Colorado Access Choice EPO Colorado Option Bronze NA Plan

Effective January 1, 2027 – December 31, 2027

Thank you for choosing us for your healthcare coverage.
We wish you good health and appreciate the opportunity to serve you!

Section 1: Schedule of Benefits (Who Pays What)

This document is your Member Handbook or Evidence of Coverage (EOC). For a full guide to the contents of this document, see Section 4: Table of Contents.

This section summarizes your covered services and cost sharing. For more details, see Section 7: Benefits/Coverage of this EOC. A list of services that are not covered can be found in Section 8: Limitations/Exclusions.

Some services may require Prior Authorization. You can find the full, most up-to-date list of services requiring Prior Authorization on our website at www.coaccesschoice.com. If you have questions, call us Monday through Friday, 8:00 a.m. to 5:00 p.m. at 720-798-5704 or toll-free at 1-833-575-8033 (TTY users call 711); holidays excluded. These numbers are also listed in Section 3: Contact Information in this Member Handbook.

Services by Providers located outside Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, El Paso, Elbert, Gilpin, Jefferson, Park, Pueblo, and Teller counties of the State of Colorado will only be Covered Services if:

- The services are for Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center; or
- The services are approved in advance by Colorado Access Choice.

If you are experiencing a life- or limb-threatening emergency, call 911 or go to the nearest Emergency Room or medical facility. You are covered at any Emergency Room or Urgent Care within the United States. You do not need a Referral or Prior Authorization for Emergency or Urgent care, and the cost you pay is the same whether the Provider is Contracted or Non-Contracted.

IMPORTANT: You are responsible for confirming that the Provider you are seeing or have been referred to see is a Contracted Provider in the Colorado Access Choice provider network. It is important to understand that Colorado Access has many contracting Providers who may not be part of the network of Providers that applies to this Plan. Colorado Access Choice can help you find a Contracted Provider specific to Your Plan by calling 720-798-5704 or toll-free at 1-833-575-8033 (TTY users call 711).

1.1 What will you pay?

Reimbursement for Covered Services is based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service.

A Deductible applies to all Covered Services unless the chart below specifically indicates that the Deductible is waived (i.e., the Deductible does not apply).

For a detailed explanation of how Your Deductibles and Out-of-Pocket Maximums are calculated, see the Section 9: Member Payment Responsibility. Except for Surprise Billing Claims, when You receive Covered Services from a Non-Contracted Provider, you may also be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges.

1.2 Colorado Access Choice EPO Colorado Option Bronze NA Schedule of Benefits

Deductible / Out-of-Pocket Maximum	Contracted	Non-Contracted
Individual Deductible Family Deductible Covered services are subject to applicable Deductible unless specifically waived. Embedded Deductible: The individual Deductible applies to each covered family Member. No one person can contribute more than the individual Deductible amount. Once two or more covered family Members' Deductibles combine to equal the family Deductible amount, the Deductible will be satisfied for the family for that Calendar Year. Please see the "Member Payment Responsibility" section for more details.	$8,100 $16,200	Does not apply
Individual Out-of-Pocket Maximum Family Out-of-Pocket Maximum Embedded Out-of-Pocket Maximum: The individual Out-of-Pocket Maximum applies to each covered family Member. Once two or more covered family Members' Out-of-Pocket Maximum combine to equal the family Out-of-Pocket Maximum amount, the Out-of-Pocket Maximum will be satisfied for the family for that Calendar Year.	$11,200 $22,400	Not Covered
Provider Services	**Contracted**	**Non-Contracted**
Preventive Care No cost sharing for ACA-required preventive services.	No charge, deductible does not apply	Not Covered
Primary Care Visit Includes virtual visits.	First 3 visits No charge, deductible does not apply, then deductible, then $50 copay	Not Covered
Other Practitioner Office Visit (Nurse, Physician Assistant)	First 3 visits No charge, deductible does not apply, then deductible, then $50	Not Covered

