if included on the formulary. Standard CHP+ copays are $0 to $5.
Skilled Nursing Facility	Covered in full.
Outpatient / Ambulatory Surgery	Covered in full.
Emergency Room and Urgent/ After-hours Care	Covered in full for a life or limb emergency. Standard CHP+ copays are $0 to $15.
Emergency Transport / Ambulance Services	Covered in full for a life or limb emergency.
Vision Services	Coverage for age-appropriate preventive care and specialty care. $50 benefit for the purchase of lenses, frames or contacts per calendar year.
Audiological Services	Coverage for age-appropriate preventive care. CHP+ Prenatal Care Program members may receive hearing aides for congenital conditions and traumatic injuries up to a maximum of $800 per calendar year.
Physical, Occupational and Speech Therapy	For outpatient physical rehabilitation (physical, occupational, and/or speech therapy) the standard CHP+ coverage is limited to 30 visits per calendar year. For children aged 0-3 the benefit of physical, occupational and speech therapy is unlimited.
Durable Medical Equipment	Maximum of $2,000 per calendar year, excluding eyeglasses, contacts or hearing aids.
Home Health Care	Skilled services covered with prior authorization
Maternity Care	All prenatal and delivery visits covered in full.
Behavioral or Mental Health	Coverage for medically necessary services and may require a prior authorization.
Alcohol and Substance Abuse	Coverage for medically necessary outpatient services and may require an authorization.
Transplant Services	Coverage for limited transplants with prior authorization.
Dental Care provided by Delta Dental	Periodic cleanings, exams, x-rays, fillings and root canals. A maximum benefit of $600 per person per calendar year. **Note**: Prenatal members receive emergency dental care only.
Exclusions: Services not shown above may not be covered. Call State Managed Care Network at 303-751-9051 or 1-800-414-6198 for more information. This is for summary purposes only and does not guarantee coverage.	

1: Member Rights & Responsibilities

As a member, you have the right to:

- Receive information regarding terms and conditions of your health care benefits
- Be treated respectfully and with consideration
- Receive all the benefits to which you are entitled under the CHP+ Member Benefits Booklet
- Obtain complete information from a provider regarding your 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 condition, regardless of cost or benefit coverage
- Participate with your provider(s) in decision-making about health care treatment
- Refuse treatment and be informed by a provider(s) of the medical consequences
- Receive wellness information to help you maintain a healthy lifestyle
- Express concerns and complaints to the State Managed Care Network about the care and services provided and to have the State Managed Care Network investigate and take appropriate action
- File a complaint or appeal a decision with the State Managed Care Network as outlined in the COMPLAINTS, APPEALS AND GRIEVANCES section without fear of reprisal
- Expect that your personal health information will be maintained in a confidential manner
- Make recommendations regarding your rights and responsibilities policies
- Receive information about the administrative services organization, managed care organization, its services, the practitioners and providers delivering care, and the rights and responsibilities of members

As a member, you have the responsibility to:

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

2: About Your Health Care Coverage

The State Managed Care Network has a network of doctors, hospitals, and other health care providers to make sure members get the health care services they need. Learning about the State Managed Care Network, can help you make the best use of your health care benefits.

The State Managed Care Network will work with you and your providers to make sure that you receive needed health care. Please work with your Primary Care Provider (PCP) to coordinate care with specialists and to get pre-authorizations for services when they are needed. This will help ensure that the care you receive is medically necessary, performed in the right setting, and is otherwise a covered service.

Identification Card (ID Card)

Your ID card shows that you are a member of the State Managed Care Network. Always bring your ID card when you need medical care. Have your ID card ready when you call for an appointment and show it to the receptionist when you sign in for your appointment. If you need a prescription, show the card to the pharmacy where it is filled. If you have not received your ID card or need a new ID card, please call Customer Service at 303-751-9051 or 1-800-414-6198.

Changing Your Information

If your membership information changes, such as changes to your address or if you would like to change your Primary Care Provider (PCP), call Customer Service at 303-751-9051 or 1-800-414-6198. Please also notify CHP+ Eligibility and Enrollment at 1-800-359-1991.

Prenatal Care

You do not need to obtain a referral from your PCP to see an in-network obstetrician or certified nurse-midwife for services related to your pregnancy. You may also see a Family Practice Physician who provides prenatal care. Please work with your Primary Care Provider (PCP) to coordinate care with specialists.

Getting Information about your Health Care Providers

To get information about health care providers, including physicians, nurses, specialists, and pharmacies, call the Colorado Division of Registration. This is the State agency that regulates providers in Colorado. They can tell you if a provider's license is active or in good standing. The Colorado Division of Registration can be reached at 303-894-7891.

Primary Care Providers (PCP)

Your PCP is responsible for delivering and coordinating all of your care. A PCP can be a Family Medicine doctor, an Internal Medicine doctor or a General Practitioner. Your 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.

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

Please work with your primary care provider (PCP) to coordinate care with specialists and to get pre-authorizations for services when they are needed A service that needs a referral is any covered service that cannot be performed by your PCP and is usually performed by a specialist. If the referral service requires pre-authorization, a PCP's referral alone does not guarantee or imply coverage for the services or procedures to be performed by the specialist.

If the State Managed Care Network does not have an in-network provider for a covered service, the State Managed Care Network will arrange for a referral with a provider with the necessary expertise.

Selecting a PCP

You must choose a Primary Care Provider (PCP) that participates in the State Managed Care Network. You can find a list of PCPs in the State Managed Care Network Provider Directory. If you need a Provider Directory, call Customer Service at 303-751-9051 or 1-800-414-6198. You can also find a provider directory online at www.chpplusproviders.com.

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

Once you choose a PCP from the Provider Directory, please call Customer Service at 303-751-9051 or 1-800-414-6198 and a new ID card will be sent.

Visiting a PCP

To visit a PCP, make an appointment with your PCP's office. The telephone number for the PCP can be found on your State Managed Care Network ID card. When you call, tell the office that you are a member of the CHP+ State Managed Care Network. The office will instruct you on next steps in a non-emergency situation.

If you need to cancel your appointment with your PCP, please call them at least 24 hours before the appointment. Talk to your PCP's office to find out if they have a cancellation policy. Your PCP may charge you a fee if you do not follow the cancellation policy. The State Managed Care Network will not pay for or reimburse for such a fee. You should also notify the PCP's office if you are going to be late for an appointment. The PCP may ask that the appointment be rescheduled.

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

- medical care after the PCP's normal business hours,
- medical care on weekends and holidays,
- non-emergency care within the service area for a condition that is not life threatening but that needs prompt medical attention.

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

Changing PCPs

You may change to another in-network PCP at any time during your eligibility period. Call Customer Service at 303-751-9051 or 1-800-414-6198 to change your PCP.
To have medical records transferred from one provider to another, contact your former PCP. You are responsible for any charges related to transferring your medical records.

Referrals

Your Primary Care Provider (PCP) provides basic health and medical services. This includes routine and preventive care. Sometimes you might need to visit a specialist or other provider. Your PCP will help coordinate your care by giving you a referral. A referral is the formal recommendation given to you by your PCP to get care from a specialist or a different provider. Your PCP will make sure that all important referral information is given to the specialist.

You do not need a referral from the PCP for:

- An emergent or urgent situation
- Care from an in-network OB/GYN provider 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 – You may self refer for mental health services; however, the services will require prior authorization from the State Managed Care Network and may be subject to benefit limits.

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

Other Insurance

Qualifying for the State Managed Care Network is contingent upon the absence of other insurance coverage excluding Indigent Care and the Health Care Program for Children with Special Needs (HCP). If you are covered by any other valid coverage, including Medicaid and individual non-group coverage, you are not eligible for the State Managed Care Network.

If you get other coverage, you must call CHP+ Eligibility and Enrollment at 1-800-359-1991. If you are found to have other insurance, your CHP+ coverage will be terminated (end). In some cases coverage will retroactively terminate for the time period the other insurance was effective. This means that we will go back and end your coverage on the date that your other insurance became effective (started). The exceptions to this rule are Medicare and Dental.

Newborn Enrollment

Contact the State Managed Care Network at 303-751-9051 or 1-800-414-6198 if you become pregnant and when you have the baby. This will help coordinate your prenatal care and coverage for the newborn. Call CHP+ Eligibility and Enrollment at 1-800-359-1991 after you have your baby. Your baby will be covered under your coverage for 30 days. Most babies born to teen mothers are eligible for Medicaid. However, some newborns may be covered by CHP+.

Newborns of women who are approved for the CHP+ Prenatal Care Program are automatically covered under the State Managed Care Network for 12 months from the date of birth. Please contact CHP+ Eligibility and Enrollment at 1-800-359-1991 to enroll your newborn.

Newborn Primary Care Provider (PCP) Assignment

Your newborn will be enrolled with your PCP on their date of birth. If your PCP only provides care to adults, the newborn will be assigned to a PCP that provides care to children. If you would like to choose a different PCP, call the State Managed Care Network at 303-751-9051 or 1-800-414-6198.

3: Managed Care

The State Managed Care Network uses some managed care tools or processes to help determine the most appropriate health care services for members. Some of the tools or processes used include:

- Pre-authorization for health care services,
- Concurrent hospital review,
- Care management and Disease Education, and
- Transition of care.

This section of the CHP+ Member Benefits Booklet explains these managed care tools or processes. This section will also help you understand the steps for obtaining care.

Pre-authorization

Some 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 services that require pre-authorization.

When reviewing a request for pre-authorization, the State Managed Care Network makes sure the service or supply is:

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

The pre-authorization process may set limits on coverage available under this CHP+ Member Benefits Booklet.

Pre-authorization is required before admission to a hospital or before receiving certain procedures or services (except in emergency situations, as explained in this booklet). Some drugs also require pre-authorization. The provider who schedules an admission or orders the procedures or service is responsible for getting pre-authorization. If you have any questions about pre-authorization, please call Customer Service at 303-751-9051 or 1-800-414-6198.

A pre-authorization does not guarantee payment. Fraud or abuse may cause a denial of payment. When the State Managed Care Network receives a claim, the State Managed Care Network will review the claims using the CHP+ Member Benefits Booklet as a tool for determining coverage.

Adverse Service Determinations

An adverse service determination means that the State Managed Care Network did not approve the pre-authorization request. The State Managed Care Network will send you and your provider a letter for all adverse service determinations. You can appeal the decision by following the procedure in the COMPLAINTS, APPEALS AND GRIEVANCES section of this booklet.

Covered Benefit Decisions

To decide if a service is a covered benefit, the State Managed Care Network considers:

- If the service is medically necessary,
- If the service is experimental/investigational,
- If the service is cosmetic, and
- If the service is excluded under this coverage.

To help make this decision, the State Managed Care Network uses a number of tools, including:

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

Medically Necessary Health Care Services

The State Managed Care Network only covers medically necessary services, procedures, supplies or visits (except as otherwise provided in this CHP+ Member Benefits Booklet). To help decide if a service is medically necessary, the State Managed Care Network uses:

- Medical policy,
- Medical practice guidelines,
- Professional standards, and
- Outside medical peer review.

Medical Policies

The State Managed Care Network's medical policies reflect current standards of practice and evaluate medical equipment, treatment and interventions according to an evidence-based review of scientific literature. The benefits, exclusions and limitations of a member's coverage take precedence over medical policy.

To make sure that medical policies are current, the State Managed Care Network reviews and updates medical policies on a regular basis.

Experimental/Investigational and/or Cosmetic Procedures

The State Managed Care Network will not pay for any services, procedures, surgeries or supplies that it considers experimental/investigational and/or cosmetic. The State Managed Care Network will not pay for complications that are the result of any service, procedure, surgery or supply that it considers experimental/investigational and/or cosmetic.

The State Managed Care Network 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.

Excluded Services

Excluded services are the services listed as not covered or excluded in this Member benefit booklet.

