

# Benefits for Health Care Coverage

## Colorado Benchmark Plan



**CO L O R A D O**

**Department of  
Regulatory Agencies**

Division of Insurance

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## I. At a Glance – Covered and Not Covered

### Disclaimer

Starting in 2027, your coverage provides benefits for many services and supplies. There are also services for which this coverage does not provide benefits. The following chart is provided for your convenience as a quick reference only. This chart is not intended to be and does not constitute a complete description of all coverage details and factors that determine whether a service is covered or not.

Nothing in this 2027 Benchmark plan should be construed as additional Essential Health Benefits (EHB) requirements under Federal Law. At no time shall the set of benefits listed below be construed to allow an issuer to NOT cover any and all federal and state required benefits.

**Table 1. List of Benefits**

Category	Covered	Not Covered	Page Number and Service Notes
Abortions	✓		Pg. 6
Accidental Dental		⊘	Pg. 42
Acupuncture	✓		Pg. 6-7, 6 visits per benefit period
Allergy Testing	✓		Pg. 31
Bariatric Surgery	✓		Pg. 12
Basic Dental Care - Adult		⊘	Pg. 42
Basic Dental Care - Child	✓		Pg. 35-37
Chemotherapy	✓		Pg. 26 and 31
Chiropractic Care	✓		Pg. 7, 20 visits per year
Cosmetic Surgery		⊘	Pg. 41
Clinical Trials and Studies	✓		Pg. 6
Delivery and All Inpatient Services for Maternity Care	✓		Pg. 13
Dental Check-Up for Children	✓		Pg. 35-37
Dental Anesthesia	✓		Pg. 33-34
Diabetes Education	✓		Pg. 32

Category	Covered	Not Covered	Page Number and Service Notes
Diabetes Care Management	✓		Pg. 38-39
Dialysis	✓		Pg. 7-8
Durable Medical Equipment	✓		Pg. 26-27
Early Intervention Services	✓		Pg. 34-35
Emergency Room Services	✓		Pg. 10-12
Emergency Transportation/Ambulance	✓		Pg. 12
Eyeglasses for Children	✓		Pg. 37, 1 item per 2 years
Gender Affirming Care	✓		Pg. 39
Habilitation Services	✓		Pg. 27-28, 20 each for physical, occupational, and speech therapy
Hearing Aids	✓		Pg. 31 and 37
Home Health Care Services	✓		Pg. 8-9, 28 hours per week
Hospice Services	✓		Pg. 12-13
Imaging (CT/PET Scans, MRIs)	✓		Pg. 30-31
Infertility Treatment	✓		Pg. 9
Infusion Therapy	✓		Pg. 31
Inherited Metabolic Disorder	✓		Pg. 39-40
Inpatient Hospital Services (e.g., Hospital Stay)	✓		Pg. 13-14
Inpatient Physician and Surgical Services	✓		Pg. 13-14
Laboratory and Radiology Services	✓		Pg. 30-31
Laboratory Outpatient and Professional Services	✓		Pg. 30-31
Long-Term/Custodial Nursing Home Care		⊘	Pg. 45
Major Dental Care - Adult		⊘	Pg. 42
Major Dental Care - Child	✓		Pg. 35-37
Mental Health/Behavioral Health Inpatient Services	✓		Pg. 20-22

<b>Category</b>	<b>Covered</b>	<b>Not Covered</b>	<b>Page Number and Service Notes</b>
Mental Health/Behavioral Health Outpatient Services	✓		Pg. 20-22
Mental Health Other	✓		Pg. 20-22
Mental Health Wellness Exam	✓		Pg. 22
Nutritional Counseling	✓		Pg. 32
Orthodontia - Adult		⊘	Pg. 42
Orthodontia - Child		⊘	Pg. 42-43
Other Practitioner Office Visit (Nurse, Physician Assistant)	✓		Pg. 9-10
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓		Pg. 9-10
Outpatient Rehabilitation Services	✓		Pg. 29, 20 visits per year
Outpatient Surgery Physician/Surgical Services	✓		Pg. 9-10
Prenatal and Postnatal Care	✓		Pg. 9
Preventive Care/Screening/Immunizations	✓		Pg. 32-33
Primary Care Visit to Treat an Injury or Illness	✓		Pg. 9
Private-Duty Nursing	✓		Pg. 13
Prosthetic Devices	✓		Pg. 27-28
Radiation	✓		Pg. 9
Reconstructive Surgery	✓		Pg. 14
Rehabilitative Occupational Therapy	✓		Pg. 28-30, 20 visits per year
Rehabilitative Physical Therapy	✓		Pg. 28-30, 20 visits per year
Rehabilitative Speech Therapy	✓		Pg. 28-30, 20 visits per year
Routine Dental Services (Adult)		⊘	Pg. 42
Routine Eye Exam (Adult)	✓		Pg. 33
Routine Eye Exam for Children	✓		Pg. 33
Routine Foot Care	✓		Pg. 40

Category	Covered	Not Covered	Page Number and Service Notes
Skilled Nursing Facility	✓		Pg. 14-15, 100 days per year
Specialist Visit	✓		Pg. 9
Substance Use Disorder Inpatient Services	✓		Pg. 20-22
Substance Use Disorder Outpatient Services	✓		Pg. 20-22
Transplant	✓		Pg. 15-16
Treatment for Temporomandibular Joint Disorders	✓		Pg. 10
Urgent Care Centers or Facilities	✓		Pg. 12
Weight Loss Programs		⊘	Pg. 7 and 25
Well Baby Visits and Care	✓		Pg. 32
X-rays and Diagnostic Imaging	✓		Pg. 30-31

**Table 2. Prescription Drug Plan**

Category	Covered	Not Covered	Page Number and Prescription Maximum
Generic Drugs	✓		Pg. 23-24
Non-Preferred Brand Drugs	✓		Pg. 23-26
Preferred Brand Drugs	✓		Pg. 23-26
Specialty Drugs	✓		Pg. 24

## II. Detail of Benefits

### **Disclaimer**

To the extent that the Essential Health Benefits (EHB) benchmark plan does not comply with current federal requirements, including MHPAEA, individual and small group market issuers must conform plan benefits to meet all EHB requirements. This includes ensuring that the availability of benefits are not discriminatory under federal law.

NOTE: To the extent hormone therapy and surgical services are already covered under the benchmark plan as medically necessary, issuers must provide these services for all medically necessary services.

No changes were made to pediatric dental or pediatric vision benefits.

There may be United States Pharmacopeia (USP) Classes that do not have any drugs covered under the benchmark plan. Under 45 CFR 156.122 issuers are required to cover at least the greater of: one drug in every USP Category and Class or the same number of prescription drugs in each category and class as the EHB benchmark. Consequently, regardless of the benchmark, issuers must cover at least one drug in every USP Category and class.

### **Ambulatory Patient Services**

#### **Abortions**

**Coverage:** All medical and surgical abortions and any related services, drugs, or supplies are covered.

#### **Access to Clinical Trials and Studies**

**Coverage:** All individual and group health benefits plans are required to provide coverage for routine patient care costs while the covered person participates in a clinical trial or study as long as the coverage is a benefit that the covered person would receive if he or she were receiving standard chronic disease treatment outside of the clinical trial or study. The clinical trials must meet specific requirements as to review board approvals and patient care.

#### **Acupuncture**

**Coverage:** Acupuncture is treatment by means of inserting needles into the body to reduce pain or to induce anesthesia. It may also be used for other diagnoses as determined appropriate by the practitioner/provider. It is recommended that acupuncture be part of a coordinated plan of care approved by the member's practitioner/provider. These benefits cover acupuncture and acupressure treatment.

**Limitations:** The acupuncture benefit is limited to 6 visits per plan year.

### **Chiropractic Care**

**Coverage:** 20 visits per year for evaluation, lab services & x-rays, treatment of musculoskeletal disorders.

Chiropractic Services are covered as shown on your health plan's "Summary Chart" when provided by contracted chiropractors. Coverage includes:

1. Evaluation;
2. Lab Services and X-rays required for chiropractic Services; and
3. Treatment of musculoskeletal disorders.

You may self-refer for visits to contracted chiropractors.

**Limitation:** 20 visits per year

### **Exclusions:**

1. Hypnotherapy.
2. Behavior training.
3. Sleep therapy.
4. Weight loss programs.
5. Services not related to the treatment of the musculoskeletal system.
6. Vocational rehabilitation Services.
7. Thermography.
8. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices and appliances.
9. Transportation costs. This includes local ambulance charges.
10. Prescription drugs, vitamins, minerals, food supplements or other similar products.
11. Educational programs.
12. Non-medical self-care or self-help training.
13. All diagnostic testing related to these excluded Services.
14. MRI and/or other types of diagnostic radiology chiro
15. Physical or massage therapy that is not a part of the chiropractic treatment.
16. Durable medical equipment (DME) and/or supplies for use in the home.

### **Dialysis**

**Coverage:** covered are dialysis services related to acute renal failure and end-stage renal disease if the following criteria are met:

1. The Services are provided inside your health plan's Service Area; and
2. You meet all medical criteria developed by your health plan and by the facility providing

- the dialysis; and
3. The facility is certified by Medicare and contracts with your health insurer; and
  4. An In-Network Physician provides a written referral for care at the facility.

After the referral to a dialysis facility, covered at no charge are: equipment; training; and medical supplies required for home dialysis.

### **Home Health Care Services**

**Coverage:** Skilled nursing care, home health aide services and medical social services:

1. Only on a Part-Time Care or Intermittent Care basis; and
2. Only within your health plan's Service Area; and
3. Only if you are confined to your home; and
4. Only if an In-Network Physician determines that it is feasible to maintain effective supervision and control of your care in your home.

Part-Time Care or Intermittent Care means part-time or intermittent skilled nursing and home health aide Services. Services must be clinically indicated; may not exceed 28 hours per week combined over any number of days per week; and must be for less than eight (8) hours per day. Additional time up to 35 hours per week but less than eight (8) hours per day may be approved by the Health Plan on a case-by-case basis.

**Note:** X-ray, laboratory and special procedures are not covered under this section. See "X-ray, Laboratory and Special Procedures".

### **Home Health Care Exclusions:**

1. Custodial care.
2. Homemaker Services.
3. Care that health plan determines may be appropriately provided in an In-Network Facility or Skilled Nursing Facility, if offered to provide that care in one of these facilities.