Specialist Visit Includes virtual visits.	50%	Not Covered
Diagnostic Services	**Contracted**	**Non-Contracted**
Diagnostic Laboratory Services		
Office Visit	50%	Not Covered
Outpatient Facility	50%	Not Covered
Diagnostic Imaging (X-Ray)		
Office Visit	50%	Not Covered
Outpatient Facility	50%	Not Covered
High Tech Imaging (CT/MRI/PET)	50%	Not Covered
Prior Authorization may apply.		
Office Visit	50%	Not Covered
Outpatient Facility	50%	Not Covered
Facility Services	**Contracted**	**Non-Contracted**
Outpatient Surgery/Ambulatory Surgical Center	50%	Not Covered
Outpatient Facility	50%	Not Covered
Outpatient Professional	50%	Not Covered
Inpatient Hospitalization Prior Authorization may apply.	50%	Not Covered
Inpatient Professional	50%	Not Covered
Inpatient and Physical Rehabilitation Limited to 60 days per year.	50%	Not Covered

Maternity Services	Contracted	Non-Contracted
Prenatal and Postnatal Visits	First 3 visits No charge, deductible does not apply, then deductible, then $50	Not Covered
Delivery & Facility	50%	Not Covered
Ambulance, Emergency Room, and Urgent Care Services	**Contracted**	**Non-Contracted**
Ambulance Services – Emergency Coverage includes ground or air Ambulance for emergencies.	50%	See Contracted
Ambulance Services – Nonemergency If prior authorized by the Plan, Non-Contracted nonemergency ambulance services are subject to the same Cost Share as Contracted services up to $50,000 per trip. In addition to Your Cost Share, You will be responsible for amounts over the Maximum Allowed Amount except for air ambulance services. Air ambulance services received Out-of-Network are not subject to the $50,000 per trip limit.	50%	Not Covered
Emergency Room Copay waived if admitted. Additional Cost Share determined based on service received. For Covered Emergency Services from a Non-Contracted Provider at a Facility in Colorado, you are not responsible for the charges over the Plan's Maximum Allowed Amount	50%	See Contracted
Urgent Care Additional Cost Share determined based on service received.	50%	See Contracted
Behavioral Health, Mental Health, and Substance Use Services	**Contracted**	**Non-Contracted**
Mental Health Wellness Exam	No charge, deductible does not apply. One visit per year.	Not Covered

Behavioral Health, Mental Health, and Substance Use – Professional Services	No charge, deductible does not apply	Not Covered
Behavioral Health, Mental Health, and Substance Use – Outpatient	50%	Not Covered
Behavioral Health, Mental Health, and Substance Use – Inpatient	50%	Not Covered
Rehabilitation Therapy	**Contracted**	**Non-Contracted**
Physical Therapy, Occupational Therapy, and Speech Therapy: Office Visit Limited to 20 visits per therapy per year. Visit limits for Physical Therapy, Occupational Therapy, and Speech Therapy do not apply to therapies when primary diagnosis is Behavioral Health/Mental Health/Substance Use Disorder, including Autism Spectrum Disorder. 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 so long as such therapies are specifically listed in the treatment plan.	50%	Not Covered
Therapy services: Outpatient Facility Includes coverage for Chemotherapy, Occupational, Physical, Radiation, Respiratory and Speech Therapies. Outpatient Habilitative and Rehabilitative Therapy Services.	50%	Not Covered
Early Intervention services up to age 3: Physical Therapy, Occupational Therapy and Speech Therapy Limited to 20 visits per therapy per year. Visit limits for Physical Therapy, Occupational Therapy, and Speech Therapy do not apply to therapies when primary diagnosis is Behavioral Health/ Mental Health/Substance Use Disorder, including Autism Spectrum Disorder.	No charge, deductible does not apply	Not Covered