Appropriate Setting and Pre-authorization

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

The State Managed Care Network covers both inpatient and outpatient care, as long as the care is provided in the appropriate setting, pre-authorized if required, and is medically necessary.

Inpatient Admissions

Examples of inpatient settings include:

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

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

You may be held financially responsible for all charges related to an inpatient stay that are not authorized by the State Managed Care Network.

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

If the State Managed Care Network determines that additional time in the hospital is not medically necessary, the State Managed Care Network will let the hospital and the provider know of this determination. The hospital will give you timely notice of this determination. If you decide to stay in the hospital after this notice, the State Managed Care Network will not pay for services after the recommended date of discharge. You will be responsible for all charges from after the recommended date of discharge. The State Managed Care Network will send you, your provider and the hospital written notification of the decision. If you disagree with the decision, you can appeal by following the procedure in the COMPLAINTS, APPEALS AND GRIEVANCES section.

Scheduled Inpatient Admissions

Your health care provider must request pre-authorization from the State Managed Care Network before a scheduled inpatient admission. Approved pre-authorizations are valid only for a specific place and during specific dates. You must receive the approved service at the specific place and during the specific dates. If you do not receive the service during the specific dates, or if you need

additional services, your provider must contact the State Managed Care Network to request another authorization.

Emergency (Unscheduled) Admissions

The State Managed Care Network requires notification of an emergency admission within one business day of the admission. You are responsible for making sure that the State Managed Care Network has been notified of the emergency admission, unless you are unable to do so. Examples of emergency admissions include admissions involving accidents or the onset of labor in pregnancy. Once the State Managed Care Network is notified, it will help with the management of the hospital benefits and planning for covered medical services during hospitalization and after discharge. Failure to notify the State Managed Care Network may result in a reduction or denial of coverage.

Appropriate Length of Stay

The State Managed Care Network works with your providers to determine the appropriate length of an inpatient stay. Some of the things used to help make this decision are medical policies and medical care guidelines. The medical care guidelines include inpatient and surgical care optimal recovery guidelines. By using these guidelines and encouraging education, you are more likely to achieve favorable outcomes.

Concurrent Review

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

Outpatient Procedures

Examples of outpatient settings include:

- Provider offices,
- Ambulatory surgery centers,
- Home health, and
- Home hospice settings.

Some procedures performed in an outpatient setting must be pre-authorized. Your health care provider is responsible for requesting pre-authorization. Outpatient services may be performed in a hospital on an outpatient basis or in a freestanding facility, such as an ambulatory surgery center. The State Managed Care Network may ask your provider for more information to determine if the service is medically necessary.

Approved pre-authorizations are valid only for a specific place and during specific dates. You must receive the approved service at the specific place and during the specific dates. If you do not receive the service during the specific dates, or if you need additional services, your provider must contact the State Managed Care Network to request another authorization.

Retrospective Claim Review

In order to make coverage payment decisions, the State Managed Care Network sometimes performs a retrospective claim review. This is when the State Managed Care Network reviews charges for services that have already been provided. This is done to determine:

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

The State Managed Care Network may request and review your medical records to help make payment decisions. If the State Managed Care Network determines that services are not covered, the State Managed Care Network will not pay for the charges.

Ongoing Care Needs

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

Utilization Management

Utilization management is used to determine if a service is medically necessary, delivered in the right setting and for the appropriate length of time. Care is compared to nationally recognized guidelines. Utilization review may be used to determine appropriate payment for covered services. However, the decision to obtain the service is made solely by you in conjunction with your provider, regardless of the decision by the State Managed Care Network about reimbursement.

Care Management and Disease Education

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

Care management is a way that the State Managed Care Network helps members with serious illnesses or injuries. The State Managed Care Network identifies members that are eligible for care management. Providers and members can also contact the State Managed Care Network directly by calling Customer Service at 303-751-9051 or 1-800-414-6198.

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

The State Managed Care Network decides which members receive care management, and may not offer care management to all members with similar conditions. The care management program is tailored to the individual. In certain circumstances involving intensive case management, the State Managed Care Network may, at its sole discretion, provide benefits for care that are not listed as a covered service. The State Managed Care Network may also extend covered services beyond the contractual benefit limits of this coverage. These decisions will be made on a case-by-case basis. A decision in one case to provide extended benefits or approve care not listed as a covered service does not obligate the State Managed Care Network to provide the same benefits again to that member or to any other member. The State Managed Care Network 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, the State Managed Care Network will notify the member in writing.

There are several ways for eligible members to become involved in the State Managed Care Network care management program. The State Managed Care Network can identify members that may benefit from the programs, or providers may refer their State Managed Care Network patients to us. A member may also contact State Managed Care Network directly by calling the Coordinated Clinical Services Department at 303-751-9051 or 1-800-414-6198.

Transition of Care

As a new member of the State Managed Care Network, you might be receiving ongoing care from a provider for a certain medical condition. An example of ongoing care is prenatal/obstetrical care. To make sure that your ongoing care is not disrupted, the State Managed Care Network has a transition of care policy. If you need transition of care, schedule a visit with your Primary Care Provider (PCP). Your PCP will help coordinate your ongoing care. If the doctor you are seeing for ongoing care is an out-of-network provider, you may need to transition care to a network provider within 60 days, unless approved by the State Managed Care Network.

4: What You Pay For Enrollment & Service

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

Hold Harmless

The contracts between the State Managed Care Network and its providers include a "hold harmless clause." This clause says that you cannot be billed by the provider beyond what is paid by the State Managed Care Network in accordance with the fee schedule. Please call the State Managed Care Network Customer Service Department at 303-751-9051 or 1-800-414-6198 should you be notified that you are being billed by a participating provider.

When You can be Billed for Services

You might have to pay for services if:

- You receive non-emergency care from a provider that does not participate with the State Managed Care Network, and the service was not authorized.
- You receive any non-covered service.
- You receive services (i.e. day surgery) without an authorization by the State Managed Care Network.
- You receive services when you are not eligible for the State Managed Care Network.

Services from Out-of-network Providers

Non-emergency services from out-of-network providers are not covered unless they are authorized by the State Managed Care Network. The co-payments for authorized services from an out-of-network provider are the same as co-payments for covered services received from an in-network provider.

Enrollment Fee

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

Co-payments

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

State Managed Care Network co-payments are based on family size and income. Co-payment amounts are listed on your ID card. The following table gives some examples of co-payment amounts.

CHP+ Benefit	Co-payment		
	Income Level 1	**Income Level 2**	**Income Level 3**
Emergency Care and Urgent/After Hours Care	$0	$3	$15
Emergency Transport/Ambulance Services	$0	$0	$0
Hospital/Other Facility Services ♦ Inpatient ♦ Physician ♦ Outpatient/ Ambulatory	$0 $0 $0 $0	$0 $0 $0 $0	$0 $0 $0 $0
Routine Medical Office Visit	$0	$2	$5
Laboratory and X-ray	$0	$0	$0
Preventive, Routine, and Family Planning Services	$0	$0	$0
Maternity Care Prenatal Delivery & inpatient well baby care	 $0 $0	 $0 $0	 $0 $0
Mental Illness Care ♦ Inpatient ♦ Outpatient (there is no co-pay for drop in-centers, school based, club house, or home based services.)	 $0 $0	 $0 $2	 $0 $5
Alcohol and Substance Abuse	$0	$2	$5
Physical Therapy, Speech Therapy, and Occupational Therapy	$0	$2	$5
Durable Medical Equipment (DME)	$0	$0	$0
Transplants	$0	$0	$0
Home Health Care	$0	$0	$0
Hospice Care	$0	$0	$0
Prescription Drugs	$0	$1	$3 – generic. $5 – brand name.
Kidney Dialysis	$0	$0	$0
Skilled Nursing Facility Care	$0	$0	$0
Vision Services	$0	$2 for referral and refraction benefits only	$5 for referral and refraction benefits only
Audiology Services	$0	$0	$0
Intractable Pain	$0	$2/office visit; $0/admission	$5/office visit; $0/admission
Autism Coverage	$0	$2/office visit; $0/admission	$5/office visit; $0/admission
Dietary Counseling /Nutritional Services	$0	$0	$0
Therapies: Chemotherapy and Radiation	$0	$0	$0

Annual Out-of-Pocket Limit

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

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

- Save your co-payment receipts from covered medical care and covered prescription drugs.
- When you have reached your annual out-of-pocket limit, call CHP+ Eligibility and Enrollment at 1-800-359-1991.
- CHP+ Eligibility and Enrollment will ask for proof that you have reached your annual out-of-pocket limit. Send them copies of your receipts as proof.

5: Membership

Enrollment Process

In order to obtain CHP+ coverage, you must follow the CHP+ enrollment process. This process includes completing required forms and selecting a CHP+ health plan, if you live in a county where this is required. The State Managed Care Network is also the health plan for members enrolled in the CHP+ Prenatal Care Program.

Once you (or your child) are determined eligible, CHP+ coverage begins on the date CHP+ receives your completed application. Your effective date will appear on your State Managed Care Network ID card.

Any services received before the effective date, are not covered by the State Managed Care Network.

The State Managed Care Network will send you an ID card. ID cards are sent to all new members. A new ID card is sent each time the information on your ID card is changed (for example, you will receive a new ID card if you change your Primary Care Provider). You will also receive a new member packet that includes this CHP+ Member Benefits Booklet, and information about in-network providers.

Newborn Enrollment

Contact the State Managed Care Network at 303-751-9051 or 1-800-414-6198 if you become pregnant and when you have the baby. This will help coordinate your prenatal care and coverage for the newborn. Call CHP+ Eligibility and Enrollment at 1-800-359-1991 after you have your baby. Your baby will be covered under your coverage for 30 days. Most babies born to teen mothers are eligible for Medicaid. However, some newborns may be covered by CHP+.

Newborns of women who are approved for the CHP+ Prenatal Care Program are automatically covered under the State Managed Care Network for 12 months from the date of birth. Please contact CHP+ Eligibility and Enrollment at 1-800-359-1991 to enroll your newborn.

Termination/Active Policy Termination

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

- The 60th day following delivery for the mother.
- The member has committed fraud or intentional misrepresentation of material fact.
- The member establishes permanent residence (moves) outside of Colorado.
- CHP+ receives written notification to cancel coverage for any member. Coverage will end at the end of the month following the written notification period.
- In accordance with Refusal to Follow Recommended Treatment under the heading REFUSAL TO FOLLOW RECOMMEDED TREATMENT in the ADMINISTRATIVE INFORMATION section, the member is unable to establish a positive patient-provider relationship with a PCP.

- The member acts in a disruptive manner that prevents the orderly business operation of any State Managed Care Network staff or provider or is dishonestly attempting to gain a financial or material advantage.
- Having or obtaining other health insurance. If you obtain other insurance, or are found to have other insurance, you are no longer eligible for CHP+ for the time period the other insurance was effective.
- Ineligibility for the program, based on the guidelines set forth in the Children's Basic Health Plan eligibility rules.
- Upon the member's death.

When Your CHP+ Coverage Ends

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

State Managed Care Network benefits end on the date that your coverage ends as described above. Except as stated below, the State Managed Care Network will not pay for services after your coverage ends, even if the State Managed Care Network pre-authorized the service, unless the provider verified eligibility within two business days before each service was received.

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

You may be responsible for payments owed or made by the State Managed Care Network for services provided after your coverage has ended.

6: Member Benefits – Covered Services

This section describes the benefits and covered services of the State Managed Care Network. In order to obtain covered services, members should follow the directions in this CHP+ Member Benefits Booklet.

Remember:

- The State Managed Care Network covers medically necessary and preventive services and supplies.
- The State Managed Care Network does not cover the services that are listed as excluded or as exclusion in this CHP+ Member Benefits Booklet.
- The State Managed Care Network covers services that are standard medical practice for the illness, injury or condition being treated, and that are legal in the United States.
- The fact that a provider prescribes, orders, recommends or approves a service, treatment or supply does not make it medically necessary or a covered service and does not guarantee payment by the State Managed Care Network.