### **Special Services Program**

If you have been diagnosed with a terminal illness with a life expectancy of one year or less, but are not yet ready to elect hospice care, you are eligible for the Special Services Program ("Program"). This Program allows you to receive up to 15 home health visits per lifetime. These visits are without Charge until you elect hospice care coverage. Coverage of hospice care is described below.

This Program gives you and your family time to become more familiar with hospice-type Services and to decide what is best for you. It helps you bridge the gap between your diagnosis and preparing for the end of life.

The difference between this Program and regular visiting nurse visits is that: you may or may not be homebound or have skilled nursing care needs; or you may only require spiritual or emotional care. Services available through this Program are provided by professionals with specific training in end-of-life issues.

### **Infertility Treatment**

**Coverage:** The following services, including X-ray and laboratory procedures are covered: (a) services for diagnosis and treatment of involuntary infertility; and (b) artificial insemination, except for donor semen, donor eggs and services related to their procurement and storage.

**Note:** Drugs, supplies and supplements are not covered under this section. See “Drugs, Supplies and Supplements” to find out if any drugs for the treatment of infertility are covered.

### **Infertility Services Exclusions:**

1. Services to reverse voluntary, surgically induced infertility.
2. All services and supplies (other than artificial insemination) related to conception by artificial means. This means prescription drugs related to such services, and donor semen and donor eggs used for such services, such as, but not limited to: in vitro fertilization, ovum transplants, gamete intra fallopian transfer and zygote intra fallopian transfer are not covered. These exclusions apply to fertile as well as infertile individuals or couples.

**Note:** To determine if your Health Plan has the infertility benefit, see your health plan “Summary Chart.”

### **Outpatient Care for Preventive Care, Diagnosis and Treatment**

**Coverage:** Covered, under this “Benefits” section and subject to any specific limitations, exclusions or exceptions as noted throughout this document, the following outpatient care for preventive care, diagnosis and treatment, including professional medical services of physicians and other health care professionals in the physician’s office, during medical office consultations, in a Skilled Nursing Facility or at home:

1. Primary care visits: Services from family medicine, internal medicine, and pediatrics.
2. Specialty care visits: Services from providers that are not primary care, as defined above.
3. Routine prenatal and postpartum visits.
4. Consultations with clinical pharmacists
5. Outpatient surgery.
6. Blood, blood products and their administration.
7. Second opinion.
8. House calls when care can best be provided in your home as determined by an In-Network Physician.

9. Medical social services.
10. Preventive care services (see “Preventive Care Services” in this “Benefits” section for more details).

**Note:** To determine if your Health Plan has the bariatric surgery benefit, see your health plan’s “Summary Chart.” If your Health Plan has the bariatric surgery benefit, you must meet your health plan’s criteria to be eligible for coverage.

### **Treatment for Temporomandibular Joint Disorders**

**Coverage:** The following Services for TMJ may be covered if an In-Network Physician determines they are Medically Necessary: diagnostic X-rays; lab testing; physical therapy; and surgery.

## **EMERGENCY SERVICES**

### **Emergency Services**

Emergency Services are available at all times - 24 HOURS A DAY, 7 DAYS A WEEK. If you have an Emergency Medical Condition, call 911 or go to the nearest hospital emergency department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, Emergency Services you receive from In-Network Providers and Out-of-Network Providers anywhere in the world are covered, as long as the services would have been covered under your plan if you had received them from In-Network Providers.

You are also covered for medical emergencies anywhere in the world. For information about emergency benefits away from home, please call Member Services.

Please note that in addition to any Copayment or Coinsurance that applies under this section, you may incur additional Copayment or Coinsurance amounts for Services and procedures covered under other sections of this EOC.

### **Emergency Services Provided by Out-of-Network Providers (Out-of-Network Emergency Services)**

“Out-of-Network Emergency Services” are Emergency Services that are not provided by an In-Network Physician. There may be times when you or a family member may receive Emergency Services from Out-of-Network Providers. The patient’s medical condition may be so critical that you cannot call or come to one of your health plan’s In-Network Medical Offices or the emergency room of an In-Network Hospital, or the patient may need Emergency Services while traveling outside your health plan’s Service Area.

Please refer to “ii. Emergency Services Limitation for Out-of-Network Providers,” below, if you

are hospitalized for Emergency Services.

1. Covered out-of-Network Emergency Services as follows:

- i. Outside your Service Area. If you are injured or become unexpectedly ill while you are outside your health plan's Service Area, your health plan will cover Out-of-Network Emergency Services that could not reasonably be delayed until you could get to an In-network Hospital, a hospital where your health plan has contracted for Emergency Services, or an In-network Facility. Covered benefits include Medically Necessary Out-of-Network Emergency Services for conditions that arise unexpectedly, including but not limited to myocardial infarction, appendicitis or premature delivery.
- ii. Inside your Service Area. If you are inside your health plan's Service Area, your health plan will cover Out-of-Network Emergency Services only if you reasonably believed that your life or limb was threatened in such a manner that the delay in going to a Plan Hospital, a hospital where your health plan has contracted for Emergency Services, or an In-Network Facility for your treatment would result in death or serious impairment of health.

2. Emergency Services Limitation for Out-of-Network Providers

If you are admitted to an Out-of-Network Hospital, Out-of-Network Facility or a hospital where your health plan has contracted for Emergency Services, you or someone on your behalf must notify your health plan within 24 hours, or as soon as reasonably possible.

Your health plan will decide whether to make arrangements for necessary continued care where you are, or to transfer you to an In-network Facility designated once you are stabilized. By notifying your health plan of your hospitalization as soon as possible, you will protect yourself from potential liability for payment for Services you receive after transfer to one of your In-Network Facilities would have been possible.

**Emergency Services Exclusions:**

1. Services outside your health plan's Service Area for conditions that, before leaving the Service Area, you knew or should have known might require Services while outside your health plan's Service Area, such as dialysis for end-stage renal disease, post-operative care following surgery performed by In-Network Physicians, full-term delivery, and treatment for continuing infections, unless determined that you were temporarily outside your health plan's Service Area because of extreme personal emergency.
2. Continuing or follow-up treatment. Covered are only the Out-of-Network Emergency Services that are required before you could, without medically harmful results, have been moved to an In-Network Facility designated either inside or outside your Service Area. When approved by your health plan or by an In-Network Physician in this Service Area,

your health plan will cover ambulance Services or other transportation Medically Necessary to move you to a designated In-Network Facility for continuing or follow-up treatment.

### **Non-Emergency, Non-Routine Care**

#### 1. **Urgent Care**

**Coverage:** Urgent care is medically necessary medical or surgical procedures, treatments, or health care services you receive in an urgent care center or in a practitioner's/provider's office for an unforeseen condition due to illness or injury. Urgent conditions are not life-threatening, but require prompt medical attention to prevent serious deterioration in your health.

#### 2. **Out-of-Network Non-Emergency, Non-Routine Care**

There may be situations when it is necessary for you to receive unauthorized non-emergency, non-routine care outside your Service Area. Non-emergency, non-routine care received from Out-of-Network Providers is covered only when obtained outside your health plan's Service Area, if all of the following requirements are met:

- a. The care is required to prevent serious deterioration of your health; and
- b. The need for care results from an unforeseen illness or injury when you are temporarily away from your health plan's Service Area; and
- c. The care cannot be delayed until you return to your health plan's Service Area.

### **Emergency Transportation/Ambulance**

**Coverage:** Ambulance Services are covered only if your condition requires the use of medical Services that only a licensed ambulance can provide.

**Exclusion:** Transportation by other than a licensed ambulance. This includes transportation by car, taxi, bus, gurney van, minivan and any other type of transportation, even if it is the only way to travel to an In-Network Provider.

## **HOSPITALIZATIONS**

### **Bariatric Surgery**

**Coverage:** Covered.

### **Hospice Services**

**Coverage:** Hospice care for terminally ill members inside the Service Area is covered. If an In-Network Physician diagnoses you with a terminal illness and determines that your life expectancy is six (6) months or less, you can choose hospice care instead of traditional Services otherwise provided for your illness.

If you elect to receive hospice care, you will not receive additional benefits for the terminal illness. However, you can continue to receive Health Plan benefits for conditions other than the terminal illness.

The following services and other benefits are covered when: (1) prescribed by an In-Network Physician and the hospice care team; and (2) received from a licensed hospice approved:

1. Physician care.
2. Nursing care.
3. Physical, occupational, speech and respiratory therapy.
4. Medical social services.
5. Home health aide and homemaker services.
6. Medical supplies, drugs, biologicals and appliances.
7. Palliative drugs in accord with your health plan's drug formulary guidelines.
8. Short-term inpatient care including respite care, care for pain control, and acute and chronic pain management.
9. Counseling and bereavement services.
10. Services of volunteers.

### **Hospitalization Services (e.g., Hospital Stay)**

**Covered:** Cover, only as described under this "Benefits" section and subject to any specific limitations, exclusions or exceptions as noted throughout this EOC, the following inpatient services in an In-Network Hospital, when the services are generally and customarily provided by acute care general hospitals in your health plan's Service Areas:

1. Room and board, such as semiprivate accommodations or, when an In-Network Physician determines it is Medically Necessary, private accommodations or private duty nursing care.
2. Intensive care and related hospital Services.
3. Professional Services of physicians and other health care professionals during a hospital stay.
4. General nursing care.
5. Obstetrical care and delivery. This includes cesarean section. Note: If you are discharged within 48 hours after delivery (or 96 hours if delivery is by Cesarean section), your Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge. If your newborn remains in the hospital following your discharge, Charges incurred by the newborn after your discharge are subject to all Health Plan provisions. This includes his/her own Copayments, Deductibles and Coinsurance requirements.
6. Meals and special diets.
7. Other hospital Services and supplies, such as:
  - i. Operating, recovery, maternity and other treatment rooms.

- ii. Prescribed drugs and medicines.
- iii. Diagnostic laboratory tests and X-rays.
- iv. Blood, blood products and their administration.
- v. Dressings, splints, casts and sterile tray Services.
- vi. Anesthetics, including nurse anesthetist Services.
- vii. Medical supplies, appliances, medical equipment, including oxygen, and any covered items billed by a hospital for use at home.

**Hospital Inpatient Care Exclusions:**

- 1. Dental Services are excluded, except for hospitalization and general anesthesia for dental Services provided to Members as required by State law.
- 2. Cosmetic surgery related to bariatric surgery.

