CHP+ Comparison Benefit Form
Covered Services & Copayments

Please contact Colorado Choice Health Plans for more information about any benefit. Customer Service 719-589-3696 or 1-800-475-8466, TTY 1-800-659-2656; translation services available. Out-of-network care is not covered except as noted. Prior authorization may be required for benefits.

SUMMARY OF BENEFITS: For further explanation on benefits, please look for exact terms and conditions of coverage further in this handbook.

	DESCRIPTION OF BENEFIT	COPAY			
		CHP+ 5 <101% FPL	**CHP+ 6 101-150% FPL**	**CHP+7 151 - 200% FPL**	**CHP+ 8 201% - 250% FPL**
1. ANNUAL DEDUCTIBLE Individual Family	Not applicable.	 None. None.	 None. None.	 None. None.	 None. None.
2. OUT-OF-POCKET LIMIT Individual Family	Maximum amount Member has to pay out of pocket in any one year for covered benefits.	None.	5% of annual family income adjusted for family size.	5% of annual family income adjusted for family size.	5% of annual family income adjusted for family size.
3. EMERGENCY CARE	Covered when deemed urgent / emergent. Out-of-network care included Co-payment is waived if client is admitted to the hospital.	$3	$3	$30	$50
4. URGENT/AFTER HOURS CARE	Covered when deemed urgent / emergent. Out-of-network care included	$1	$1	$20	$30
5. EMERGENCY TRANSPORT/AMBULANCE SERVICES	Covered.	$0	$2	$15	$25
6. HOSPITAL/OTHER FACILITY SERVICES A. INPATIENT B. PHYSICIAN C. OUTPATIENT/ AMBULATORY	 Covered. Prior authorization required. Prior authorization required.	 $0 $0 $0	 $2 $2 $2	 $20 $5 $5	 $50 $10 $10
7. ROUTINE MEDICAL OFFICE VISIT	Covered. Includes physician, mid-level practitioner and specialist visits, including outpatient mental health visits.	$0	$2	$5	$10

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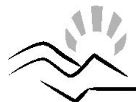
8. FLUORIDE VARNISH APPLICATION	Covered.	$0	$0	$0	$0
9. Laboratory and X-ray	Covered. Prior authorization may apply.	$0	$0	$5	$10
10. Prenatal care and prepregnancy family planning services and supplies	Covered. Elective termination is only covered in specific circumstances. See full benefits.	$0	$0	$0	$0
11. Maternity Care Prenatal Delivery & inpatient well baby care	Covered. Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. Covered. State law requires infant to be covered for first 31 days.	$0 $0	$0 $0	$0 $0	$0 $0



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12. Mental Illness Care A. Neurobiologically-Based Mental Illnesses	Covered. Prior authorization required. Schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive compulsive disorder, and panic disorder are all to be treated as any other illness or condition.	$0	$2/office visit; $2/admission	$5/office visit; $20/admission	$10/office visit $50/admission
B. Mental disorders	Covered. Prior authorization required. Post traumatic stress disorder, drug and alcohol disorders, Dysthymia, Cyclothymia, social phobia, Agoraphobia with panic disorder, general anxiety, Anorexia Nervosa exclusive of residential treatment, Bulimia exclusive of residential treatment are to be treated the same as any other health condition (e.g., there are no limits on the number of hospital days covered).	$0	$2/office visit; $2/admission	$5/office visit; $20/admission	$10/office visit; $50/admission
C. All other	Coverage for all mental health conditions recognized by the DSM-IV manual.				
1. Inpatient	Covered. Prior authorization required. No limits apply if medically necessary.	$0	$2	$20	$50
	The day cost of residential care must be less than or equal to the cost of partial day hospitalization. Each two days of residential or partial hospital care counts as one day of inpatient care.				
2. Outpatient	Covered. No limits apply if medically necessary.	$0	$2	$5	$10
13. Outpatient Substance Abuse treatment services	Covered.	$0	$2	$5	$10

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14. Physical Therapy, Speech Therapy, and Occupational Therapy	Limited coverage. Prior authorization required. 30 visits per diagnosis per year. Physical, Speech and Occupational Therapy services shall be unlimited for children with developmental delays from birth up to the child's third birthday.	$0	$2	$5	$10
15. Durable Medical Equipment (DME)	Limited coverage. Prior authorization required. Maximum $2,000/year paid by plan. Coverage for lesser of purchase price or rental price for medically necessary durable medical equipment, including home administered oxygen. DME includes, but is not limited to, home-administered oxygen, reusable equipment for the treatment of diabetes, and prostheses. Although the cost of prosthetic devises applies to the annual DME cap, benefits for prosthetic devices for arms or legs (or any part thereof) themselves are not subject to this limitation. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered up to the benefit cap; and repair and replacement needed due to misuse/abuse by the member is **not** covered.	$0	$0	$0	$0