All covered services are subject to the exclusions listed in this section, in addition to the exclusions in other sections of this CHP+ Member Benefits Booklet, including those listed in GENERAL EXCLUSIONS. All covered services are subject to other conditions and limitations of this CHP+ Member Benefits Booklet.

Member Benefits – Covered Services – Preventive Care Services

This section describes covered services and exclusions for preventive care.

Who Should I See for Preventive Care Services?

- You should see your Primary Care Provider (PCP) for preventive services.

What Preventive Care Services are Covered?

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

Additional services provided are also covered and include:

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

The State Managed Care Network 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	12 Months	5 Years	11 Years
Newborn	15 Months	6 Years	12 Years
First Week	18 Months	7 Years	13 Years
1 Month	24 Months	8 Years	14 Years
2 Months	30 Months	9 Years	15 Years
4 Months	3 Years	10 Years	16 Years
6 Months	4 Years		17 Years
9 Months			18 Years

What Preventive Services are not Covered?

The following services are not covered services (exclusions):

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

Member Benefits – Covered Services – Family Planning /Reproductive Health

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

Who Should I see for Family Planning/Reproductive Health Services?

- Any in-network reproductive health provider. This could be a PCP or OB/GYN.

What Family Planning/Reproductive Health Services are Covered?

Covered family planning/reproductive health services include:

- Injection of Depo-Provera for birth control purposes.
- Fitting of a diaphragm or cervical cap.
- Surgical implantation and removal of an Implantable Contraceptive device.
- Fitting, inserting, or removing IUDs.
- The purchase of IUDs, diaphragms, Implantable Contraceptive Devices, and cervical caps given in a provider's office.
- Tests to diagnose a possible genetic illness/disease.
- STI/HIV testing and treatment.

Note: Birth control pills are also covered; see PRESCRIPTION DRUGS.

What Family Planning Reproductive Health Services are not Covered?

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

- Surgical sterilization (for example, tubal ligation or vasectomy) and related services.
- 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 to determine the sex or physical characteristics of an unborn child).
- Elective termination of pregnancy, unless the elective termination is to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

Member Benefits – Covered Services – Maternity and Newborn Care

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

Who Should I see for Maternity and Newborn Care?

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

What Maternity and Newborn Care Services a Covered?

Benefits are provided for maternity and newborn care, including diagnosis, care during pregnancy, and delivery services.

Covered services include:

- Inpatient, outpatient, and provider office services (including prenatal care, such as prescription prenatal vitamins) for vaginal delivery, cesarean section and complications of pregnancy.
- Anesthesia services.
- Routine nursery care for a covered newborn including provider 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/disease.
- Circumcision of a covered newborn male.
- Laboratory services related to prenatal care, postnatal care or termination of a pregnancy.
- Spontaneous termination of pregnancy prior to full term.
- Elective termination of pregnancy, only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.
- 2 antenatal ultrasounds are covered. After the 2nd ultrasound, prior authorization is needed. In addition, the State Managed Care Network Care Management department will review documentation for pending high risk pregnancy.
- At-home post delivery follow-up care visits are covered at your residence by a provider, nurse or certified nurse midwife when performed no later than 72 hours following your and your newborn child's discharge from the hospital. Coverage for this visit includes, but is not limited to:
  - parent education,
  - physical assessments,
  - assessment of the home support system,
  - assistance and training in breast or bottle feeding, and
  - Performance of any maternal or neonatal tests routinely performed during the usual course of inpatient care for the mother or newborn child, including the collection of an adequate sample for the hereditary disease and metabolic newborn screening. At the mother's discretion, this visit may occur at the Providers' office.

The State Managed Care Network covers services performed by a certified nurse midwife or a direct-entry midwife. The following services are covered benefits:

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

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

Newborn Coverage

Contact the State Managed Care Network at 303-751-9051 or 1-800-414-6198 if you become pregnant and when you have the baby. This will help coordinate your prenatal care and coverage for the newborn. Call CHP+ Eligibility and Enrollment at 1-800-359-1991 after you have your baby. Your baby will be covered under your coverage for 30 days. Most babies born to teen mothers are eligible for Medicaid. However, some newborns may be covered by CHP+.

Newborns of women who are approved for the CHP+ Prenatal Care Program are automatically covered under the State Managed Care Network for 12 months from the date of birth. Please contact CHP+ Eligibility and Enrollment at 1-800-359-1991 to enroll your newborn.

What Maternity and Newborn Care Services are not Covered?
The following services, supplies and care are not covered (exclusions):

- 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,
  - genetic counseling and testing, (unless related to the determination of disease or other circumstances not excluded above)
  - testing for inherited disorders,
  - screening for disorders,
  - discussion of family history or test results to determine the sex or physical characteristics of an unborn child.
- Storage costs for umbilical blood.

Member Benefits – Covered Services – Provider Office Services

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

Who Should I see for Provider Office Services?

- In order to receive these benefits, you must receive the medical care and services in the office of an in-network provider (unless otherwise authorized).
- Please work with your primary care provider (PCP) to coordinate care with specialists and to get pre-authorizations for services when they are needed.
- You do not need a referral for:
- An in-network OB/GYN provider or certified nurse midwife for obstetrical or gynecologic, or
- An 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 the State Managed Care Network.
- For information about receiving after-hours office services, call the PCP's office and request instructions; see the EMERGENCY 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 provider 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.

What Provider Office Services are Covered?

- Benefits are provided for medical care, consultations and second opinions to examine, diagnose, and treat an illness or injury when received in a provider's office.
- A provider may also provide medication management for medical conditions or mental health disorders.
- Consultations and second opinions may be provided with a referral from your PCP. In certain cases, the State Managed Care Network 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 heading in the ABOUT YOUR HEALTH CARE COVERAGE section for information about pre-authorization guidelines.
- Benefits are provided for diagnostic services received in a provider's office when they are required to diagnose or monitor a symptom, disease or condition. Benefits for diagnostic services done in a provider's office include, but are not limited, to the following:
  - X-ray and other radiology services.
  - Laboratory and pathology services.

- Ultrasound services for non-pregnancy related conditions. For pregnancy-related ultrasounds, see the MATERNITY AND NEWBORN CARE heading in this section.
- Allergy tests - coverage is available for the following 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.

What Provider Office Services are not Covered (exclusions)?

The following services, supplies and care are not covered:

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

Member Benefits – Covered Services – Inpatient Facility Services

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

Where can I get Inpatient Facility Services?

The State Managed Care Network does not cover services at an out-of-network facility unless the services are for emergency care or otherwise authorized by the State Managed Care Network.

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

- An acute care hospital,
- A long-term acute care hospital,
- A rehabilitation hospital, or
- Other covered inpatient facility.

What Inpatient Facility Services are Covered?

Note: All inpatient services are subject to pre-authorization by the State Managed Care Network 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. For accident or emergency medical care, see the EMERGENCY AND URGENT CARE heading in this section. For dental services, see the DENTAL RELATED SERVICES heading in this section.

Facility Services

Many services are provided in the inpatient hospital setting. Some of the covered services include, but are not limited to the following examples:

- Charges for a semi-private room (with two or more beds) and general nursing services for the treatment of medical conditions and rehabilitation care, which is part of an acute care hospital stay.
- Use of an operating room, recovery room and related equipment.
- Medical and surgical dressings, supplies, surgical trays, casts and splints when supplied by the facility as part of an inpatient admission.
- Prescribed drugs and medicines given during an inpatient admission.
- A room in a special care unit approved by the State Managed Care Network. The unit must have facilities, equipment and supportive services for the intensive care of critically ill patients.

Inpatient Rehabilitation Services

Inpatient rehabilitation for non-acute hospital admissions are covered for medically necessary care to restore and/or improve lost functions following an injury or illness. These inpatient rehabilitation

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

Ancillary Services

Many providers work together in the inpatient hospital setting to provide comprehensive care to patients. Some covered ancillary services include, but are not limited to, the following 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 the surgical and medical care provided during an inpatient admission. Some of the covered professional services include, but are not limited to, the following examples:

- Provider services for the medical condition(s) during an inpatient admission.
- Surgical services, which include normal post-operative care.
- Anesthesia and anesthesia supplies and services for a covered surgery.
- Intensive medical care for constant attendance and treatment when the member's condition requires it for a prolonged period of time.
- Surgical assistants or assistant surgeons as determined by the State Managed Care Network medical policy. The State Managed Care Network does not pay for a surgical assistant for all surgical procedures.
- Surgical services for the treatment of morbid obesity. These services are subject to meeting the criteria included in the State Managed Care Network's medical policy. The hospital performing the morbid obesity surgery must be designated and approved to perform specific covered services provided under this benefit.
- Reconstruction of a breast on which a mastectomy has been performed, and surgery and reconstruction of the other breast to produce a symmetrical appearance. Benefits are provided for physical complications for all stages of mastectomy, including lymphedemas. If a member chooses not to have surgical reconstruction after a mastectomy, the State Managed Care Network will provide coverage for an external prosthesis.
- Consultations (including second opinions).
- Medical care by two or more providers at the same time because of multiple illnesses.
- Medical care for an eligible newborn (also see MATERNITY AND NEWBORN CARE in this section).

Long-Term Acute Care Facility

Long-term acute care facilities provide long-term critical care services to members with serious illnesses or injuries. Long-term acute care is provided for members with complex medical needs, including members with high-risk pulmonary disease with ventilator or tracheostomy needs, members who are medically unstable, members needing extensive wound care or who have post-

operative surgery wounds and members with closed head or brain injuries. Long-term acute care facilities do not provide care for low-intensity member needs.

The State Managed Care Network requires authorization for admission and for continued stay. See the MANAGED CARE heading in the ABOUT YOUR HEALTH CARE COVERAGE section for information about pre-authorization guidelines.

Skilled Nursing Facility

Skilled nursing facilities provide skilled nursing care, therapies, and protective supervision for patients who have uncontrolled, unstable, or chronic conditions. Skilled nursing care is provided under medical supervision for the non-surgical treatment of chronic conditions or care during the recovery from an acute disease or injury. Skilled nursing facility coverage does not include care for members with significant medical needs.

When skilled nursing care is pre-authorized by the State Managed Care Network, benefits are available for up to 30 days per calendar year or until maximum medical improvement is achieved and no further significant measurable improvement can be anticipated as determined by the State Managed Care Network. 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. See the MANAGED CARE heading in the ABOUT YOUR HEALTH CARE COVERAGE section for information on pre-authorization guidelines.

What Inpatient Facility Services are not Covered (exclusions)?
The following inpatient facility services are not covered services:

- Consultations or visits related to any non-covered service.
- Inpatient provider services received on a day for which facility charges were denied.
- Telephone consultations.
- Private room expenses, unless the member's medical condition requires isolation to protect the member from exposure to dangerous bacteria and diseases (conditions that require isolation include, but are not limited to, severe burns and conditions that require isolation according to public health laws).
- Admissions related to non-covered services or procedures (also see DENTAL-RELATED SERVICES in this section for exceptions).
- Room and board and related services in a nursing home.
- Custodial care facility admissions or admissions to similar institutions.
- Charges related to the non-compliance of care if the member leaves a hospital or other facility against the medical advice of the provider.
- Facility room and board charges for the day of discharge.
- Surgical benefits for subsequent procedures to correct further injury or illness resulting from 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 after 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.

Member Benefits – Covered Services – Outpatient Facility Services

This section describes covered services and exclusions for outpatient facility services.

Where can I get Outpatient Facility Services?

All outpatient facility services must be at an in-network facility. The State Managed Care Network does not cover outpatient facility services at an out-of-network facility unless services are for an emergency or otherwise authorized by the State Managed Care Network.