**Reconstructive Surgery**

**Coverage:** Reconstructive surgery when an In-Network Physician determines it: (a) will correct significant disfigurement resulting from an injury or Medically Necessary surgery; or (b) will correct a congenital defect, condition, disease or anomaly to produce major improvement in physical function; or (c) will treat congenital hemangioma (port wine stains) on the face and neck. Following Medically Necessary removal of all or part of a breast, also covered are reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas.

**Reconstructive Surgery Exclusions:** Plastic surgery or other cosmetic Services and supplies primarily to change your appearance. This includes cosmetic surgery related to bariatric surgery.

**Women’s Health and Cancer Rights Act:** In accord with the “Women’s Health and Cancer Rights Act of 1998,” and as determined in consultation with the attending physician and the patient, the following is covered after a mastectomy:

- a. Reconstruction of the breast on which the mastectomy was performed.
- b. Surgery and reconstruction of the other breast to produce a symmetrical (balanced) appearance.
- c. Prosthesis (artificial replacements).
- d. Services for physical complications resulting from the mastectomy.

**Skilled Nursing Facility**

**Coverage:** Covered up to 100 days per year of skilled inpatient Services in a licensed Skilled Nursing Facility. The skilled inpatient Services must be those usually provided by Skilled Nursing Facilities. A prior three-day stay in an acute care hospital is not required. The following Services are covered:

- 1. Room and board.

2. Nursing care.
3. Medical social services.
4. Medical and biological supplies.
5. Blood, blood products and their administration.

A Skilled Nursing Facility is an institution that: provides skilled nursing or skilled rehabilitation Services, or both; provides Services on a daily basis 24 hours a day; is licensed under applicable state law; and is approved in writing by your health insurer.

**Note:** The following are covered, but not under this section: drugs, see “Drugs, Supplies and Supplements”; DME and prosthetics and orthotics, see “Durable Medical Equipment and Prosthetics and Orthotics”; X-ray, laboratory and special procedures, see “X-ray, Laboratory and Special Procedures”.

**Skilled Nursing Facility Care Exclusion:** Custodial Care, as defined in “Exclusions” under “Exclusions, Limitations and Reductions”, below.

### **Transplant**

**Coverage:** Transplants are covered on a LIMITED basis as follows:

1. Covered transplants are limited to: kidney transplants; heart transplants; heart-lung transplants; liver transplants; liver transplants for children with biliary atresia and other rare congenital abnormalities; small bowel transplants; small bowel and liver transplants; lung transplants; cornea transplants; simultaneous kidney-pancreas transplants; and pancreas alone transplants.
2. Bone marrow transplants (autologous stem cell or allogeneic stem cell) associated with high dose chemotherapy for germ cell tumors and neuroblastoma in children and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich syndrome.
3. If all medical criteria developed by your health plan are met, your health plan covers: stem cell rescue; and transplants of organs, tissue or bone marrow.

### **Related Prescription Drugs**

Prescribed post-surgical immunosuppressive outpatient drugs required after a transplant are provided at the applicable outpatient prescription drug Copayment or Coinsurance shown on your health plan’s “Summary Chart.”

### **Terms and Conditions**

1. Your health Plan and In-Network Physicians do not undertake: to provide a donor or donor organ or bone marrow or cornea; or to assure the availability of a donor or donor organ or bone marrow or cornea; or to assure the availability or capacity

of referral transplant facilities approved by your health insurer. In accord with your health plan's guidelines for living transplant donors, your health plan provides certain donation-related Services for a donor, or a person your health insurer or an In-network Physician identifies as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered transplant for you. For information specific to your situation, please call your assigned Transplant Coordinator or the Transplant Administrative Offices.

2. In-Network Physicians must determine that the Member satisfies the health plan's medical criteria before the Member receives Services.
3. An In-Network Physician must provide a written referral for care at a transplant facility. The transplant facility must be from a list of approved facilities selected by your health insurer. The referral may be to a transplant facility outside your health plan's Service Area. Transplants are covered only at the facility your health insurer selects for the particular transplant, even if another facility within the Service Area could also perform the transplant.
4. After referral, if an In-Network Physician or the medical staff of the referral facility determines the Member does not satisfy its respective criteria for the Service, Health Plan's obligation is only to pay for covered Services provided prior to such determination.

#### **Transplant Services Exclusions and Limitations:**

1. Bone marrow transplants, associated with high dose chemotherapy for solid tissue tumors, (except bone marrow transplants covered under this EOC) are excluded.
2. Non-human and artificial organs and their implantation are excluded.
3. Pancreas alone transplants are limited to patients without renal problems who meet set criteria.
4. Travel and lodging expenses are excluded, except that in some situations, when an In-Network Physician refers you to an Out-of-Network Provider outside your health plan's Service Area for transplant Services, as described in "Getting a Referral" in the "How to Obtain Services" section, your health plan may pay certain expenses pre authorized under your health plan's internal travel and lodging guidelines. Travel and lodging expenses related to non-transplant Services are not covered. For information specific to your situation, please call your assigned Transplant Coordinator; or the Transplant Administrative Offices.

## **MATERNITY & NEWBORN CARE**

### **Congenital defects and birth abnormalities**

**Citation:** Colorado Revised Statute § 10-16-104(1.3)(b)(IV)(B) and § 10-16-104(1.7)

**(1.7) Therapies for congenital defects and birth abnormalities.**

- (a)** After the first thirty-one days of life, policy limitations and exclusions that are generally applicable under the policy may apply; except that all individual and group health benefit plans shall provide medically necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for a covered child from the child's third birthday to the child's sixth birthday.
- (b)** The level of benefits required in paragraph (a) of this subsection (1.7) shall be the greater of the number of such visits provided under the policy or plan or twenty therapy visits per year each for physical therapy, occupational therapy, and speech therapy. Said therapy visits shall be distributed as medically appropriate throughout the yearly term of the policy or yearly term of the enrollee coverage contract, without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.
- (c)** Repealed.
- (d)** The health care service plan issued by an entity subject to the provisions of part 4 of this article may provide that the benefits required pursuant to this subsection (1.7) shall be covered benefits only if the services are rendered by a provider who is designated by and affiliated with the health maintenance organization.

**Newborns**

**Citation:** Colorado Revised Statute § 10-16-104 (1) and § 10-16-104 (3)

**(1) Newborn Children**

**(b)**

- (I)** Coverage for a hospital stay for a newborn following a normal vaginal delivery shall not be limited to less than forty-eight hours. If forty-eight hours following delivery falls after 8 p.m., coverage shall continue until 8 a.m. the following morning.
- (II)** Coverage for a hospital stay for a newborn following a cesarean section shall not be limited to less than ninety-six hours. If ninety-six hours following the cesarean section falls after 8 p.m., coverage shall continue until 8 a.m. the following morning.
- (III)** The provisions of subparagraphs (I) and (II) of this paragraph (b) shall not apply in any case in which the decision to discharge the newborn prior to the minimum length of stay otherwise required under subparagraphs (I) and (II) of this paragraph (b) is made by an attending provider with the agreement of the mother.
- (IV)** Nothing in this paragraph (b) shall be construed to require a mother who is a participant or beneficiary to give birth in a hospital or to stay in the hospital for a fixed period of time after the birth of her child.
- (V)** Nothing in this paragraph (b) shall be construed as preventing a carrier from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or newborn child under the plan; except that such coinsurance or other cost-sharing for any portion of a

period within a hospital length of stay required under subparagraphs (I) and (II) of this paragraph (b) may not be greater than such coinsurance or cost-sharing for any other sickness, injury, disease, or condition that is otherwise covered under the policy or contract.

(c)

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

(II)

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

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

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

(III)

- (A) Coverage for inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids as well as severe protein allergic conditions includes, without limitation, the following diagnosed conditions: Phenylketonuria; maternal phenylketonuria; maple syrup urine disease; tyrosinemia; homocystinuria; histidinemia; urea cycle disorders; hyperlysinemia; glutaric acidemias; methylmalonic acidemia; propionic acidemia; immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders as evidenced by the results of a biopsy; and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. Covered care and treatment of such conditions shall include, to the extent medically necessary, medical foods for home use for which a physician who is a participating provider has issued a written, oral, or electronic prescription.
- (B) There is no age limit on benefits for inherited enzymatic disorders specified in sub-subparagraph (A) of this paragraph (III) except for phenylketonuria. The maximum age to receive benefits for phenylketonuria is twenty-one years of age; except that the maximum age to receive benefits for phenylketonuria for women who are of child-bearing age is thirty-five years of age.
- (C) As used in this subparagraph (III), “medical foods” means prescription metabolic formulas and their modular counterparts and amino acid-based elemental formulas, obtained through a pharmacy, that are specifically designated and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and for severe allergic conditions, if diagnosed by a board-certified allergist or board-certified gastroenterologist, for which medically standard methods of diagnosis, treatment, and monitoring exist. Such formulas are specifically processed or formulated to be deficient in one or more nutrients. The formulas for severe food allergies contain only singular form elemental amino acids. The formulas are to be consumed or administered enterally either via tube or oral route under the direction of a physician who is a participating provider. This sub-subparagraph (C) shall not be construed to apply to cystic fibrosis patients or lactose- or soy-intolerant patients.
- (D) Coverage of medical foods, as provided under this subparagraph (III), shall only apply to insurance plans that include an approved pharmacy benefit and shall not apply to alternative medicines. Such coverage shall only be available through participating pharmacy providers. Nothing in this subparagraph (III) shall be construed as preventing a carrier from imposing deductibles, coinsurance, or other cost-sharing methods.
- (d) If payment of a specific premium is required to provide coverage for a child, the policy

may require that notification of birth of the newborn child and payment of the required premium must be furnished to the insurer or other entity within thirty-one days after the date of birth in order to have the coverage continue beyond such thirty-one-day period.

- (e) The requirements of this section shall apply to all individual sickness and accident policies issued on and after July 1, 1975, and to all blanket and group sickness and accident policies issued, renewed, or reinstated on and after July 1, 1975, and to all subscriber or enrollee coverage contracts delivered or issued for delivery in this state on and after July 1, 1975.
- (f)
  - (I) Any contract of a prepaid dental plan of an entity subject to the provisions of part 5 of this article applied for that provides family coverage shall, as to such coverage of individuals in the family, also provide that the benefits applicable for children shall be payable with respect to a newly born child of the insured from the instant of such child's birth to the same extent that such coverage applies to other individuals in the family. If payment of a specific premium or capitation amount is required to provide coverage for a child, the contract may require that notification of birth of a newly born child and payment of the required premium or capitation amount shall be furnished to the organization within thirty-one days after the date of birth in order to have the coverage continue beyond the thirty-one-day period.
  - (II) The coverage for newborn children shall include any orthodontics or dental care needed as the result of the child being born with a cleft lip or cleft palate or both. The contract providing such coverage may contain the same copayment provisions as apply to other conditions or procedures covered by the contract.
- (g) The health care service plan issued by an entity subject to the provisions of part 4 of this article may provide that the benefits required pursuant to this subsection (1) shall be covered benefits only if the services are rendered by a provider who is designated by and affiliated with the health maintenance organization.