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16. TRANSPLANTS	Limited coverage. Prior authorization required. Does include liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, and bone marrow for Hodgkin's disease, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and stage III breast cancer, and Wiskott Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants. Transplants will be covered only if they are Medically Necessary and the facility meets clinical standards for the procedure. Coverage is no less extensive than the coverage for any other physical illness. Coverage for all covered organ transplants and all transplant-related services, including travel, lodging, and donor expenses or organ procurement is limited to a maximum lifetime benefit for major organ transplants of $1,000,000 per member.	$0	$0	$0	$0
17. HOME HEALTH CARE	Covered. Prior authorization required.	$0	$0	$0	$0
18. HOSPICE CARE	Covered. Prior authorization required.	$0	$0	$0	$0
19. PRESCRIPTION DRUGS	Covered. (includes expendable medical supplies for the treatment of diabetes) Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.	$0	$1 – generic or brand name	$3 – generic. $10 – brand name.	$5-generic $15-brand name
20. KIDNEY DIALYSIS	Covered, only when Member is not eligible for Medicare. Prior authorization required.	$0	$0	$0	$0
21. SKILLED NURSING FACILITY CARE	Coverage for medically necessary skilled nursing facility care only. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated. Prior authorization required.	$0	$0	$0	$0
22. VISION SERVICES	Limited coverage. Vision screenings are covered as age appropriate preventive care. $50 annual benefit for eyeglasses. Services provided by a VSP contracted provider. Contact plan for more information.	$0	$2 for referral and refraction benefits only	$5 for referral and refraction benefits only	$10 for referral and refraction benefits only
23. AUDIOLOGY SERVICES	Limited coverage. Hearing screenings are covered as age appropriate preventive care. Hearing aides covered as medically necessary with no capitation.	$0	$0	$0	$0
24. INTRACTABLE PAIN	Covered. Included as a benefit with the medical office visit copay. Prior authorization required.	$0	$2/office visit; $2/admission	$5/office visit; $20/admission	$10 office visit $50 admission

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25. AUTISM COVERAGE	Covered. Included as a benefit with the medical office visit copay. Prior authorization is required.	$0	$2/office visit; $2/admission	$5/office visit; $20/admission	$10 office visit $50 admission
26. CASE MANAGEMENT	Covered, when Medically Necessary.	$0	$0	$0	$0
27. DIETARY COUNSELING /NUTRITIONAL SERVICES	Limited coverage. Prior authorization required. Formula for metabolic disorders, total parenteral nutrition, enterals and nutrition products, and formulas for gastrostemy tubes are covered for people with documented medical need. Documentation includes prior authorization which lists medical condition including gastrointestinal disorders, malabsorption syndromes or a condition that affects normal growth patterns or the normal absorption of nutrition.	$0	$0	$0	$0
28. LIFETIME MAXIMUM	The CHP+ program does not have a lifetime maximum benefit except for organ transplants.	None.	None.	None.	None.
29. DENTAL RELATED	Medical coverage in connection with treatment of the teeth or periodontium is excluded unless such treatment: is performed by a physician or legally licensed dentist, is begun within 72 hours after an accidental injury to sound natural teeth. Orthodontic and prosthodontic treatment for cleft lip or cleft palate for newborns is covered.	None.	None.	None.	None.
30. PRE-EXISTING CONDITION LIMITATIONS	No pre-existing condition limitations.	Not applicable.	Not applicable.	Not applicable.	Not applicable.
31. THERAPIES: CHEMOTHERAPY AND RADIATION	Covered. Prior authorization required. When received during a covered admission and billed as part of the facility service, therapy charges will be paid in the same manner as room expenses and other ancillary services. This provision shall not be interpreted as an exclusion of Chemotherapy and Radiation therapy when delivered in an outpatient setting.	$0	$0	$0	$0

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32. EXCLUSIONS	Benefits covered by a no-fault auto policy or employers liability laws; care that is not medically necessary; cosmetic surgery; custodial care; educational training programs; experimental and investigational procedures; learning disorders; marital or social counseling; nursing home care except as specifically otherwise covered under this plan; sexual dysfunction, infertility treatment and counseling except as specifically otherwise covered under this plan; TMJ with no medical basis; treatment for work-related illnesses and injuries except for those individuals who are not required to maintain or be covered by workers' compensation insurance as defined by worker's compensation laws (the worker's compensation policy, not this plan, is responsible for medical benefits for work-related illnesses and				
	injuries); transplants except for those listed above; and war.Any service not identified as a Covered Service under this Contract may be interpreted by the Contractor as an exclusion. The Contractor may, in accordance with this provision and all other the terms of this Contract, further describe and/or enumerate exclusions in member materials it develops for the Program.				
33. ADDITIONAL POLICY ISSUES	This is only a summary of the benefits provided. For further terms and conditions of coverage, please refer to the remaining pages of this handbook, which contain all terms, covenants and conditions of coverage. The benefits shown may only be available if required plan procedures are followed (ex. Plan may require prior authorization, a referral from your PCP, or use of specified providers or facilities.				

TYPE OF COVERAGE:

Type of Plan	Health Maintenance Organization (HMO)
Out-of-Network care covered?	Only for emergency and urgent care
Areas of Colorado where plan is available	Plan is available only in the following areas: Alamosa, Baca, Bent, Chaffee, Cheyenne, Conejos, Costilla, Crowley, Custer, Fremont, Huerfano, Kiowa, Kit Carson, Las Animas, Mineral, Otero, Prowers, Rio Grande, Saguache, Washington and Yuma.

USING THE PLAN:	IN-NETWORK (Out-of-network care is not covered except as noted)
Can I go to any doctor I want to?	No, but you may go to any doctor in Colorado Choice's provider network. Please see our provider directory to locate providers.
Is prior authorization required for surgical procedures and hospital care?	Yes (except in an emergency).
If the provider charged more for a covered service than the plan paid, does the member have to pay the difference?	No. If you are receiving a bill from an in-network provider for the remainder of the bill, please contact Colorado Choice and we will contact the provider. However, if you choose to go out-of-network, or proceed with a service without prior authorization, payment will remain the Member's responsibility.
What is the main customer service number?	Local: 719-589-3696 Toll free: 1-800-475-8466 TTY 1-800-659-2656

Whom do I write / call if I want to file an appeal?	Colorado Choice Health Plans, Attn: CHP+ Appeals 700 Main Street, Suite 100 719-589-3696 or 1-800-475-8466 Alamosa, CO 81101 TTY 1-800-659-2656
What if I have a pre-existing condition?	Colorado Choice does not exclude coverage for pre-existing conditions.