Outpatient facility services may be obtained at the following locations:

- An acute hospital outpatient department,
- An ambulatory surgery center,
- A radiology center,
- A dialysis center, and
- Outpatient hospital clinics.

What Outpatient Facility Services are Covered?

Note: Some outpatient facility services require a pre-authorization. See the MANAGED CARE 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 the State Managed Care Network.
- See the EMERGENCY AND URGENT CARE/AFTER HOURS heading in this section for information about emergency care.
- For dental services covered by the State Managed Care Network, see the DENTAL RELATED SERVICES heading in this section.

Facility Services

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

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

Ancillary Services

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

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

Therapeutic Dialysis

Therapeutic dialysis services are covered:

- when the member is not eligible for Medicare or is covered by Medicare but does not have a Medicare supplemental insurance policy (see COORDINATION OF BENEFITS AND SUBROGATION), and
- when services are performed by an in-network dialysis provider.

Home dialysis services require pre-authorization by the State Managed Care Network.

Covered dialysis services include:

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

Professional Services

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

- Provider services for the medical condition(s) while you are in an outpatient facility.
- Surgical services. The surgical fee includes normal post-operative care.
- Anesthesia and anesthesia supplies and services for a covered surgery.
- Surgical assistants or assistant surgeons as determined by the State Managed Care Network medical policy. The State Managed Care Network does not pay for a surgical assistant for all surgical procedures.
- Consultation by another provider when requested by the member's provider. Staff consultations required by facility rules are not covered.

What Outpatient Facility Services are not Covered (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 after a tonsillectomy.
- Procedures that are solely cosmetic in nature.
- Any services or care for the treatment of sexual dysfunction.
- Sex change operations, preparation for a sex change operation or complications arising from a sex change operation.
- Personal comfort and convenience items such as televisions, telephones, guest meals, articles for personal hygiene and other similar services and supplies.
- Surgical services for refractive keratoplasty, including radial keratotomy or lasik, or any procedure to correct visual refractive defect.
- Additional procedures routinely performed during the course of the main surgery.
- Peripheral bone density scans.

Member Benefits – Covered Services – Emergency and Urgent/After Hours Care

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

Emergency Care

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

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

Where can I get Emergency Care?

- Medically necessary emergency care includes emergency accident care and emergency medical care received at a hospital or other facility.
- The State Managed Care Network covers emergency care that is provided at in-network and out-of-network hospitals or other facilities.
- If you are unable to get to an in-network hospital, go to the nearest medical facility.
- You do not need a prior authorization for in-network and out-of-network emergency care.
- Unless your condition makes it impossible to do so, you should notify your PCP within 48 hours of receiving emergency care.

What Emergency Care Services are Covered?

The State Managed Care Network covers emergency care that is necessary to screen and stabilize, 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.

For emergency services for mental health (whether biologically based or non-biologically based) or substance abuse, you are responsible for notifying the State Managed Care Network of the emergency admission.

What do I do if I am Admitted to the Hospital after I receive Emergency Care?

- If you are admitted into the hospital, the emergency room co-payment is waived.
- You must contact the State Managed Care Network within one (1) business day of admission, for authorization for continued care after the emergency admission.
- The State Managed Care Network will authorize a certain number of days based on medical necessity, as determined by the State Managed Care Network medical policy and guidelines.
- If you are treated at an out-of-network hospital in an urgent situation or for an emergency, let the hospital know that the itemized bill from the hospital must be sent to:

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

If the out-of-network hospital accepts payment from the State Managed Care Network, then the hospital is reimbursed directly. You will be responsible for the co-payment (if applicable). If the hospital will not accept payment, the State Managed Care Network requires proof of payment (for example, a receipt) to reimburse you directly.

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

What Emergency Care Services are not Covered (exclusions)?

- Do not use an emergency center for non-emergency services. It is not covered.
- Follow-up care, including but not limited to, removal of stitches and dressing changes, received in an emergency room or urgent care center are not considered emergency care. You should get any follow up care from your PCP.
- Services received outside of the service area if you knew you needed the care before you left the service area.
- Maternity care and/or deliveries outside the service area within five weeks of your due date, except in an emergency.

Urgent/After Hours Care

Urgent care means situations that are not life threatening but require prompt medical attention to prevent serious deterioration of your health. Urgent care is not considered a life-or limb-threatening emergency and does not require the use of an emergency room.

By choosing an urgent care center, when appropriate, instead of an emergency room, your out-of-pocket expenses may be reduced.

What Urgent/After Hours Care is Covered?

Benefits are provided for accident or medical care received from an urgent care center or other facility, such as a provider's office.

- Urgent and after-hours care received within the State Managed Care Network service area is covered only when it is provided by your PCP or urgent care center/provider.
- When you are temporarily out of the State Managed Care Network service area, urgent/after-hours care is covered.

What Urgent/After Hours Care is not Covered (exclusions)?

- The State Managed Care Network will not cover urgent/after-hours care provided more than 50 miles from the service area if you knew you might need care before you left, or if you could have traveled to the PCP's office without medically harmful results.
- If you are sick, please visit your PCP before you leave town. If you receive care away from home, call your doctor within 48 hours.
- Maternity care and/or deliveries outside the service area within five weeks of your due date, except in an emergency.

Travel Outside the Country

In an emergency only care situation you should go to the nearest medical facility. Let the hospital know that the itemized bill from the hospital must be sent to:

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

If the hospital accepts payment from the State Managed Care Network, then the hospital is reimbursed directly. You will be responsible for the co-payment. If the hospital will not accept payment from the State Managed Care Network, then you will be reimbursed for payment. The State Managed Care Network requires proof of payment (for example, a receipt and documentation of the amount paid in U.S. dollars) to reimburse you directly.

If you have to pay the medical facility directly, we encourage you to pay with a credit card because the credit card company will automatically transfer the foreign currency into American dollars. When you return home, contact the State Managed Care Network. The State Managed Care Network may require medical records for the services received. You are responsible for providing these medical records and it may be necessary to provide an English translation of the medical records.

Member Benefits – Covered Services – Ambulance and Transportation Services

This section describes covered services and exclusions for ambulance and transportation services.

What Ambulance and Transportations Services are Covered?

- The State Managed Care Network covers 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 you from your home or the scene of an accident or medical emergency to the closest hospital with appropriate emergency facilities or from one hospital to another for medically necessary transport by ambulance for continuing inpatient or outpatient care.

Air Ambulance

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

What Ambulance and Transportation Services are not Covered (exclusions)?

The following services, supplies and care are not covered:

- Commercial transport (air or ground), private aviation or air taxi services.
- Transportation by private car/automobile, commercial or public transportation or wheelchair ambulance (ambu-cab).
- Ambulance transportation if you could have been transported by automobile or commercial or public transportation without endangering the member's health and/or safety.
- If you elect not to receive transport to an emergency facility after an ambulance has been called then you are responsible for any charges.
- Ambulance transportation from an emergency facility to your residence.

Member Benefits – Covered Services – Outpatient Therapies

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

Where Can I Get Outpatient Therapy?

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

What Outpatient Therapies are Covered?

- Physical, occupational, and/or speech therapy are covered.
- The standard CHP+ coverage is limited to 30 visits per calendar year.
- The services must be initiated within six months of the date the injury or illness occurred.
- For children aged 0-3, the benefit for physical, occupational and speech therapy is unlimited.
- After the third birthday outpatient therapy (physical, occupational, and/or speech therapy) coverage is limited to 30 visits per diagnosis per year.

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

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

Physical Therapy

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

Speech Therapy

Speech therapy is for the correction of speech impairment resulting from illness, injury or surgery. Speech therapists can also help with the medical management of swallowing disorders.

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

Occupational Therapy

Occupational therapy is therapy that helps you regain independence.

What Outpatient Therapy Services are not Covered (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 you have reached your rehabilitative potential as determined by the State Managed Care Network.
- Home programs for on-going conditioning and maintenance.
- Therapies for learning disorders, stuttering, voice disorders, or rhythm disorders. However, up until the child'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 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 the State Managed Care Network.
- The purchase of pools, whirlpools, spas and personal hydrotherapy devices.
- Therapies and self-help programs not specifically identified above.
- Recreational, sex, primal scream, sleep and Z therapies.
- Biofeedback.
- Rebirthing therapy.
- Self-help and weight-loss programs.
- Transactional analysis, encounter groups and transcendental meditation (TM).
- Sensitivity and assertiveness training.
- Rolfing, Pilates, myotherapy and prolotherapy.
- Holistic medicine and other wellness programs.
- Educational programs such as behavior modification or arthritis classes, except as otherwise specifically provided for under this certificate.
- Services for sensory integration disorder.
- Occupational therapies for diversional, recreational or vocational therapies (e.g., hobbies, arts and crafts).
- Acupuncture care.

Member Benefits – Covered Services - Home Health Care/Home Infusion Therapy

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

Who Can Provide Home Health Care/Home Infusion Therapy?

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

What Home Health Care/Home Infusion Therapy Services are Covered?

Home Health Care Services

Home health care services are covered only when they are necessary as alternatives to hospitalization. Prior hospitalization is not required.

- In order to receive home health services you must have a written order from your provider. Your provider will work with the home health agency to establish a care plan. A registered nurse from the home health agency will coordinate the services in the care plan.
- All home health care/home infusion therapy services require pre-authorization from the State Managed Care Network. The State Managed Care Network reserves the right to review treatment plans at any time while you are receiving home health care or home infusion therapy.

Covered home health care services include the following:

- Professional-nursing services performed by a registered nurse (RN) or a licensed practical nurse (LPN) on a defined schedule of visits.
- Certified nurse aide services if under the supervision of a registered nurse or a qualified therapist with professional nursing services.
- Physical therapy provided by a licensed physical therapist.
- Occupational therapy provided by a licensed occupational therapist or 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 parenteral nutrition, enteral nutrition and nutrition products, and formulas for gastrostomy tubes are covered for documented medical needs including attainment of normal growth and development.
- Intravenous (IV) medications and other prescription drugs that are not ordinarily available through a retail pharmacy.
- Nutritional counseling by a nutritionist or dietitian.

Home Infusion Therapy

Home infusion therapy is also known as home IV therapy or home injection therapy. Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services in the home.

Covered home infusion therapy services include but are not limited:

- 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.

What Home Health Care/Home Infusion Therapy Services are not Covered (exclusions)?
The following services, supplies and care are not covered:

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

Member Benefits – Covered Services – Hospice Care

This section describes covered services and exclusions for hospice care.

Who Can Provide Covered Hospice Services?

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

What Hospice Services are Covered?

- The State Managed Care Network must authorize inpatient or home hospice services for a terminally ill member before care is received.
- To be eligible for home or inpatient hospice benefits, the member must have a life expectancy of six months or less, as certified by the attending provider.
- Hospice care includes medical, physical, social, psychological and spiritual services that stress palliative care for patients.

The State Managed Care Network initially approves hospice care for a period of three months. Benefits may continue for up to two additional three-month benefit periods. After the exhaustion of three benefit periods, the State Managed Care Network will work with the provider and the hospice provider to determine the appropriateness of continuing hospice care. The State Managed Care Network reserves the right to review treatment plans while the member is receiving hospice care.

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

- Provider visits by hospice providers.
- Skilled nursing services of a registered nurse (RN) or licensed practical nurse (LPN).
- Medical supplies and equipment supplied by the hospice provider that are used during a covered visit (if the equipment is not supplied by the hospice provider, see SUPPLIES, EQUIPMENT, AND APPLIANCES, section).
- Drugs and medications for a terminally ill child that are supplied by the hospice provider (if the drugs are not supplied by the hospice provider, see the PRESCRIPTION DRUGS, section).
- Services from a licensed or certified therapist for physical, occupational, respiratory, and speech therapy.
- Medical social services provided by a qualified individual with a degree in social work, psychology, or counseling, or the documented equivalent in a combination of education, training, and experience (such services must be provided at the recommendation of a provider for assisting you in coping with a specified medical condition).
- Services of a home health aid under the supervision of a registered nurse.
- Nutrition assessment, counseling and support, such as intravenous feeding, hyperalimentation and enteral feeding.
- Benefits are also available for inpatient hospice accommodations and services.