## **MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT**

### **Behavioral, mental health, and substance use disorders**

**Citation:** Colorado Revised Statute § 10-16-104 (5.5)

(5.5) Behavioral, mental health, and substance use disorders

- (A) For the prevention of, screening for, and treatment of behavioral, mental health, and substance use disorders that is no less extensive than the coverage provided for any physical illness and that complies with the requirements of the MHPAEA; and
- (B) At a minimum, for the treatment of substance use disorders in accordance with the American Society of Addiction Medicine criteria for placement,

medical necessity, and utilization management determinations as set forth in the most recent edition of “The ASAM Criteria for Addictive, Substance-related, and Co-occurring Conditions”; except that the commissioner may identify by rule, in consultation with the department of health care policy and financing and the office of behavioral health in the department of human services, an alternate nationally recognized and evidence-based substance-use-disorder-specific criteria for placement, medical necessity, or utilization management, if American Society of Addiction Medicine criteria are no longer available, relevant, or do not follow best practices for substance use disorder treatment.

### **Chemical Dependency Services**

#### **1. Inpatient Medical and Hospital Services**

**Coverage:** services for the medical management of withdrawal symptoms. Medical Services for alcohol and drug detoxification are covered in the same way as for other medical conditions. Detoxification is the process of removing toxic substances from the body.

#### **2. Residential Rehabilitation**

The determination of the need for services of a residential rehabilitation program and referral to such a facility or program is made by or under the supervision of an In-Network Physician.

Coverage for inpatient services and partial hospitalization in a residential rehabilitation program approved for the treatment of alcoholism, drug abuse or drug addiction.

#### **3. Outpatient Services**

Outpatient rehabilitative services for the treatment of alcohol and drug dependency are covered when referred by an In-Network Physician.

Mental health services required in connection with the treatment of chemical dependency are covered as provided in the “Mental Health Services” section below.

Members who are disruptive or abusive may have their membership terminated for cause.

### **Mental Health Services**

**Coverage:** Mental health services are covered as shown below. Coverage includes evaluation and Services for conditions which, in the judgment of a Physician, would respond to therapeutic management.

**1. Outpatient Therapy**

**Covered:** diagnostic evaluation; individual therapy; psychiatric treatment; and psychiatrically oriented child and teenage guidance counseling.

Visits for the purpose of monitoring drug therapy are covered.

Psychological testing as part of diagnostic evaluation is covered.

**2. Inpatient Services**

Covered are psychiatric hospitalization in a facility designated by the Health Plan. Hospital Services for psychiatric conditions include all Services of Physicians and mental health professionals and the following Services and supplies as prescribed by an In-Network Physician while you are a registered bed patient: room and board; psychiatric nursing care; group therapy; electroconvulsive therapy; occupational therapy; drug therapy; and medical supplies.

**3. Partial Hospitalization**

Covered are partial hospitalization in an In-Network Hospital-based program.

**Mental Health Services Exclusions:**

1. Evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless a Physician determines such evaluation to be Medically Necessary.
2. Mental health Services ordered by the court, to be used in a court proceeding, or as a condition of parole or probation, unless a Physician determines such Services to be Medically Necessary.
3. Court-ordered testing and testing for ability, aptitude, intelligence or interest. I.e. Services which are custodial or residential in nature.

**Mental Health Wellness Exam**

**Coverage:** One 45-60 minute visit by a qualified mental health care provider per plan year that can include services such as behavioral health screening, education and consultation on healthy lifestyle change, referrals to ongoing mental health treatment, and discussion of potential options for medication.

**PRESCRIPTION DRUGS**

**Alternatives to Opioids**

This expands the number of drugs required to be covered in certain United States Pharmacopeia classes to provide alternatives to opioids. Please see your Health Plan's drug Formulary for specific drug coverage.

### **Prescription Drug Benefit**

**Note:** The term "preferred" refers to drugs that are included in the Health Plan Drug Formularies. The term "non-preferred" refers to drugs that are not included in the Health Plan Drug Formularies.

**Coverage:** Prescribed covered drugs are provided at the applicable prescription drug Copayment or Coinsurance for each tier of drug coverage. This may include: a preferred generic drug tier; a tier for preferred brand-name drugs or medications not having a generic or a generic equivalent; and a tier for prescribed non-preferred drugs authorized through the non-preferred drug process.

Prescribed supplies and accessories include, but may not be limited to:

- a. Home glucose monitoring supplies.
- b. Glucose test strips.
- c. Acetone test tablets.
- d. Nitrate urine test strips for pediatric patients.
- e. Disposable syringes for the administration of insulin.

Such items are provided when obtained from sources designated by the Health Plan.

Prescribed specialty drugs, including self-administered injectable drugs, are provided at the specialty drug Coinsurance up to the maximum amount per drug dispensed.

### **Contraceptive drugs and devices:**

- a. For Copayment or Coinsurance information related to contraceptive drugs and certain devices, please refer to your health plan's "Summary Chart."

For each drug, the amount covered will be the lesser of the quantity prescribed or the day supply limit. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply limit, you will be charged as a non-Member for any prescribed amount exceeding the limit. Certain drugs have a significant potential for waste and diversion. Those drugs will be provided for up to a 30-day supply. Each prescription refill is provided on the same basis as the original prescription. The health plan may, in its sole discretion, establish quantity limits for specific prescription drugs.

### **Generic drugs that are:**

- a. Available in the United States only from a single manufacturer; and
- b. Not listed as generic in the then-current commercially available drug database(s) the Health Plan subscribes to are provided at the brand-name Copayment. The amount covered will be

the lesser of the quantity prescribed or the day supply limit.

### **Administered Drugs**

Covered are the following administered drugs as part of your Hospital Inpatient Care and Skilled Nursing Facility benefit. If the following are administered in a Physician's Office or during home visits if administration or observation by medical personnel is required, they are covered at the applicable office administered drug Copayment or Coinsurance shown on your health plan's "Summary Chart." This Copayment or Coinsurance may be in addition to your Outpatient Care Copayment or Coinsurance.

- a. Drugs and injectables; radioactive materials used for therapeutic purposes; vaccines and immunizations approved for use by the U.S. Food and Drug Administration (FDA); and allergy test and treatment materials.

### **Prescriptions by Mail**

If requested, refills of maintenance drugs will be mailed through health plan's mail-order prescription service by First-Class U.S. Mail with no charge for postage and handling. Refills of maintenance drugs prescribed by In-Network Physicians may be obtained for up to the day supply by mail order, at the applicable Copayment or Coinsurance. Maintenance drugs are determined by Health Plan. Certain drugs have a significant potential for waste and diversion. Those drugs are not available by mail-order service. For information regarding your health plan's mail-order prescription service and specialty drugs not available by mail order, please contact **Member Services**.

### **Specialty Drugs**

Prescribed specialty drugs, including self-administered injectable drugs, are provided at the specialty drug Copayment or Coinsurance up to the maximum amount per drug dispensed.

### **Food Supplements**

Prescribed amino acid modified products used in the treatment of congenital errors of amino acid metabolism, elemental enteral nutrition and parenteral nutrition are provided under your hospital inpatient care benefit. Such products are covered for self-administered use upon payment of a \$3.00 Copayment per product, per day. Food products for enteral feedings are not covered.

### **Prescribed Supplies and Accessories**

Prescribed supplies, when obtained from sources designated by your Health Plan, will be provided. Such items include, but may not be limited to:

1. home glucose monitoring supplies;
2. disposable syringes for the administration of insulin;
3. glucose test strips;
4. acetone test tablets and nitrate screening test strips for pediatric patient home use.

Prescription drugs are covered only when prescribed by a:

1. In-Network Physician; or
2. Physician to whom a Member has been referred by an In-Network Physician; or
3. Dentist (when prescribed for acute conditions); and are obtained at in network Pharmacies.

Covered drugs include:

1. Drugs for which a prescription is required by law. In-Network Pharmacies may substitute a generic equivalent for a brand-name drug unless prohibited by the In-Network Physician. If a Member requests a brand-name drug when a generic equivalent drug is the preferred product, the Member must pay the brand-name Copayment, plus any difference in price between the preferred generic equivalent drug prescribed or authorized by the In-Network Physician and the requested brand-name drug. If the brand-name drug is prescribed due to Medical Necessity, the Member pays only the brand-name Copayment.
2. Insulin.
3. Compounded medications as long as they are on the compounding formulary.

**Limitations:**

Adult and pediatric immunizations are limited to those that are not experimental, are medically indicated and are consistent with accepted medical practice.

**Drugs, Supplies and Supplements Exclusions:**

1. Drugs for which a prescription is not required by law.
2. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
3. Drugs and injections for the treatment of sexual dysfunction.
4. Any packaging except the dispensing pharmacy's standard packaging.
5. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged or stolen prescriptions.
6. Drugs or injections for treatment of involuntary infertility.
7. Drugs to shorten the length of the common cold.
8. Drugs to enhance athletic performance.
9. Drugs for the treatment of weight control.
10. Drugs available over the counter and by prescription for the same strength.
11. Unless approved by Health Plan, drugs:
  - i. Not approved by the FDA; and
  - ii. Not in general use as of March 1 of the year prior to your effective date or last renewal.
12. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
13. Prescription drugs necessary for Services excluded in the health plan Evidence of Coverage

or Membership Agreement.

### **Oral Anticancer Medications**

**Citation:** Colorado Revised Statute § 10-16-104 (21)

#### **(21) Oral anticancer medication**

- (a) Any health benefit plan that provides coverage for cancer chemotherapy treatment shall provide coverage for prescribed, orally administered anticancer medication that has been approved by the federal food and drug administration and is used to kill or slow the growth of cancerous cells. The orally administered medication shall be provided at a cost to the covered person not to exceed the coinsurance percentage or the copayment amount as is applied to an intravenously administered or an injected cancer medication prescribed for the same purpose. A medication provided pursuant to this subsection (21) shall be prescribed only upon a finding that it is medically necessary by the treating physician for the purpose of killing or slowing the growth of cancerous cells in a manner that is in accordance with nationally accepted standards of medical practice, clinically appropriate in terms of type, frequency, extent site, and duration, and not primarily for the convenience of the patient, physician, or other health care provider. This subsection (21) does not require the use of orally administered medications as a replacement for other cancer medications. Nothing in this subsection (21) prohibits coverage for oral generic medications in a health benefit plan. Nothing in this subsection (21) prohibits a carrier from applying an appropriate formulary or other clinical management to any medication described in this subsection (21). For the purposes of this subsection (21), the treating physician for a patient covered under a health maintenance organization's health benefit plan shall be a physician who is designated by and affiliated with the health maintenance organization.

## **REHABILITATIVE & HABILITATION SERVICES AND DEVICES**

### **Durable Medical Equipment (DME) and Prosthetics and Orthotics**

DME and prosthetics and orthotics are covered, when prescribed by an In-Network Physician as described below; when prescribed by an In-Network Physician during a covered stay in a Skilled Nursing Facility, but only if Skilled Nursing Facilities ordinarily furnish the DME or prosthetics and orthotics.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for your health plan's DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines. Please note that this EOC may contain some, but not all, of these exclusions.

**Limitation:** Coverage is limited to the standard item of DME, prosthetic device or orthotic device

that adequately meets your medical needs.

### **Durable Medical Equipment (DME)**

**Coverage:** DME, with the exception of the following, is not covered unless your health plan has purchased additional coverage for DME, including prosthetic and orthotic devices. See “Additional Provisions.”

- a. Oxygen dispensing equipment and oxygen used in your home are covered. Oxygen refills are covered while you are temporarily outside the Service Area. To qualify for coverage, you must have a pre-existing oxygen order and must obtain your oxygen from the vendor designated by Health Plan.
- b. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by your Health Plan.
- c. Infant apnea monitors are provided.

### **Durable Medical Equipment Exclusions:**

- a. All other DME not described above, unless your Health Plan has purchased additional coverage for DME. See “Additional Provisions.”
- b. Replacement of lost equipment.
- c. Repair, adjustments or replacements necessitated by misuse.
- d. More than one piece of DME serving essentially the same function, except for replacements; spare equipment or alternate use equipment is not covered.

### **Habilitation Services**

**Coverage:** Services that help a Member retain, learn, or improve skills and functioning for daily living are covered at the same level, and in addition to, rehabilitative benefits. See the “Physical, Occupational and Speech Therapy and Multidisciplinary Rehabilitation Services” section for a complete description of rehabilitative benefits.

**Note:** Outpatient Habilitative and Rehabilitative Therapy Services (limits on Physical, Occupational and Speech Therapy services) are not combined but separate based on determination of Habilitative Service or Rehabilitative Service). The limits do not apply to Mental Health and Substance Abuse conditions. Visit limits for physical therapy, occupational therapy and speech therapy do not apply to therapies that are Medically Necessary to treat Autism Spectrum Disorder and listed in the Member's treatment plan.

### **Prosthetic Devices**

**Coverage:** The following prosthetic devices are covered, including repairs, adjustments and replacements other than those necessitated by misuse or loss, when prescribed by an In-Network Physician and obtained from sources designated by your Health Plan:

- a. Internally implanted devices for functional purposes, such as pacemakers and hip joints.

- b. Prosthetic devices for Members who have had a mastectomy. Your health insurer or Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prostheses is no longer functional. Custom-made prostheses will be provided when necessary.
- c. Prosthetic devices, such as obturators and speech and feeding appliances, required for treatment of cleft lip and cleft palate in newborn Members when prescribed by an In-Network Physician and obtained from sources designated by Health Plan.
- d. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by an In-Network Physician, as Medically Necessary and provided in accord with this EOC. Including repairs and replacements, of such prosthetic devices.

Your Health Plan may have purchased additional coverage for prosthetic devices. See “Additional Provisions.”

**Prosthetic Devices Exclusions:**

- a. All other prosthetic devices not described above, unless your Health Plan has purchased additional coverage for prosthetic devices. See “Additional Provisions.” Your Physician can provide the Services necessary to determine your need for prosthetic devices and help you make arrangements to obtain such devices at a reasonable rate.
- b. Internally implanted devices, equipment and prosthetics related to treatment of sexual dysfunction, unless your Health Plan has purchased additional coverage for this benefit.

**Orthotic Devices**

Orthotic devices are not covered unless your Health Plan has purchased additional coverage for DME, including prosthetic and orthotic devices. See “Additional Provisions.”

**Oxygen and Oxygen Equipment**

Oxygen and oxygen dispensing equipment used in the Member’s home is covered in the Service Area as shown on your health plan’s “Summary Chart.” A Member’s home includes an institution used as his or her home.

Oxygen refills are covered when a Member is temporarily traveling outside the Service Area. This applies only if the Member: (1) has an existing oxygen order; and (2) obtains refills from Health Plan’s designated oxygen vendor.

**Physical, Occupational and Speech Therapy and Multidisciplinary Rehabilitation Services**

**Coverage:**

1. **Hospital Inpatient Care, Care in a Skilled Nursing Facility and Home Health Care**  
Covered are physical, occupational and speech therapy as part of your Hospital Inpatient

Care, Skilled Nursing Facility and Home Health Care benefit if, in the judgment of an In-Network Physician, significant improvement is achievable within a two-month period. There is a 60 day limit for inpatient rehabilitation.

## **2. Outpatient Care**

Covered are 20 visits per year of each of three (3) types of outpatient therapy (i.e., physical, occupational, and speech therapy) in a Plan Facility if, in the judgment of an In-Network Physician, significant improvement is achievable within a two-month period. See your health plan's "Summary Chart."

## **3. Multidisciplinary Rehabilitation Services**

If, in the judgment of a Physician, significant improvement in function is achievable within a two-month period, your health plan will cover treatment for up to two (2) months per condition per year, in an organized, multidisciplinary rehabilitation Services program in a designated facility or a Skilled Nursing Facility. This covers multidisciplinary rehabilitation Services without charge while you are an inpatient in a designated facility.

## **4. Pulmonary Rehabilitation**

Treatment in a pulmonary rehabilitation program is provided if prescribed or recommended by an In-Network Physician and provided by therapists at designated facilities. Clinical criteria are used to determine appropriate candidacy for the program, which consists of: an initial evaluation; up to six (6) education sessions; up to twelve exercise sessions; and a final evaluation to be completed within a two to three-month period. See your health plan's "Summary Chart."

## **5. Therapies for Congenital Defects and Birth Abnormalities**

After the first 31 days of life, the limitations and exclusions applicable to this EOC apply, except that Medically Necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered children from age three (3) to age six (6) shall be provided. The benefit level shall be the greater of the number of such visits provided under this health benefit plan or 20 therapy visits per year for each physical, occupational and speech therapy. Such visits shall be distributed as Medically Necessary throughout the year without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or improve functional capacity. See your health plan's "Summary Chart."

**Note 1:** This benefit is also available for eligible children under the age of three (3) who are not participating in Early Intervention Services.

**Note 2:** The visit limit for therapy to treat congenital defects and birth abnormalities is not applicable if such therapy is Medically Necessary to treat

autism spectrum disorders.

## **6. Therapies for the Treatment of Autism Spectrum Disorders**

Coverage of the following therapies for the treatment of Autism Spectrum Disorders:

- a. Outpatient physical, occupational and speech therapy in a Plan Medical Office when prescribed by an In-Network Physician as Medically Necessary. See your health plan's "Summary Chart."
- b. Applied behavior analysis, including consultations, direct care, supervision, or treatment, or any combination thereof by autism services providers, up to the maximum benefit permitted by State law. See your health plan's "Summary Chart."

### **Limitations**

1. Speech therapy is limited to treatment for speech impairments due to injury or illness.
2. Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.

## **Physical, Occupational and Speech Therapy and Multidisciplinary Rehabilitation Services**

### **Exclusions**

1. Long-term rehabilitation, except in instances where long-term rehabilitation is prescribed by an In-Network Physician as Medically Necessary for the treatment for autism spectrum disorders. See the "Therapies for the Treatment of Autism Spectrum Disorders" section.
2. Speech therapy that is not Medically Necessary, such as: (i) therapy for educational placement or other educational purposes; or (ii) training or therapy to improve articulation in the absence of injury, illness or medical condition affecting articulation; or (iii) therapy for tongue thrust in the absence of swallowing problems.

## **LABORATORY, RADIOLOGY, AND INFUSION SERVICES**

### **Laboratory and Radiology Services**

#### **Coverage:**

#### **1. Outpatient**

The following Services are covered:

- a. Diagnostic X-ray and laboratory tests, Services and materials, including isotopes, electrocardiograms, electroencephalograms and mammograms.
- b. Therapeutic X-ray Services and materials.
- c. Special procedures such as MRI, CT, PET and nuclear medicine. Note: Members will be billed for each individual procedure performed. As such, if more than one procedure is performed in a single visit, more than one Copayment will apply. A procedure is defined in accordance with the Current Procedural Terminology (CPT) medical billing codes published annually by the American Medical Association. The Member is responsible for any applicable Copayment or Coinsurance for Special

Procedures performed as a part of or in conjunction with other outpatient Services, including but not limited to Emergency Services, non-emergency, non-routine care, and outpatient surgery.

## **2. Inpatient**

During hospitalization, prescribed diagnostic X-ray and laboratory tests, Services and materials, including diagnostic and therapeutic X-rays and isotopes, electrocardiograms, electroencephalograms, MRI, CT, PET and nuclear medicine are covered without Charge.

### **X-ray, Laboratory and Special Procedures Exclusions:**

1. Testing of a Member for a non-Member's use and/or benefit.
2. Testing of a non-Member for a Member's use and/or benefit.

### **Infusion Services**

All Medically Necessary infusion services including chemotherapy are covered in-network.

## **PREVENTIVE & WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT**

### **Allergy testing**

**Coverage:** This plan provides coverage for allergy evaluation and testing.

### **Audiology/Hearing tests**

1. Hearing exams and tests to determine the need for hearing correction are covered. For members with a verified hearing loss, coverage shall also include:
  - a. Initial hearing aids and replacement hearing aids not more frequently than every 5 years;
  - b. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the member; and
  - c. Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

### **Family Planning Services**

**Coverage:**

1. Family planning counseling. This includes pre-abortion and post-abortion counseling and information on birth control; and
2. Tubal ligations; and
3. Vasectomies; and
4. Voluntary termination of pregnancy.