Respite Care

Respite care is total care that is provided to terminally ill patients for a short period of time so that the family of the patient can have a short break.

- The patient may be placed in respite care for a period not to exceed five continuous days for every 60 days of hospice care.
- The patient may not be placed in respite care for more than two respite care stays during a hospice benefit period (1 hospice care period is equal to 3 months).

What Hospice Services are not Covered (exclusions)?

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/religious and spiritual counseling outside of the hospice setting.
- Grief counseling for family members outside the hospice setting.

Member Benefits – Covered Services – Human Organ and Tissue Transplant Services

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

Who Can Provide Human Organ and Tissue Transplant Services?

Covered transplant services must be performed at designated transplant facilities.

What Human Organ and Tissue Transplant Services are Covered?

Coverage is available for transplant services that are medically necessary and are not experimental procedures.

Benefits are provided for services directly related to the following transplants:

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

Services are covered based on criteria established by the medical community and by the State Managed Care Network. A referral from your PCP and pre-authorization from the State Managed Care Network is needed before human organ and tissue transplant services. You must also follow all provisions in this benefit program.

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

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

Hospital, Surgical, Medical and Other Services

The following hospital, surgical, medical and other services are covered services if they are pre-authorized by the State Managed Care Network. See the MANAGED CARE 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 the State Managed Care Network 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 when a condition requires a provider's constant attendance and treatment for a prolonged period of time.
- Medical care by a provider other than the operating surgeon rendered concurrently during the hospital stay for treatment of a medical condition separate from the condition for which the surgery was performed.
- Medical care by 2 or more providers rendered concurrently during the hospital stay when the nature or severity of your condition requires the skills of separate providers.
- Consultation services rendered by another provider at the request of the attending provider, other than staff consultations required by hospital rules and regulations.
- Home, office and other outpatient medical care visits for examination and treatment.

Surgical Covered Services

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

Other Covered Services

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

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

Maximum Lifetime Benefit for 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 also 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 CHP+ Member Benefits Booklet, and is received during the transplant benefit period (up to five days before, or within one year following, the transplant). Exception: A pre-transplant evaluation may be received more than five days before a transplant and may be considered transplant-related (this exception does not extend to travel required to receive a transplant evaluation). Covered services received during the evaluation will be subject to the maximum lifetime benefit for organ transplants and subject to the limitations of this "Organ Transplant" benefit.

If a member receives a covered transplant under State Managed Care Network (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 CHP+ Member Benefit Booklet.

What Human Organ and Tissue Transplant Services are not Covered (exclusions)?
The following services, supplies and care are not covered:

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

Member Benefits – Covered Services – 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.

Where can I get Medical Supplies and Equipment?

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

What Supplies and Equipment are Covered?

The 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 of $2,000 per calendar year.

Remember:

- Supplies are subject to pre-authorization requirements. See the MANAGED CARE heading in the ABOUT YOUR HEALTH CARE COVERAGE section for information about pre-authorization requirements.
- Covered supplies and equipment must meet the State Managed Care Network medical policy criteria.

Medical Supplies

Disposable items received from an in-network provider and required for the treatment of an illness or injury on an inpatient or outpatient basis are covered. Benefits are provided for the following:

- Syringes,
- Needles,
- 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 the State Managed Care Network.

Durable Medical Equipment

Durable medical equipment, includes items like crutches, wheelchairs, breathing equipment and hospital beds, is covered if it is medically necessary and prescribed by an in-network provider.

- Durable medical equipment generally can withstand repeated use and must serve a medical purpose.
- Durable medical equipment can be rented or purchased. This decision is up to the State Managed Care Network. 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 the State Managed Care Network purchased the equipment or if it would have been approved. The State Managed Care Network will review other situations on a case-by-case basis.
- During repair or maintenance of durable medical equipment, the State Managed Care Network will provide coverage for replacement rental equipment.
- Durable medical equipment used during an inpatient admission is covered as part of the inpatient hospital admission.

Orthopedic Appliances
Orthopedic appliances include items like a knee brace. An orthopedic appliance is a rigid or semi-rigid supportive device that helps increase the use of a malfunctioning body part, limb or extremity, limiting or stopping the motion of a weak or poorly functioning body part. Benefits are provided for the purchase, fitting and repairs of and the needed adjustments to orthopedic appliances. The State Managed Care Network covers the most appropriate model that adequately meets your medical needs.

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. Benefits for a prosthetic device are not limited to the the maximum payment of $2,000. However, the payment for prosthetic devices is applied toward the maximum payment.

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.
- Oxygen and oxygen equipment.

Durable Medical Equipment Payment Limit
If your PCP has ordered the following medically necessary items, these items will not be subject to the durable medical equipment maximum payment of $2,000:

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

The following durable medical equipment items are subject to the $2,000 benefit payment limit per calendar year. The State Managed Care Network will not pay for any cost after the $2,000 limit has been reached.

- Orthopedic appliances.
- Crutches.
- Glucometers.
- The rental or approved purchase of durable medical equipment, including repairs, when prescribed by a provider and required for therapeutic use (for example, wheelchairs and walkers).
- Prostheses and orthopedic appliances or devices (for example, neck brace); their fitting, adjustment, repairs, or replacement because of wear or a change in your condition which causes you to need a new appliance.

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

Member Benefits – Covered Services – Dental-Related Services

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

Routine Dental Coverage – Delta Dental

Delta Dental provides coverage for non accident related dental services. Contact Delta Dental at 303-741-9300 or 1-800-610-0201 for questions about dental services covered by Delta Dental for CHP+ members (excluding CHP+ Prenatal Care Program members).

Coverage for routine dental care is not covered under the CHP+ Prenatal Care Program. Dental coverage is limited to accident-related dental services.

What Dental Related Services does the State Managed Care Network Cover?

- The State Managed Care Network covers accident-related dental services, inpatient services for dental-related services, and cleft palate and cleft lip conditions.
- Routine dental services are not covered by the CHP+ Prenatal Care Program. The CHP+ Prenatal Care Program covers the accident-related dental services described below.
- This CHP+ Member 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 heading in the ABOUT YOUR HEALTH CARE COVERAGE section for information about pre-authorization guidelines.

Accident-Related Dental Services

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

Dental Anesthesia

The State Managed Care Network covers the following dental anesthesia services:

- General anesthesia when provided in a hospital, outpatient surgical facility or other facility
- The associated hospital or facility charges for dental care.
- In order for dental anesthesia services to be covered, you must:
  1. Have a physical, mental or medically compromising condition;
  2. Have dental needs for which local anesthesia is not effective due to acute infection, anatomic variation or allergy;
  3. Be considered extremely uncooperative, unmanageable, uncommunicative, or anxious by your provider and your dental needs must be deemed sufficiently important that dental care cannot be deferred; or
  4. Have sustained extensive orofacial and dental trauma.

Inpatient Admission for Dental Care

When medically necessary, the State Managed Care Network covers inpatient facility services related to dental care, including room and board. Delta Dental covers eligible dental services.

Cleft Lip and Cleft Palate

The State Managed Care Network covers the following services in connection with cleft lip and/or cleft palate when provided by or under the direction of a provider, and are included to the extent medically necessary. Coverage is provided only if you do not have an effective dental insurance policy or plan at the time the following services are received:

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

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

What Dental Related Services are not Covered (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.

Member Benefits – Covered Services – Food and Nutrition

This section describes covered services and exclusions for nutrition therapy.

Who Can Supply Food and Nutrition Services?

- An in-network licensed therapist or home health agency must provide the nutrition services.
- Covered medical foods require a prescription from your provider and must be obtained through an in-network pharmacy and are subject to the pharmacy co-payment.

What Food and Nutrition Services are Covered?

- The State Managed Care Network covers enteral (tube feeding) therapy and Total Parenteral Nutrition (TPN) include a combination of nursing, durable medical equipment and pharmaceutical services.
- The durable medical equipment and supplies related to food and nutrition services are subject to the payment limit described in the MEDICAL SUPPLIES AND EQUIPMENT section of this booklet.
- All services must be pre-authorized. See the MANAGED CARE heading in the ABOUT YOUR HEALTH CARE COVERAGE section for information about pre-authorization guidelines.

Enteral Therapy and Total Parenteral Nutrition (TPN)

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

- Medically necessary and non-custodial nursing visits to assist with enteral nutrition are covered under the home health benefits. These services are usually provided by a home health agency. For more information, see the HOME HEALTH CARE/HOME IV THERAPY and HOSPICE CARE headings in this section.

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

- Medically necessary TPN received in the home is a covered benefit for the first 21 days following a hospital discharge.
- If medically necessary, additional days may be allowed up to a maximum of 42 days per calendar year as determined to be medically necessary and when pre-authorized by the State Managed Care Network.

Medical Foods

The State Managed Care Network covers medical foods for home use for metabolic disorders.

- Covered medical foods must be prescribed by your provider.
- The State Managed Care Network covers medical foods that are appropriate for inherited enzymatic disorders involved in the metabolism of amino, organic and fatty acids. Such disorders include phenylketonuria, maternal phenylketonuria, maple syrup urine disease, tyrosinemia, homocystinuria, histidinemia, urea cycle disorders, hyperlysinemia, glutaric acidemias, methylmalonic acidemia and propionic acidemia.
- This benefit does not include medical foods for members with lactose or soy-intolerance.

Other Medical Nutrition

The State Managed Care Network also covers the following services:

- Diagnosis of diabetes - inpatient nutrition counseling, outpatient nutrition and self-management training and follow-up visits for members diagnosed as diabetic.
- Hospice care - nutrition assessment, counseling and support, such as intravenous feeding, hyperalimentation and enteral feeding.
- Formulas for metabolic disorders, total 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 pre-authorized 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.

What Food and Nutrition Services are not Covered (exclusions)?

The following services, supplies and care are not covered:

- Enteral feedings, except as provided previously in this section.
- Tube feeding formula except as provided 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.

Member Benefits – Covered Services – Mental Health and Substance Abuse Care

This section describes covered services and exclusions for mental health care and substance abuse care.

How do I get Mental Health and Substance Abuse Services?

- You do not need a referral from your primary care provider for mental health care.
- You must contact The State Managed Care Network at 303-751-9051 or 1-800-414-6198.
- The State Managed Care Network will work with you and your mental health provider to determine medical necessity, the appropriate treatment level and the appropriate setting for mental health and substance abuse services.

If you do not get pre-authorization or if you receive services from a provider other than the provider pre-authorized by the State Managed Care Network, the services will not be covered.

Counselors who know sign language and sign language interpreters are available.

If you are receiving services from a mental health professional at the time of your enrollment, please call the State Managed Care Network at 303-751-9051 or 1-800-414-6198 to receive authorization for additional services. If an out-of-network mental health professional is selected, you must contact the State Managed Care Network to receive authorization to see the out-of-network mental health professional.

The State Managed Care Network must be notified about all emergency admissions, including those that occur on weekends or holidays, by the next business day.

What Mental Health Services are Covered?

Outpatient Treatment

The State Managed Care Network covers outpatient mental health services. Covered outpatient treatments require pre-authorization. Covered services include, but are not limited to:

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

Medication Management

The State Managed Care Network covers medication management of mental health conditions by the member's medical provider, psychiatrist or prescriptive nurse.

Day Treatment

Day treatment services are for children who have specific mental health and educational needs and

are sometimes part of the child's Individual Education Plan (IEP). Covered day treatment services require pre-authorization. Day treatment services can include, but are not limited to:

- Individual counseling.
- Family counseling.
- Group counseling.
- Educational support services.