**Note:** The following are covered, but not under this section: diagnostic procedures, see “X-ray, Laboratory and Special Procedures”; contraceptive drugs and devices, see the “Drugs, Supplies and Supplements” section.

### **Health Education Services**

**Coverage:** Health education appointments to support understanding of chronic diseases such as diabetes and hypertension. Also includes teaching self-care on topics such as stress management and nutrition.

### **Preventive Care/Screening/Immunizations**

**Coverage:** Certain preventive care Services that do one or more of the following:

1. Protect against disease;
2. Promote health; and/or
3. Detect disease in its earliest stages before noticeable symptoms develop.

**Note:** If you receive any other covered Services during a preventive care visit, you may pay the applicable Copayment and Coinsurance for those Services.

**Coverage:** The following services are covered as Preventive Care Services:

1. Preventive Care Visits
  - a. Adult preventive care exams
  - b. Well-woman exams
  - c. Immunizations
  - d. Perinatal maternal counseling for persons at risk
  - e. Influenza vaccinations pursuant to the schedule established by the ACIP
  - f. Pneumococcal vaccinations pursuant to the schedule established by the ACIP
2. Colorectal Cancer Screenings
  - a. Colonoscopies
  - b. Flexible sigmoidoscopies
3. Adult preventive care screenings
  - a. Well-woman care screenings
  - b. Unhealthy alcohol use screening for adults
  - c. Cervical cancer screening
  - d. Cholesterol screening for lipid disorders
  - e. Tobacco use screening of adults and tobacco cessation interventions by primary care providers
  - f. Preventive breast cancer screening study
4. Well-child care
  - a. Child health supervision services and childhood immunizations pursuant to the schedule established by the ACIP

5. Any other preventive services included in the A or B recommendation of the task force or required by federal law

**Note:** Citation Colorado Revised Statute § 10-16-104 (18)

### **Vision Services**

**Coverage:** Wellness and refraction exams to determine the need for vision correction and to provide a prescription for eyeglasses. Also covered are professional exams and the fitting of Medically Necessary contact lenses when an In-Network Physician or In-Network Optometrist prescribes them for a specific medical condition.

Professional Services for exams and fitting of contact lenses that are not Medically Necessary are provided at an additional Charge.

### **Vision Services Exclusions:**

1. Eyeglass lenses and frames.
2. Contact lenses.
3. Professional exams for fittings and dispensing of contact lenses except when Medically Necessary as described above.
4. All Services related to eye surgery for the purpose of correcting refractive defects such as myopia, hyperopia or astigmatism (for example, radial keratotomy, photo-refractive keratectomy and similar procedures).
5. Orthoptic (eye training) therapy.

## **PEDIATRIC SERVICES, INCLUDING ORAL & VISION CARE**

**NOTE:** Pediatric dental and pediatric vision benefits are supplemented by Colorado's CHIP plan. There are no changes to these benefits in this benchmark plan.

### **Allergy testing**

**Coverage:** This plan provides coverage for allergy evaluation and testing

### **Children's Dental Anesthesia**

**Citation:** Colorado Revised Statute § 10-16-104 (12)

#### **(12) Hospitalization and general anesthesia for dental procedures for dependent children**

- (a) All individual and all group sickness and accident insurance policies that are delivered or issued for delivery within the state by an entity subject to part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to part 3 or 4 of this article, except supplemental policies that cover a specific disease or other limited benefit, must provide coverages for general anesthesia, when rendered in a

hospital, outpatient surgical facility, or other facility licensed pursuant to section 25-3-101, C.R.S., and for associated hospital or facility charges for dental care provided to a dependent child, as dependent is defined in section 10-16-102 (17), of a covered person. Such dependent child shall, in the treating dentist's opinion, satisfy one or more of the following criteria:

- (I) The child has a physical, mental, or medically compromising condition; or
  - (II) The child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or
  - (III) The child is an extremely uncooperative, unmanageable, anxious, or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred; or
  - (IV) The child has sustained extensive orofacial and dental trauma.
- (b) A carrier may:
- (I) Require prior authorization for general anesthesia and outpatient surgical facilities or hospitalization for dental care procedures in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions; and
  - (II) Require that if coverage is provided through a managed care plan, the benefits mandated pursuant to this subsection (12) shall be covered benefits only if the services are rendered by a provider who is designated by and affiliated with the carrier; and
  - (III) Restrict coverage to include anesthesia provided by an anesthesia provider only during procedures performed by an educationally qualified specialist in pediatric dentistry or other dentist educationally qualified in a recognized dental specialty for which hospital privileges are granted or who is certified by virtue of completion of an accredited program of post-graduate hospital training to be granted hospital privileges.
- (c) The provisions of this subsection (12) shall not apply to treatment rendered for temporal mandibular joint (TMJ) disorders.

### **Children's Early Intervention Services**

**Coverage:** Covered children, from birth up to age three (3), who have significant delays in development or have a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development as defined by State law, are covered for Early Intervention Services (EIS) up to the maximum amount permitted by State law. EIS are not subject to any Copayments or Coinsurance; or to any annual Out-of-Pocket Maximum or Lifetime Maximum.

**Note:** You may be billed as a non-Member for any EIS received after the maximum amount permitted by State law is satisfied.

**Limitations:** The maximum amount of coverage permitted by State law does not apply to:

1. Rehabilitation or therapeutic Services that are necessary as a result of an acute medical

- condition; or
2. Services provided to a child that is not participating in the Early Intervention program for infants and toddlers under Part C of the federal “Individuals with Disabilities Act”; or
  3. Services that are not provided pursuant to an Individualized Family Service Plan developed pursuant to 20 U.S.C. Sec. 1436 and 34 C.F.R. 303.340, as amended.

**Early Childhood Intervention Services Exclusions:**

1. Respite care;
2. Non-emergency medical transportation;
3. Service coordination, as defined by State or federal law; and
4. Assistive technology, not to include durable medical equipment that is otherwise covered under this Evidence of Coverage.

**Cleft Palate and Cleft Lip Conditions**

**Citation:** Colorado Revised Statute § 10-16-104 (1)(c)(II)

**(II)**

- (A) With regard to newborn children born with cleft lip or cleft palate or both, there shall be no age limit on benefits for such conditions, and care and treatment shall include to the extent medically necessary: Oral and facial surgery, surgical management, and follow-up care by plastic surgeons and oral surgeons; prosthetic treatment such as obturators, speech appliances, and feeding appliances; medically necessary orthodontic treatment; medically necessary prosthodontic treatment; habilitative speech therapy; otolaryngology treatment; and audiological assessments and treatment.
- (B) Cleft lip, cleft palate, or any condition or illness which is related to or developed as a result of the cleft lip or cleft palate shall be considered to be compensable for coverage under the provisions of sub-subparagraph (A) of this subparagraph (II).
- (C) If a dental insurance policy, a contract for dental insurance, or an enrollee coverage contract issued pursuant to this article is in effect at the time of the birth, or is purchased after the birth, of a child with cleft lip or cleft palate or both, it shall provide fully for any orthodontics or dental care needed as a result of the cleft lip or cleft palate or both. Such policy or contract may contain the same copayment provisions for the coverage of cleft lip or cleft palate or both as apply to other conditions or procedures covered by the policy or contract.

**Dental for Children**

**Coverage:** Below is a summary of the benefits your child can receive (subject to specific procedures and limitations).

1. Diagnostic Services (annual exam and x-rays)
2. Preventive Services (annual cleaning, fluoride and sealants)
3. Basic Restorative Services (fillings and stainless steel crowns)

4. Oral Surgery Services (extractions)
5. Endodontic Services (root canal)

### **Diagnostic and Preventive Limitations**

1. Prophylaxis (cleaning) is a benefit only ONCE in a 12 month period.
2. Oral evaluations (exams) are a benefit twice in a 12 month period.
3. Topical fluoride application is a benefit twice in a 12 month period.
4. Bitewing x-rays are a benefit only ONCE in a 12 month period and are not a benefit in addition to a complete mouth series. Complete mouth x-rays are a benefit only once in sixty (60) months.
5. Space maintainer is a benefit only for premature loss of deciduous (baby) posterior (back) teeth.
6. Sealant Benefits include the application of sealants only to permanent molar teeth with the occlusal surfaces intact, no caries (decay), and/or with no restorations.
7. Separate benefit shall not be made for any preparation or conditioning of the tooth or any other procedure associated with sealant application.
8. Sealant Benefits do not include any repair or replacement of a sealant on any tooth within thirty-six (36) months of its application. Such repair or replacement done by the same dentist is considered included in the fee for the initial placement of the sealant.

### **Basic Restorative Limitations**

1. Benefits for the same covered Amalgam (metal) or Resin (white plastic) Restoration shall not be provided more than once in any 24 month period.
2. Resin or plastic restorations on posterior (back) teeth are not a benefit, unless prior to placement, you are informed and agree to pay the cost difference between the Amalgam (metal) filling fee and Resin (white plastic) filling fee.
3. Pulpotomy/pulpectomy is a benefit only for primary (baby) teeth.
4. If more than one restoration is used to restore a tooth, benefit allowance will be paid for the most inclusive service.
5. Prefabricated crowns per tooth are a benefit only once in 24 months.
6. Have your dentist complete a pre-treatment estimate form for a third molar extraction to determine if it will be covered. Prophylactic removal of third molars is not a covered benefit. Removal because of malocclusion or orthodontic reasons is not covered. The removal of third molars for active caries that renders the tooth unrestorable and/or involves the pulp may be covered with prior approval. Third molar removal may be covered with prior written approval for active periodontal infections that cannot be treated in another manner. Third molars fully impacted in bone are not covered for removal. Partial bony impactions and soft tissue impactions may be covered with prior approval if the tooth and/or supporting structures are involved with active disease such as an acute periodontal infection. Second opinions may be required as part of the approval process prior to

treatment. If emergency removal of a third molar is needed, radiographs and/or documentation of the pathological condition causing the emergent situation may be required prior to payment.

### **Eyeglasses for Children**

**Covered:** Prescribed vision hardware, such as eyeglasses, lenses, or contact lenses, no less than one pair or one set every two (2) years to age nineteen.