Case Management

A State Managed Care Network case manager can help you:

- Get the right care from doctors, providers, schools and other programs.
- Help you find resources (such as food, clothing, and housing).
- If you would like information about case management, please call the State Managed Care Network at 303-751-9051 or 1-800-414-6198.

Emergency Services

Please see EMERGENCY AND URGENT/AFTER HOURS CARE in this section for more details.

If you have a mental health emergency or crisis, go directly to the nearest emergency room or call 911. Emergency services are available 24 hours a day, 7 days a week.

Inpatient Services

The State Managed Care Network covers medically necessary inpatient stays to treat mental health conditions. Covered inpatient stays require pre-authorization. Inpatient stay is 24-hour mental health services provided for you in a hospital for the care of a mental illness. Covered services include:

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

Residential treatment service

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

Home-Based Services (Wrap Around Services)

This is specialized mental health care that you get in your home when traditional mental health

services have not been effective. Covered services require pre-authorization. The goal is to help your family stay together.

Evaluation/Assessments

An evaluation (also called an assessment) is a way to find out your or your family member's mental health needs. Covered services require pre-authorization. This tells you about the best kind of care for you.

More Services

If you have questions about other mental health services that are not listed, please call the State Managed Care Network 303-751-9051 or 1-800-414-6198.

What Substance Abuse Services are Covered?
The State Managed Care Network covers medically necessary outpatient and in-patient substance abuse treatments. Covered outpatient substance abuse treatments require pre-authorization.

What Mental Health and Substance Abuse Services are not Covered (exclusions)?
The following services, supplies and care are not covered:

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

Member Benefits – Covered Services – Prescription Drugs

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

Where can I get Prescription Drugs?

The State Managed Care Network administered by Colorado Access includes a nationwide network of retail pharmacies. The pharmacy network is very broad and includes most pharmacies in Colorado. A list of in-network pharmacies is in the provider directory. You can also call Customer Service at 303-751-9051 or 1-800-414-6198.

To get prescription drugs, give your written prescription order from the provider and your State Managed Care Network ID card to the pharmacist at an in-network retail pharmacy.

How do you fill a Prescription Through the State Managed Care Network's Mail-order Pharmacy Service?

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

If you would like to use this mail order service, please call Customer Service at 303-751-9051 or 1-800-414-6198. We will send you the mail order prescription forms. Please take the form to your PCP or Specialist. Your PCP or Specialist will help you complete the form. Remember the mail order pharmacy service is for "maintenance drugs" that you take on a regular basis, for chronic or long-term medical conditions. You are not required to use our mail order services to get an extended supply of maintenance medications.

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

Do I have a Prescription Drug Co-payment?

Some members of the State Managed Care Network have a prescription drug co-payment. If you have a co-payment, your co-payment amount will be listed on your State Managed Care Network ID card.

- If you have a prescription drug co-payment, it will be charged by the retail pharmacy before they give you the medication.
- If you are filling more than one prescription, a separate co-payment is required for each covered drug or supply.
- If the retail price of the drug is less than your co-payment amount, you will pay the retail price.
- The co-payment will not be reduced by any discounts or rebates.
- The State Managed Care Network does not pay for any covered drug or supply unless the negotiated rate exceeds any applicable co-payment for which the member is responsible.

What Prescription Drugs are Covered?

- The State Managed Care Network covers a 30-day supply of a prescription drug from an in-network pharmacy or up to a 90-day supply from the mail order service.
- Oral contraceptives are limited to 1 pill pack (normally 28 days) at an in-network pharmacy, or 3 pill packs by mail order service.
- When medically necessary, a 1-month vacation override is available if the member is traveling out of the service area.

For certain prescription drugs, the prescribing provider may be asked to send additional information to the State Managed Care Network to determine medical necessity. The State Managed Care Network 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 the Plan or utilization guidelines.

Prescription Drug Formulary List

The State Managed Care Network uses a formulary list. This is a list of drugs covered by the State Managed Care Network. The current formulary is available at www.coaccess.com. The formulary list promotes and enforces the appropriate use of medications by reviewing for improper dosage, potential drug-to-drug interactions or drug-pregnancy interactions.

If your provider prescribes a medication that is not on the drug formulary list, the drug requires pre-authorization.

If you would like a copy of the formulary list, please contact Customer Service at 303-751-9051 or 1-800-414-6198. The formulary list is subject to review and may be changed. Inclusion of a drug or related item on the formulary list is not a guarantee of coverage.

Prescription Drug Pre-authorization

Certain prescription drugs or the prescribed quantity of a particular drug may require pre-authorization. A list of prescription drugs that require pre-authorization can be found in the formulary list located online at www.coaccess.com or by calling Customer Service at 303-751-9051 or 1-800-414-6198.

If you need a prescription drug that requires pre-authorization, the prescribing doctor should contact the State Managed Care Network. If pre-authorization is denied, you can appeal the decision by following the instructions in the COMPLAINTS, GRIEVANCES AND APPEALS section.

If your doctor does not get the pre-authorization, and you try to fill the prescription, the in-network retail pharmacist will let you know that the drug requires pre-authorization. You should then contact the prescribing provider and ask them to send information to the State Managed Care Network. If you need help, please call Customer Service at 303-751-9051 or 1-800-414-6198.

Inpatient Pharmacy Benefits

The State Managed Care Network covers drugs provided 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.

Other Benefits

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.

If you do not get certain supplies, equipment and appliances through an in-network pharmacy, they may be covered as medical supplies or durable medical equipment. See the MEDICAL SUPPLIES AND EQUIPMENT heading in this section for benefit information about medical supplies and durable medical equipment.

What do I do if I pay for a Medication that is Covered by the State Managed Care Network?
If you do not have your ID card when you go to an in-network pharmacy, or you fill a prescription at an out-of-network pharmacy, you may be charged for the full cost of the prescription medication. If you pay the full charge for a covered prescription drug please follow these steps:

- Ask the pharmacist for an itemized receipt that shows that you paid for the covered prescription drug.
- Send the itemized receipt to the State Managed Care Network along with a written request for reimbursement.
- Send the itemized receipt with your name and address to:

  Colorado Access/State Managed Care Network
  Grievance and Appeals Department
  PO Box 17950
  Denver, CO 80217-0950

The State Managed Care Network will review your request for reimbursement and the itemized receipt. If your request is approved, you will be reimbursed based on the charge for the covered drug, less the in-network pharmacy discount and any applicable co-payment. Prescription drugs dispensed in excess of a 30-day supply are not reimbursable.

What Prescription Drugs are not Covered (exclusions)?
The following services, supplies and care are not covered:

- Prescription drugs and supplies received from a non-network pharmacy.
- 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 a provider.

- 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®, Vaniqa® 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. State Managed Care Network 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.
- The standard CHP+ benefit does not cover special formulas, food or food supplements (unless for metabolic disorders); see the FOOD AND NUTRITION heading in this section for benefit information), and vitamins, or minerals, except for prenatal vitamins.
- Delivery charges for prescriptions.
- Charges for the administration of any drug, unless it is dispensed in the provider'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).
- Prescription drugs dispensed in quantities that exceed the applicable limits, which are established by the Plan at its sole discretion.
- Refills that exceed the quantity prescribed by the provider or that are refilled more than one year from the date of such order.
- Prescription 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).
- Prescription drugs dispensed for the purpose of international travel.

Member Benefits – Covered Services – Audiology Services

This section describes covered audiology services.

Where can I get Audiology Services?

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

What Audiology Services are Covered?

The following audiology services are covered:

- Age appropriate hearing screenings for preventive care.
- Newborn hearing screening and follow-up for a failed screen.
- 1 Hearing aid once every five years. Additional hearing aids can be provided if medically necessary, including:
  - A new hearing aid when alterations to the existing hearing aid cannot adequately meet your needs.
- Services and supplies including, but not limited to the initial assessment fitting, adjustments, and auditory training that is provided according to accepted professional standards.
- The CHP+ Prenatal Care Program covers hearing aides for congenital and traumatic injuries up to a maximum of $800 per calendar year.

Member Benefits – Covered Services – Vision Services

This section describes covered services and exclusions for vision services.

Where Can I get Covered Vision Services?

- You must receive routine and specialty vision services from an in-network ophthalmologist or optometrist.
- Lenses, frames, and/or contacts can be purchased from an in-network or out-of-network provider, subject to benefit limits.

What Vision Services are Covered?

- Routine vision services do not require pre-authorization.
- The State Managed Care Network covers age appropriate vision screening and routine eye exam.
- One routine eye exam is covered per calendar year.
- The State Managed Care Network benefit provides a $50 credit per member per calendar year towards the purchase of lenses, frames, and/or contacts. Remember, lenses, frames, and/or contacts can be purchased from an in-network or out-of-network provider.
- The State Managed Care Network covers specialty vision services with a referral from your PCP.
    - A specialty vision service is when you see a vision provider for something other than a routine exam.
    - Specialty vision services require a pre-authorization.

What Vision Services are not Covered (exclusions)?

The following vision services are not covered:

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

7: General Exclusions & Limitations

This list of exclusions describes services that are not covered by the State Managed Care Network. The list of exclusions is not a complete list of all services, supplies, conditions or situations that are not covered services. If you have questions about covered benefits or exclusions, please call Customer Service at 303-751-9051 or toll free at 800-414-6198.

These general exclusions apply to all benefits described in this CHP+ Member Benefits Booklet. In addition to these general exclusions, specific limitations, conditions and exclusions apply to specific covered services, which may be found in the MEMBER BENEFITS section and elsewhere in this Booklet.

Remember:

- You may be billed for services that are not covered.
- Even if you receive a service or a referral from your PCP, benefits will not be provided if the service is an exclusion.
- If a service is not covered, then all services performed in conjunction with that service are not covered.
- The State Managed Care Network may not cover any services not obtained from the member's PCP except as set forth in the MEMBER BENEFITS section.

The State Managed Care Network is the final authority for determining if services and supplies are medically necessary for the purpose of payment.

The State Managed Care Network 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 that are considered alternative or complementary medicine include, but are not limited to, holistic medicine, homeopathy, hypnosis, aromatherapy, massage therapy, reike therapy, herbal medicine, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), colonics, or iridology.

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

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

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

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

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

Chiropractic services
This coverage does not cover any services or supplies for care received by a chiropractor.

- Spinal manipulation procedures must be performed by an osteopathic physician (DO).
- Care provided by a Chiropractor is not a covered benefit under the State Managed Care Network plan.

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

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

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

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

Convenience/luxury/deluxe services or equipment
This coverage does not cover services and supplies used primarily for the member's personal comfort or convenience. Such services and supplies include, but are not limited to: guest trays, beauty or barbershop services, gift shop purchases, telephone charges, televisions, admission kits, personal laundry services, and hot and/or cold packs. This coverage does not cover supplies, equipment or appliances that are comfort, luxury or convenience items (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. Some examples of cosmetic procedures include, but are not limited to, Face lifts, botox injections, breast augmentation, rhinoplasty and scar revisions.

Court-ordered services
This coverage does not cover services rendered under court order, parole or probation, unless those services would otherwise be covered under this CHP+ Member 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.
- Examples of custodial care include, but are not limited to, the following:
    - Assistance with walking, bathing or dressing;
    - Transferring or positioning in bed;
    - Administration of self-administered or self-injectable medicine;
    - Meal preparation;
    - Assistance with feeding;
    - Oral hygiene;
    - Routine skin and nail care;
    - Suctioning;
    - Toileting; and
    - Supervision of medical equipment or its use.

Dental services
This coverage does not cover dental services for the CHP+ Prenatal Care Program, except as provided under the DENTAL RELATED SERVICES heading in the MEMBER BENEFITS section.

Discharge (services received beyond approved discharge date)
This coverage does not cover any services after the date that the State Managed Care Network determines discharge is appropriate based on managed care guidelines.

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

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

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.

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

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

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 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 the State Managed Care Network 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 provider prescription, and a medical reason for the hair loss.

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

Illegal conduct
This coverage does not cover any loss to which a contributing cause was the result of your

commission of or attempt to commit a felony or to which a contributing cause was the result of your being engaged in an illegal occupation.

Infant formula
This coverage does not cover infant formula unless specifically allowed as a benefit under this CHP+ Member 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 the State Managed Care Network, 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 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 CHP+ Member Benefits Booklet.

Missed appointments
This coverage does not cover charges for the member's failure to keep scheduled appointments. You are solely responsible for the charges.

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

- Health spa or health fitness centers (whether or not services are provided by a licensed or registered provider
- School infirmary
- 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 non-medical 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 Benefits 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 the State Managed Care Network medical othognathic 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
This coverage does not cover orthotic shoe inserts (except for members with diabetes), whether functional or otherwise, regardless of the relief they provide.

Other Insurance
The member cannot be eligible or covered by another insurance except for Dental and Medicare while enrolled with the State Managed Care Network coverage.

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

- 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 a provider.

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 post-termination even if the inpatient facility admission was allowed.

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

Private room expenses
This coverage does not cover services related to a private room, except as provided in the MEMBER BENEFITS 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, or routine screening.
- Ultrasounds are covered as described in this Booklet. 2 antenatal ultrasounds are covered. After the 2nd ultrasound, prior authorization is needed. This gives the CHP+ State Managed Care Network care management department a chance to review the case for pending high risk pregnancy.

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.

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 provider, 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 weight loss programs.

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 while enrolled in the State Managed Care Network Plan.

Enrollment Fee

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. There is no enrollment fee for the CHP+ Prenatal Care Program.

Co-payments (cost-sharing)

Co-payments are paid when you see a doctor or when prescription drugs are purchased. The standard CHP+ co-payments range from $0 to $5 per visit. Your co-payment amount will be listed on your State Managed Care Network ID card. You are responsible for paying the co-payment to your provider or pharmacy at the time of service. There are no co-payments for preventive visits. In addition, there are no co-payments for family planning services or prenatal care services.

State Managed Care Network ID Card

Your State Managed Care Network ID card shows that you are a member of this plan and gives you the information needed when you see a provider or get a prescription. Always carry your State Managed Care Network ID card. Have it handy when you call for an appointment and show it to the receptionist when you sign in for an appointment. Also, show your ID card to the pharmacist whenever you fill a prescription.

Changing Member Information

If your membership information changes in any way, such as your address or PCP, call the State Managed Care Network Customer Service department at 303-751-9051 or 1-800-414-6198. If the change cannot be made over the phone, Customer Service staff will explain how to make the change. Please notify CHP+ Eligibility and Enrollment of this change as well, at 1-800-359-1991.

Change of Residence

A member must notify CHP+ of an address change within 31 days after moving to a new residence. Failure to receive a renewal notice because you did not report your address change (or any other reason) does not relieve you of the responsibility to submit a renewal application by the renewal date.

If you move to a location that is not convenient to your current PCP office, you may choose a PCP nearer to your new residence. Please call Customer Service at 303-751-9051 or 1-800-414-6198 if

you would like to change your PCP. You must notify CHP+ within 31 days after you move to a new residence by calling or writing the CHP+ Customer Service department.

How to File Claims

In-Network

When an in-network provider bills the State Managed Care Network for covered services, the Plan will pay the appropriate charges for the covered service directly to the provider. You are responsible for giving the in-network provider all necessary information, such as your ID card, so that the provider can submit a claim. You pay the applicable co-payment to the in-network provider when you receive covered services.

Out-of-Network

Services performed by an out-of-network provider (one who is not contracted to provide services for the State Managed Care Network) will be covered only in an emergency as described under EMERGENCY AND URGENT CARE/AFTER HOURS or when approved in advance by the State Managed Care Network. Let the hospital or urgent care provider know that the claim must be sent to:

Colorado Access/State Managed Care Network
P.O. Box 17470
Denver, CO 80217

If the hospital accepts payment from the State Managed Care Network, then the hospital is reimbursed directly. You will be responsible for any co-payments that might apply. If the hospital will not accept payment from the State Managed Care Network, then you will be reimbursed for payment. The State Managed Care Network requires proof of payment (for example, a receipt and documentation of the amount paid in U.S. dollars) to reimburse you directly.

Remember:

- You may be responsible for non-emergency and non-urgent care services received outside of the service area or from an out-of-network provider.
- It is your responsibility to make sure that the provider is in-network with the State Managed Care Network.
- If you have any questions about a provider, or need help finding an in-network provider, call Customer Service at 303-751-9051 or 1-800-414-6198.

Where and When to Send Claims

Providers must file claims within 180 days after the date of service or as otherwise defined between the State Managed Care Network and the provider. Any claims filed after this timeframe may be refused unless the provider has a valid reason for not submitting the claim within the timeframe.

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

Colorado Access/State Managed Care Network
P.O. Box 17470
Denver, CO 80217

Overpayments

If the State Managed Care Network makes an overpayment, the Plan may require the provider or the ineligible person to refund the amount that was paid in error. The State Managed Care Network may collect overpayments made to a provider by subtracting them from future claim payments. The State Managed Care Network also reserves the right to take legal action to correct overpayments.

Catastrophic Events

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

Changes to the CHP+ Member Benefits Booklet

No agent or employee of the State Managed Care Network or Colorado Access may change this CHP+ Member Benefits Booklet by giving incomplete or incorrect information, or by contradicting the terms of this document. Any such situation will not prevent the State Managed Care Network from administering this CHP+ Member Benefits Booklet in strict accordance with its terms. Oral or written statements do not supersede the terms of this CHP+ Member 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 causes the health of health care coverage to go up. You can 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 insurance company will be charged for the test.

- Always review this CHP+ Member Benefits Booklet received from the State Managed Care Network. If there are any discrepancies, call Customer Service at 303-751-9051 or 1-800-414-6198.
- Be very cautious about giving health insurance coverage information over the phone.

If you suspect fraud, you should contact the State Managed Care Network. The Plan reserves the right to take back any benefit payments paid on behalf of a member if the member has committed fraud or material misrepresentation in applying for coverage or in receiving or filing for benefits.

Independent Contractors

The State Managed Care Network has an independent contractor relationship with in-network providers. Providers are not agents or employees of the State Managed Care Network, and Colorado Access employees are not employees or agents of any of the State Managed Care Network's in-network providers. The State Managed Care Network has no control over any diagnosis, treatment, care or other service provided to a member by any facility or professional providers. The Plan 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 in-network providers by reason of negligence or otherwise.

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

Notice of Privacy Practices

The State Managed Care Network is committed to protecting the confidentiality of your medical information to the fullest extent of the law. In addition to the laws that govern your privacy, the State Managed Care Network has its own privacy policies and procedures to help protect your information. The State Managed Care Network is required by law to give you notice of the legal duties and privacy practices. If you would like a copy of the notice, visit www.coaccess.com or call Customer Service.

No Withholding of Coverage for Necessary Care

The State Managed Care Network does not compensate, reward or incent, financially or otherwise, associates for inappropriate restrictions of care. The State Managed Care Network does not promote or otherwise provide an incentive to employees or provider reviewers for withholding benefit approval for medically necessary services to which you are entitled. Utilization review and benefit coverage decisions are based on appropriateness of care and service and the applicable terms of this CHP+ Member Benefits Booklet. The State Managed Care Network 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.

Section and Paragraph Headings

The headings used throughout this CHP+ Member Benefits Booklet are for reference only and are not to be used by themselves for interpreting the provisions of the Booklet.

Physical Examinations and Autopsies

The State Managed Care Network has the right and opportunity, at its expense, to request an examination of a person covered by the Plan when and as often as it may reasonably be required during the review of a case or claim. On the death of a member, the State Managed Care Network may request an autopsy where it is not forbidden by law.

Refusal to Follow Recommended Treatment

If you refuse treatment that has been recommended by an in-network provider, the provider may decide that your refusal compromises the provider-patient relationship and makes the provision of proper medical care difficult. Providers will try to deliver all necessary and appropriate services according to your wishes, when they are consistent with the provider's judgment. If you refuse to follow the recommended treatment or procedure, you are entitled to see another provider of the same specialty for a second opinion. You can also pursue the appeal process. If the second provider's opinion upholds the first provider's opinion and you still refuse to follow the recommended treatment, then your coverage may be terminated by CHP+ following a 30-day notice. If your coverage is terminated, neither the State Managed Care Network nor any provider associated with the Plan will have any further responsibility to provide your care. The State Managed Care Network may also cancel any member's coverage who acts in a disruptive manner that prevents the orderly operation of any in-network provider or State Managed Care Network staff.

Sending Notices

All member notices are considered sent to and received by the member when deposited in the United States mail with postage prepaid and addressed to the member at the latest address in the State Managed Care Network'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 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 & Subrogation

This plan does not coordinate benefits with any other coverage except Medicare.

Medicare and Coordination of Benefits

Members with Medicare Part A are to be coordinated with Medicare Parts A and B as the primary coverage (even though they do not have Part B). It is not acceptable to have double coverage. If the member is covered by any other valid coverage, including Medicaid and individual non-group coverage, they are not eligible for coverage under CHP+ or the CHP+ Prenatal Care Program. If you have access to the State of Colorado Employee Benefits Plan, you are not eligible for coverage under CHP+ or the CHP+ Prenatal Care Program.

Workers' Compensation

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

Services and supplies resulting from work-related illness or injury are not a benefit under this CHP+ Member Benefits Booklet.

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

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

The State Managed Care Network will not pay for services related to Workers' Compensation claims because:

- The member 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 fails to comply with any other provisions of the Workers' Compensation Act.

Automobile Insurance Provisions

The State Managed Care Network will coordinate the benefits of this CHP+ Member 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 the State Managed Care Network Coordinates Benefits with Complying Policies
Member benefits under this CHP+ Member Benefits Booklet may be coordinated with the coverages afforded by complying policy. After any primary coverages offered by the complying policy are exhausted (run out), the State Managed Care Network will pay benefits subject to the terms and conditions of this CHP+ Member Benefits Booklet. If there is more than one complying policy that offers primary coverage, each must be exhausted before the State Managed Care Network is liable for any further payments.

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

The State Managed Care Network may require proof that the complying policy has paid all primary benefits prior to making any payments. The State Managed Care Network may also, but is not be required to, make payments under this CHP+ Member Benefits Booklet and later coordinate with or seek reimbursement under the complying policy. In all cases, upon payment, the State Managed Care Network 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, the State Managed Care Network 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?
The State Managed Care Network will pay benefits for injuries received by the member while the member is riding in or operating a motor vehicle that the member owns if the vehicle is not covered by an automobile complying policy as required by law.

The State Managed Care Network will also pay benefits under the terms of the CHP+ Member 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, the State Managed Care Network may exercise the rights found in the next section, Third Party Liability: Subrogation.

Third-Party Liability: Subrogation

Third-party liability means that someone other than the member is or may be legally responsible for the member's condition or injury. The State Managed Care Network will not pay for any services or supplies under this CHP+ Member Benefits Booklet for which a third party is liable.

However, the State Managed Care Network may provide benefits under the following conditions:

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

- When the member guarantees in writing to reimburse the State Managed Care Network for any claims paid by the State Managed Care Network 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.

State Managed Care Network's Rights under Third-Party Liability

The State Managed Care Network has subrogation rights 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 CHP+ Member Benefits Booklet. This means that the Plan 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 has an obligation to cooperate in satisfying the State Managed Care Network's subrogation interest or to refrain from taking any action that may prejudice the State Managed Care Network's rights under this CHP+ Member Benefits Booklet. If the State Managed Care Network must take legal action to uphold its rights and if the State Managed Care Network prevails in that action, the Plan will be entitled to receive, and the member will be required to pay, the State Managed Care Network'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 benefit program, then the following must occur:

- The member must promptly notify the State Managed Care Network of the member's claim against the third party.
- The member and the member's attorney must provide for the amount of benefits paid by the State Managed Care Network 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 must fully reimburse the State Managed Care Network for the amount of benefits provided to the member under this certificate. The member may not exclude recovery for the State Managed Care Network's health care benefits from any type of damages or settlement recovered by the member.
- The member must cooperate in every way necessary to help the State Managed Care Network enforce its subrogation rights.