**Exclusion:** Replacement of lost or broken lenses or frames.

### **Hearing Aids**

**Citation:** Colorado Revised Statute § 10-16-104 (19)

**(19) Hearing aids for children.** See the “Audiology/Hearing Tests” section.

- (b) Any health benefit plan that provides hospital, surgical, or medical expense insurance, except supplemental policies covering a specified disease or other limited benefit, must provide coverage for hearing aids for minor children who have a hearing loss that has been verified by a physician licensed pursuant to article 240 of title 12 and by an audiologist licensed pursuant to article 210 of title 12. The hearing aids must be medically appropriate to meet the needs of the child according to accepted professional standards. Coverage must include the purchase of the following:
  - (I) Initial hearing aids and replacement hearing aids not more frequently than every five years;
  - (II) A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child;
  - (III) Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.
- (c) The benefits accorded pursuant to this subsection (19) shall be subject to the same annual deductible or copayment established for all other covered benefits within the insured’s policy and utilization review as provided in sections 10-16-112, 10-16-113, and 10-16-113.5. The benefits shall also be subject to part 7 of this article.
- (d) Health benefit plans issued by an entity subject to this part 1 may provide that the benefits required pursuant to this section shall be covered benefits only if the services are deemed medically necessary.

### **Physical, Occupational, and Speech Therapy for Congenital Defects up to Age 5**

**Citation:** Colorado Revised Statute § 10-16-104(1.7)

**(1.7) Therapies for congenital defects and birth abnormalities.**

- (a) After the first thirty-one days of life, policy limitations and exclusions that are generally applicable under the policy may apply; except that all individual and group health benefit

plans shall provide medically necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for a covered child from the child's third birthday to the child's sixth birthday.

- (b) The level of benefits required in paragraph (a) of this subsection (1.7) shall be the greater of the number of such visits provided under the policy or plan or twenty therapy visits per year each for physical therapy, occupational therapy, and speech therapy. Said therapy visits shall be distributed as medically appropriate throughout the yearly term of the policy or yearly term of the enrollee coverage contract, without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.

## **MISCELLANEOUS**

### **Autism Spectrum Disorders**

**Citation:** Colorado Revised Statute § 10-16-104(1.4)

#### **(1.4) Autism spectrum disorders**

(XII) "Treatment for autism spectrum disorders" shall be for treatments that are medically necessary. The treatments listed in this subparagraph (XII) are not considered experimental or investigational and are considered appropriate, effective, or efficient for the treatment of autism.

"Treatment for autism spectrum disorders" shall include the following, as medically necessary:

- (A) Evaluation and assessment services;
- (B) Behavior training and behavior management and applied behavior analysis, including but not limited to consultations, direct care, supervision, or treatment, or any combination thereof, for autism spectrum disorders provided by autism services providers;
- (C) Habilitative or rehabilitative care, including, but not limited to, occupational therapy, physical therapy, or speech therapy, or any combination of those therapies. For a person who is also covered under subsection (1.7) of this section [CRS 10-16-104], the level of benefits for occupational therapy, physical therapy, or speech therapy shall exceed the limit of twenty visits for each therapy if such therapy is medically necessary to treat autism spectrum disorders under this subsection (1.4).
- (D) Pharmacy care and medication, if covered by the health benefit plan;
- (E) Psychiatric care;
- (F) Psychological care, including family counseling; and
- (G) Therapeutic care.

### **Diabetes Care Management**

**Citation:** Colorado Revised Statute § 10-16-104(13)

#### **(13) Diabetes.**

- (a) Any health benefit plan, except supplemental policies covering a specified disease or other limited benefit, that provides hospital, surgical, or medical expense insurance shall provide

coverage for diabetes that shall include equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy if prescribed by a health care provider licensed to prescribe such items pursuant to Colorado law, and, if coverage is provided through a managed care plan, such qualified provider shall be a participating provider in such managed care plan.

- (b) Diabetes outpatient self-management training and education when prescribed shall be provided by a certified, registered, or licensed health care professional with expertise in diabetes.
- (c) The benefits provided in this subsection (13) are subject to the same annual deductibles or copayments established for all other covered benefits within a given policy.
- (d) Private third-party payors shall not reduce or eliminate coverage due to the requirements of this subsection (13).

### **Gender Affirming Care**

Medically-necessary treatment includes treatment for gender dysphoria and includes the following gender-affirming care services, at minimum:

1. Blepharoplasty (eye and lid modification)
2. Face/forehead and/or neck tightening
3. Facial bone remodeling for facial feminization
4. Genioplasty (chin width reduction)
5. Rhytidectomy (cheek, chin, and neck)
6. Cheek, chin, and nose implants
7. Lip lift/augmentation
8. Mandibular angle augmentation/creation/reduction (jaw)
9. Orbital recontouring
10. Rhinoplasty (nose reshaping)
11. Laser or electrolysis hair removal
12. Breast/Chest Augmentation, Reduction, Construction

### **Phenylketonuria (PKU) testing & treatment**

**Citation:** Colorado Revised Statute § 10-16-104 (1)(c)(III)

#### **(III)**

- (A) Coverage for inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids as well as severe protein allergic conditions includes, without limitation, the following diagnosed conditions: Phenylketonuria; maternal phenylketonuria; maple syrup urine disease; tyrosinemia; homocystinuria; histidinemia; urea cycle disorders; hyperlysinemia; glutaric acidemias; methylmalonic acidemia; propionic acidemia; immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders as evidenced by the results of a biopsy; and impaired absorption of nutrients

caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. Covered care and treatment of such conditions shall include, to the extent medically necessary, medical foods for home use for which a physician who is a participating provider has issued a written, oral, or electronic prescription.

- (B) There is no age limit on benefits for inherited enzymatic disorders specified in sub-subparagraph (A) of this paragraph (III) except for phenylketonuria.
- (C) As used in this subparagraph (III), “medical foods” means prescription metabolic formulas and their modular counterparts and amino acid-based elemental formulas, obtained through a pharmacy, that are specifically designated and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and for severe allergic conditions, if diagnosed by a board-certified allergist or board-certified gastroenterologist, for which medically standard methods of diagnosis, treatment, and monitoring exist. Such formulas are specifically processed or formulated to be deficient in one or more nutrients. The formulas for severe food allergies contain only singular form elemental amino acids. The formulas are to be consumed or administered enterally either via tube or oral route under the direction of a physician who is a participating provider. This sub-subparagraph (C) shall not be construed to apply to cystic fibrosis patients or lactose- or soy-intolerant patients.
- (D) Coverage of medical foods, as provided under this subparagraph (III), shall only apply to insurance plans that include an approved pharmacy benefit and shall not apply to alternative medicines. Such coverage shall only be available through participating pharmacy providers. Nothing in this subparagraph (III) shall be construed as preventing a carrier from imposing deductibles, coinsurance, or other cost-sharing methods.

### **Preventive Services Rider**

Preventive care services, as defined under the Patient Protection and Affordable Care Act, are provided at no charge when prescribed by an In-Network Physician. Please contact health plan Member Services for a complete list of covered Preventive Services.

### **Routine Foot Care**

Routine foot care services are covered when Medically Necessary.

### III. General Conditions of Coverage, Exclusions, and Limitations

The provisions in this section describe general conditions of coverage and important exclusions and limitations that apply generally to all types of services or supplies.

#### Conditions of Coverage

**Medically Necessary:** This health benefit plan helps pay for health care expenses that are medically necessary and specifically covered by this plan. Medically necessary means health care services determined by a practitioner/provider in consultation the health plan, to be appropriate or necessary, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines, for the diagnosis or direct care and treatment of physical, behavioral or mental health condition, illness, injury, or disease.

#### General Exclusions

The Services listed below are not covered. These exclusions apply to all covered Services under this EOC. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the “Benefits” section.

1. **Alternative Medical Services.** The following are not covered unless your Health Plan has purchased additional coverage for these Services:
  - a. Naturopathy Services.
  - b. Massage therapy.See your health plan’s “Summary Chart.”
2. **Certain Exams and Services.** Physical examinations and other Services, and related reports and paperwork, in connection with third-party requests or requirements, such as those for:
  - a. Employment;
  - b. Participation in employee programs;
  - c. Insurance;
  - d. Disability;
  - e. Licensing; or
  - f. On court order or for parole or probation.
3. **Cosmetic Services.** Services that are intended: primarily to change or maintain your appearance; and that will not result in major improvement in physical or mental function. This includes cosmetic surgery related to bariatric surgery. Exception: Services covered under “Reconstructive Surgery” in the “Benefits” section.

4. **Custodial Care.** Assistance with activities of daily living or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. Assistance with activities of daily living include: walking; getting in and out of bed; bathing; dressing; feeding; toileting and taking medicine.
5. **Dental Services (Adult).** Dental Services and dental X-rays, including: dental Services following injury to teeth; dental appliances; implants; orthodontia; TMJ; and dental Services as a result of and following medical treatment such as radiation treatment. This exclusion does not apply to: (a) Medically Necessary Services for the treatment of cleft lip or cleft palate for newborn Members when prescribed by an In-Network Physician, unless the Member is covered for these Services under a dental insurance policy or contract; or (b) hospitalization and general anesthesia for dental Services, prescribed or directed by an In-Network Physician for Dependent children who: (i) have a physical, mental, or medically compromising condition; or (ii) have dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or (iii) are extremely uncooperative, unmanageable, anxious, or uncommunicative with dental needs deemed sufficiently important that dental care cannot be deferred; or (iv) have sustained extensive orofacial and dental trauma and, unless otherwise specified herein, (a) and (b) are received at an In-Network Hospital, In-Network Facility or Skilled Nursing Facility.

The following Services for TMJ may be covered if an In-Network Physician determines they are Medically Necessary: diagnostic X-rays; lab testing; physical therapy; and surgery.

6. **Dental Service (Child).** The following charges are not covered:
  - a. Procedures (or services) not listed in the Coinsurance and Procedure Code List are not a benefit. If your child's dentist performs a procedure that is not listed, you will be responsible for the full billed charges.
  - b. Services for injuries or conditions which are compensable under Workers' Compensation or employer's liability laws, or services which are provided to the eligible member by any federal or state government agency or are provided without cost to the eligible member by any municipality, county or other political sub-division, or any services for which the eligible member would have no obligation to pay in absence of this coverage, except as such exclusion may be prohibited by law.
  - c. Any covered service started during any period when your child was not eligible for such service under the CHP+ Dental Program.
  - d. Services for treatment of congenital (present at birth) or developmental (following birth) malformations, except intraoral dental services for treatment of a condition

which is related to or developed as a result of cleft lip and/or cleft palate, unless otherwise included as a covered procedure of the CHP+ Dental Program.