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

10: Complaints, Appeals & Grievances

This section explains what to do if you disagree with a State Managed Care Network denial, in whole or in part, of a claim or requested service or supply. This section includes instructions for initiating a complaint, filing an appeal or filing a grievance with the State Managed Care Network.

Complaints / Grievances

If you have a complaint about any aspect of the State Managed Care Network's service, please call Customer Service at 303-751-9051 or 1-800-414-6198. A trained representative will acknowledge receipt of the complaint / grievance and work to resolve your concerns.

If you would like to submit your grievance in writing, send a letter to:

Colorado Access
Grievance and Appeals Department
P.O. Box 17950
Denver, CO 80217-0950

The State Managed Care Network will acknowledge receipt of your grievance. The grievance department will investigate your concerns and will treat the grievance investigation in a strictly confidential manner.

If you are not satisfied with the outcome of the Grievance or Appeal you can send a letter to:

Health Plan Manager
Child Health Plan Plus
Department of Health Care Policy & Financing
1570 Grant St.
Denver, CO 80203

Appeals

If you disagree with a State Managed Care Network denial, in whole or in part, of a claim or requested service or supply, you can appeal.

- You have 180 days from the adverse benefit determination (denial) to send the State Managed Care Network a written appeal.
- To make sure your appeal is reviewed in a timely manner, the State Managed Care Network encourages you to file an appeal within 60 days of an adverse benefit determination (denial).
- Appeals may be for pre-service denials (an example of a pre-service denial is the denial of a pre-authorization) or post-service denials (an example of a post-service denial is the denial of a claim).
- If you need help with the appeal process, please call the State Managed Care Network at 303-751-9051 or 1-800-414-6198.
- Written complaints, grievances and appeals may be sent to:
  Colorado Access

Grievance and Appeals Department
P.O. Box 17950
Denver, CO 80217-0950

- In the appeal, state the reason(s) the claim or requested service or supply should not have been denied.
- Be sure to include any documents not originally submitted with the claim or request for the service or supply, and any information that can help the State Managed Care Network make a decision.
- You have access to 2 internal levels of appeal. In the case of a benefit denial based on utilization review, an independent external review appeal is also available.

A representative (such as a provider or family member) may file any level of appeal on your behalf. If you would like to designate a representative, you must submit it in writing.

Level 1 Appeal

At this appeal level, the State Managed Care Network 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, you will receive a response to the Level 1 Appeal within 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

If you are not satisfied with the decision from the Level 1 appeal, you or your designated representative (as described above) can request a level 2 appeal. This is a voluntary level of appeal. You must be request the level 2 appeal within 60 calendar days after you receive the State Managed Care Network's adverse determination from the Level 1 Appeal. You and/or your designated representative may appear in person or by teleconference to present testimony, introduce documentation you believe supports the appeal and provide documentation requested by the State Managed Care Network at a hearing concerning the appeal.

The panel of reviewers shall include a minimum of 3 people and may be comprised of State Managed Care Network 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 appeal 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.

The review panel shall schedule a review meeting within 60 calendar days of receiving a request from a covered person for a Level 2 Appeal. The State Managed Care Network will issue a copy of the written decision to you within 7 calendar days of the Level 2 Appeal decision. If a provider submitted the appeal on your behalf they will also receive the written decision. . The State Managed Care Network may extend the appeal decision timeframes if you request and extension or if you voluntarily agree to the extension.

Expedited Appeals

You or your designated representative have the right to request an expedited appeal when the timeframes for a standard review would:

- seriously jeopardize your life or health,
- Jeopardize your ability to regain maximum function, or,
- for persons with a disability, create an imminent and substantial limitation on your existing ability to live independently.

The decision of an expedited appeal will be made as soon as possible, but no later than within 72 hours after the start of the review. Expedited appeals will be evaluated by an appropriate clinical peer or peers who were not involved in the initial denial. The State Managed Care Network 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 the State Managed Care Network's Level 1 or Level 2 Appeal process. You or your designated representative do not need to go through the State Managed Care Network's voluntary Level 2 Appeal process in order to request an Independent External Review Appeal.

To request an Independent External Review Appeal, you or your representative must complete and submit a written request on the Request for Independent External Review of Carrier's Final Adverse Determination Form. You can get a copy of this form by calling the State Managed Care Network Customer Service department. The request must be made within 60 calendar days after the date of receipt of notice of the Level 1 or 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 the State Managed Care Network receives a request for the 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

You or your designated representative may request an Expedited Independent External Review

Appeals if you have a medical condition where the timeframe for a standard independent external review appeal would

- seriously jeopardize your life or health;
- jeopardize your ability to regain maximum function; or,
- for persons with a disability, create an imminent and substantial limitation on your existing ability to live independently.

The request must include a provider's certification that your medical condition meets the criteria for an Expedited Independent External Review Appeal. The request must be made on the Request for Independent External Review of Carrier's Final Adverse Determination Form. You can get a copy of this form by calling the State Managed Care Network Customer Service department. Decisions will be made by the independent external review entity within 7 business days after the State Managed Care Network receives a request for an Expedited Independent External Review Appeal. This timeframe may be extended for an additional 5 business days if the independent external review entity requests additional information. An Expedited Independent External Review Appeal may not be provided for retrospective denials.

Binding Arbitration

The binding arbitration provision under this CHP+ Member 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 may obtain a copy of the Uniform Arbitration Act by calling the Customer Service department. The law of the State of Colorado shall govern the dispute. The arbitration decision is binding on both the member and the State Managed Care Network. 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, the State Managed Care Network 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. The State Managed Care Network is not liable for punitive damages or attorney fees.

Legal Action

Before a member 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 CHP+ Member Benefits Booklet.

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

11: Glossary

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

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 a member 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 a member 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 provider or certified registered nurse anesthetist (CRNA).

Annual enrollment fee - There is no enrollment fee for the CHP+ Prenatal Care Program.

Appeal - a process for reconsideration of State Managed Care Network'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".

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

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, from January through December.

Care 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.

Care manager/Case manager - a professional (e.g., nurse, doctor or social worker) who works with members, providers and State Managed Care Network to coordinate services deemed medically necessary for the member.

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

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

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

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

Chronic pain - ongoing pain that lasts more than six months that is due to non-life threatening causes, 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 State Managed Care Network's services or the practices of an in-network 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 provider at the request of the attending provider in charge of a specific case or the PCP who gives an opinion about the treatment of the member's condition. The consulting provider 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 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 State Managed Care Network 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.

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 State Managed Care Network 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 the State Managed Care Network. This list is subject to periodic review and modification by the Plan.

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 the State Managed Care Network determines, in its sole discretion, to be experimental or investigational.

The State Managed Care Network 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 the State Managed Care Network. In determining if a service is experimental or investigational, the State Managed Care Network 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 the State Managed Care Network 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 providers, other medical professionals or facilities, or by other treating providers, 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 providers, other medical professionals or facilities or by other treating providers, 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) The State Managed Care Network 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.

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 member ID card - the card the State Managed Care Network gives members with information such as the member's name, ID number, PCP, and, co-payment amount (if applicable). This is also known as the State Managed Care Network member ID card.

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.

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

In-Network Provider – a provider that is contracted with the State Managed Care Network.

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 provider and one or more providers specializing in the treatment of the area, system or organ of the body perceived as the source of the pain.

IUD - 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 the State Managed Care Network'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 calendar year, per diagnosis, or as specifically defined in this CHP+ Member Benefits Booklet.

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

Medically necessary - an intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that the State Managed Care Network 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 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 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 person 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). The State Managed Care Network 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.

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 may require a referral within the State Managed Care Network. Medical nutrition therapy includes nutrition assessment, support and counseling to determine a treatment plan to increase nutritional intake to promote adequate growth, healing and improved health.

Occupational therapy - the use of educational and rehabilitative techniques to improve a 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. Organ transplant may be subject to a lifetime maximum benefit.

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

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

Out-of-network provider - an appropriately licensed health care provider that has not contracted with the State Managed Care Network. The Plan may not cover services provided by an out-of-network provider unless prior authorization is obtained. A member may be 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 the State Managed Care Network or if a service does not require a referral.

Out-of-area services - covered services provided to a member when he or she is outside the State Managed Care Network service area. See the State Managed Care Network 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 calendar year 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 calendar year.

Outpatient medical care - non-surgical services provided in a provider's office, the outpatient department of a hospital or other facility, or the 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 a primary care provider who has contracted with State Managed Care Network to supervise, coordinate and provide initial and basic care to members, initiate a referral for specialist care and maintain continuity of patient care.

Physical therapy - the use of physical agents to treat a disability resulting from disease or injury. Physical agents used include heat, cold, electrical currents, ultrasound, ultraviolet radiation,

massage and therapeutic exercise. A provider or registered physical therapist must perform physical therapy.

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

Pharmacy - an establishment licensed to dispense prescription drugs and other medications through a licensed pharmacist upon an authorized health care professional's order. A pharmacy may be a State Managed Care Network provider or an out-of-network provider. An in-network pharmacy is contracted with the State Managed Care Network to provide covered drugs to members under the terms and conditions of this certificate. An out-of-network pharmacy is not contracted through the State Managed Care Network administrator.

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 providers 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.

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

Prior Authorization - a process during which requests for procedures, services, or certain prescription drugs are reviewed prior to being rendered, for approval of benefits, length of stay and appropriate location. For prescription drugs, the designated State Managed Care Network pharmacy and therapeutics committee defines the drugs and criteria for coverage, including the need for prior authorization for certain medications.

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 provider for the continuous medical treatment of the condition.

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

Provider - a person or facility that is recognized by the State Managed Care Network as a health care provider and fits one or more of the following descriptions:

Professional provider - A provider who is licensed or otherwise authorized by the state or jurisdiction where services are provided to perform designated health care services. For benefits to be payable, services of a provider must be within the scope of the authority granted by the license and covered by this certificate. Such services are subject to review by a medical authority appointed by the State Managed Care Network. 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 the State Managed Care Network.

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

- An inpatient facility provider is a hospital, substance abuse treatment center, residential facility, hospice facility skilled nursing facility or other facility that the State Managed Care Network 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 the State Managed Care Network and licensed or certified to perform designated health care services by the state or jurisdiction where services are provided. Services of such a provider must be among those covered by this certificate and are subject to review by a medical authority appointed by the State Managed Care Network.

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, STI/HIV testing and treatment, health education, counseling, and a variety of contraceptive options including abstinence (family planning).

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

- Payment of Colorado income tax.
- Employment in Colorado, other than that normally provided on a temporary basis to students.
- Ownership 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 provider, devoted to a specific disease, condition or body part. Example: orthopedist- a provider who specializes in the treatment of bones and muscles.

Speech therapy (also called speech pathology) - services used for the diagnosis and treatment of

speech and language disorders. A licensed and accredited speech/language pathologist must perform speech therapy.

State Managed Care Network Provider - a professional health care provider or facility (i.e., a provider, hospital or home health agency) that contracts with the State Managed Care Network to provide services to State Managed Care Network members. In-network providers agree to bill the State Managed Care Network 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. The State Managed Care Network pays the in-network provider directly. The State Managed Care Network may add, change or delete specific providers at its discretion or recommend a specific provider for specialized care as medical necessity warrants.

State Managed Care Network service area- the geographic area where enrollment in the State Managed Care Network health plan is available.

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. The State Managed Care Network, at its sole discretion, determines which surgeries do or do not require a surgical assistant.

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

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

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