- e. Services for cosmetic reasons.
- f. Services for restoring tooth structure lost from wear or for any services related to protecting, altering, correcting, stabilizing, rebuilding or maintaining teeth due to improper alignment, occlusion or contour or for splinting or stabilization of teeth.
- g. Pre-medication, analgesia, hypnosis or any other patient management services.
- h. Experimental procedures, or any procedures other than those covered services for which the prognosis is good. Any procedures done in anticipation of future need (except covered preventive services).
- i. Hospital costs and any additional fees charged by the dentist or hospital for hospital services, visits, or charges for use of any facility.
- j. General anesthesia, intravenous sedation or analgesia.
- k. Prescription drugs.
- l. Orthodontic services.
- m. Services for the treatment of any disturbances of the temporomandibular joint (jaw joint), facial pain, or any related conditions.
- n. Services not performed in accordance with the laws of the state of Colorado, services performed by any person other than a person authorized by license to perform such services, or services performed to treat any condition other than an oral or dental disease, malformation, abnormality or condition.
- o. Oral hygiene instructions or dietary instructions.
- p. Completion of forms, providing diagnostic information or records, or duplication of x-rays or other records.
- q. Services for which payment is prohibited by any law of the jurisdiction in which the eligible person resides at the time the expenses are incurred.

**7. Directed Blood Donations.**

**8. Disposable Supplies.** Disposable supplies for home use such as:

- a. Bandages;
- b. Gauze;
- c. Tape;
- d. Antiseptics;
- e. Dressings;
- f. Ace-type bandages; and
- g. Any other supplies, dressings, appliances or devices, not specifically listed as covered in the “Benefits” section.

**9. Employer or Government Responsibility.** Financial responsibility for Services that an

employer or a government agency is required by law to provide.

**10. Experimental or Investigational Services:**

- a. Service is experimental or investigational for a Member's condition if any of the following statements apply at the time the Service is or will be provided to the Member. The Service:
  - i. has not been approved or granted by the U.S. Food and Drug Administration (FDA); or
  - ii. is the subject of a current new drug or new device application on file with the FDA; or
  - iii. is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial or in any other manner that is intended to determine the safety, toxicity or efficacy of the Service; or
  - iv. is provided pursuant to a written protocol or other document that lists an evaluation of the Service's safety, toxicity or efficacy as among its objectives; or
  - v. is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research on the safety, toxicity or efficacy of Services; or
  - vi. the Service has not been recommended for coverage by the Regional New Technology and Benefit Interpretation Committee, the Interregional New Technology Committee or the Medical Technology Assessment Unit based on analysis of clinical studies and literature for safety and appropriateness, unless otherwise covered by Health Plan; or,
  - vii. is provided pursuant to informed consent documents that describe the Service as experimental or investigational or in other terms that indicate that the Service is being looked at for its safety, toxicity or efficacy; or
  - viii. is part of a prevailing opinion among experts as expressed in the published authoritative medical or scientific literature that (A) use of the Service should be substantially confined to research settings or (B) further research is needed to determine the safety, toxicity or efficacy of the Service.
- b. In determining whether a Service is experimental or investigational, the following sources of information will be solely relied upon:
  - i. The Member's medical records; and
  - ii. The written protocol(s) or other document(s) under which the Service has been or will be provided; and
  - iii. Any consent document(s) the Member or the Member's representative has executed or will be asked to execute to receive the Service; and
  - iv. The files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar

- body; and
  - v. The published authoritative medical or scientific literature on the Service as applied to the Member's illness or injury; and
  - vi. Regulations, records, applications and other documents or actions issued by, filed with, or taken by the FDA, or other agencies within the U.S. Department of Health and Human Services, or any state agency performing similar functions.
  - c. If two (2) or more Services are part of the same plan of treatment or diagnosis, all of the Services are excluded if one of the Services is experimental or investigational.
  - d. Health Plan uses the criteria described above to decide if a particular Service is experimental or investigational.
11. **Genetic Testing.** Genetic testing unless determined to be: Medically Necessary; and meets your health insurer's criteria.
12. **Intermediate Care.** Care in an intermediate care facility.
13. **Long-Term/Custodial Nursing Home Care.**
14. **Services for Members in the Custody of Law Enforcement Officers.** Out-of-Network Provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers, unless the Services are covered as out-of-Plan Emergency Services or out-of-Plan non-emergency, non-routine care.
15. **Services Not Available in your health plan's Service Area.** Services not generally and customarily available in your health plan's Service Area, except when it is a generally accepted medical practice in your health plan's Service Area to refer patients outside your health plan's Service Area for the Service.
16. **Services Related to a Non-Covered Service.** When a Service is not covered, all Services related to the non-covered Service are excluded. This does not include Services that would otherwise be covered to treat complications as a result of the non-covered Service.
17. **Travel and Lodging Expenses.** Travel and lodging expenses are excluded. The plan may pay certain expenses preauthorized in accord with your health plan's internal travel and lodging guidelines in some situations, when In-Network Physician refers you to a Out-of-Network Provider outside your health plan's Service Area for transplant Services as described under "Getting a Referral" in the "How to Obtain Services" section. Travel and lodging expenses are not covered for Members who are referred to an Out-of-Network Facility for non-transplant medical care. For information specific to your situation, please

call your assigned Transplant Coordinator; or the Transplant Administrative Offices.

18. **Unclassified Medical Technology Devices and Services.** Medical technology devices and Services which have not been classified as durable medical equipment or laboratory by a National Coverage Determination (NCD) issued by the Centers for Medicare & Medicaid Services (CMS), unless otherwise covered by Health Plan.
19. **Weight Management Facilities.** Services received in a weight management facility.
20. **Workers' Compensation or Employer's Liability.** Financial responsibility for Services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"), is provided under any workers' compensation or employer's liability law. Your health plan will provide Services even if it is unclear whether you are entitled to a Financial Benefit, but your health plan may recover charges for any such Services from the following sources:
  - a. Any source providing a Financial Benefit or from whom a Financial Benefit is due.
  - b. You, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

## **Limitations**

Your health plan will do its best efforts to provide or arrange covered Services in the event of unusual circumstances that delay or render impractical the provision of Services. Examples include: major disaster; Epidemic; war; riot; civil insurrection; disability of a large share of personnel at a Plan Facility; complete or partial destruction of facilities; and labor disputes. In these circumstances, the health plan will not have any liability for any delay or failure in providing covered Services. In the case of a labor dispute the carrier may postpone care until the dispute is resolved if delaying your care is safe and will not result in harmful health consequences.

## IV. Appendix

### Colorado – State Required Benefits

Colorado Revised Statute section 10-16-104 for full list of Colorado required benefits

<b>Benefit</b>	<b>Name of Required Benefit</b>	<b>Market Applicability</b>	<b>Citation Number</b>
Prenatal and Postnatal Care	Newborns	Individual, group	Section 10-16-104 (1), C.R.S.; Section 10-16-104 (3), C.R.S.
Prenatal and Postnatal Care	Congenital defects and birth abnormalities	Individual, group	Section 10-16-104 (1.3)(b)(IV)(B), C.R.S. Section 10-16-104 (1.7), C.R.S.
Delivery and All Inpatient Services for Maternity Care	Maternity coverage	Individual, group	Section 10-16-104 (3), C.R.S.
Mental/Behavioral Health Outpatient Services	Mental illness	Small group	Section 10-16-104 (5), C.R.S.; Section 10-16-104 (5.5)
Mental/Behavioral Health Inpatient Services	Mental illness	Small group	Section 10-16-104 (5), C.R.S.; Section 10-16-104 (5.5)
Habilitation Services	Applied behavior analysis based therapies and other treatment services	Group	Section 10-16-104 (1.4), C.R.S.
Durable Medical Equipment	Prosthetic devices	Individual, group	Section 10-16-104 (14), C.R.S.
Hearing Aids	Hearing aids for children	Individual, group	10-16-104 (19), C.R.S
Preventive Care/Screening/ Immunization	Cervical cancer vaccination	Individual, group	Section 10-16-104 (17), C.R.S.

<b>Benefit</b>	<b>Name of Required Benefit</b>	<b>Market Applicability</b>	<b>Citation Number</b>
Preventive Care/Screening/Immunization	Preventative services (including immunizations for children up to age 13)	Individual, group	Section 10-16-104 (11), C.R.S.; Section 10-16-104 (18) (VI), (VII), (VIII), C.R.S.
Preventive Care/Screening/Immunization	Contraception	Individual, group	10-16-104 (3)(a)(I), C.R.S.
Preventive Care/Screening/Immunization	Prostate cancer screening	Individual, group	Section 10-16-104 (10), C.R.S.
Congenital Anomaly, including Cleft Lip/Palate	Cleft lip and cleft palate	Individual, group	Section 10-16-104 (1)(c)(II), C.R.S.
Clinical Trials	Clinical trials and studies	Individual, group	Section 10-16-104 (20), C.R.S
Dental Anesthesia	Hospitalizations and general anesthesia for dental procedures for dependent children	Individual, group	Section 10-16-104 (12), C.R.S.
Diabetes Care Management	Diabetes	Individual, group	Section 10-16-104 (13), C.R.S.
Prescription Drugs Other	Oral anticancer medication	Individual, group	Section 10-16-104 (21), C.R.S.
Early Intervention Services	Early intervention services	Individual, group	Section 10-16-104 (1.3), C.R.S.

<b>Benefit</b>	<b>Name of Required Benefit</b>	<b>Market Applicability</b>	<b>Citation Number</b>
Rehabilitative Occupational Therapy	Congenital defects and birth abnormalities	Individual, group	Section 10-16-104 (1)(c)(I), C.R.S.; Section 10-16-104 (1.7), C.R.S.; Section 10-16-104 (1.3), C.R.S.
Rehabilitative Physical Therapy	Congenital defects and birth abnormalities	Individual, group	Section 10-16-104 (1)(c)(I), C.R.S.; Section 10-16-104 (1.7), C.R.S.; Section 10-16-104 (1.3), C.R.S.; Section 10-16-104 (1.3), C.R.S.
Rehabilitative Speech Therapy	Congenital defects and birth abnormalities	Individual, group	Section 10-16-104 (1)(c)(I), C.R.S.; Section 10-16-104 (1.7), C.R.S.; Section 10-16-104 (1.3), C.R.S.
Inherited Metabolic Disorder -PKU	Phenylketonuria (PKU)	Individual, group	Section 10-16-104 (1)(c)(III), C.R.S.
Mental Health Other	Biologically based mental illness	Small group	Section 10-16-104 (5.5), C.R.S.
Off Label Prescription Drugs	Off-label use of cancer drugs	Individual, group	Section 10-16-104.6, C.R.S.