Other Medical Services	Contracted	Non-Contracted
Abortion	No charge, deductible does not apply	Not Covered
Acupuncture Services Limited to 6 Visit(s) per year.	50%	Not Covered
Autism Spectrum Disorders Includes Applied Behavioral Analysis Services.	Cost Share determined by place of service and the Covered Service received	Not Covered
Bariatric Surgery (Diagnosis of Morbid Obesity required) Prior Authorization required. Must meet all conditions of applicable medical policy.	50%	Not Covered
Cardiac & Pulmonary Rehabilitation When services rendered in the home, home healthcare limits apply. If part of physical therapy, the physical therapy limit will apply.	50%	Not Covered
Chiropractic Services Limited to 20 visits per year.	50%	Not Covered
Dental Services (Adult)	Not Covered	Not Covered
Diabetic Education	$5 copay/visit, deductible does not apply	Not Covered
Diabetic Supplies	No charge, deductible does not apply	Not Covered
Dialysis	50%	Not Covered

Durable Medical Equipment (DME)	50%	Not Covered
Gender Affirming Care Services Prior Authorization may apply.	Cost share determined by place of service and the Covered Service received	Not Covered
Hearing Aids Up to age 18 with verified hearing loss. Replacements no more than once every five (5) years.	50%	Not Covered
Home Health Care Limited to 60 visit(s) per year. Prior Authorization may apply.	50%	Not Covered
Hospice Care Inpatient Outpatient	 50% 50%	 Not Covered Not Covered
Infertility Prior Authorization required.	50%	Not Covered
Infusion Therapy	50%	Not Covered
Medical Foods	50%	Not Covered
Orthotics	50%	Not Covered
Prosthetics Prosthetic Limbs For prosthetic arms and legs, we cover up to the benefits amounts provided by federal laws for Medicare or where needed to meet State insurance laws.	20% 20%; deductible does not apply	Not Covered Not Covered
Skilled Nursing Facility Limited to 100 days per year.	50%	Not Covered
Temporomandibular Joint (TMJ) Services	50%	Not Covered

Transplant Performed at an approved transplant center. Transplant Donor Services	Cost Share determined by place of service and the Covered Service received Living organ donor expenses will be covered at the Cost Share, if any, required by law	Not Covered
Vision Services (Adult)	Not Covered	Not Covered
Prescription Drugs	**Contracted**	**Non-Contracted**
Tier 1 - Preventive Drugs (ACA) No cost share for eligible drugs.	No charge, deductible does not apply	Not Covered
Tier 2 - Preferred Generics	30-day supply (retail): $30 copay, deductible does not apply	Not Covered
Tier 3 – Preferred Brands	30-day supply (retail): $200 copay, deductible does not apply	Not Covered
Tier 4 – Non-Preferred	30-day supply (retail): $350 copay, deductible does not apply	Not Covered
Tier 5 – Specialty	30-day supply (retail): $700 copay, deductible does not apply	Not Covered
Contraceptives Up to twelve (12) months of contraceptive at one time. (Considered Tier 1 - Preventive Drugs.)	No charge, deductible does not apply	Not Covered

Pediatric Benefits	Contracted	Non-Contracted
Pediatric Vision (through age 18)		
Annual Exam	No charge, deductible does not apply	Not Covered
Frames / Lenses Limited to one (1) pair every two (2) years up to $120.	No charge, deductible does not apply	Not Covered
Pediatric Dental	Not Covered	Not Covered

Note: The table above shows how the Plan pays for covered services. Copayments are amounts paid by you for covered services. Deductible amounts are separate from and not reduced by copayments. Copayments do not count toward your deductible. For more details, see Section 7: Benefits/Coverage of the Evidence of Coverage (EOC).
Prescription Insulin Drug Cost-Sharing: You will not pay more than $100 total for all covered insulin you receive in a 30-day supply.
Epinephrine Auto-Injectors: You will not pay more than $60 for a two-pack for covered prescription epinephrine auto-injectors, regardless of the type of device prescribed or the amount of epinephrine you need.
Exclusions: If a service you need is not on the list above, it may not be covered. Please call us to learn more. Call us at 720-798-5704 or toll-free at 1-833-575-8033 (TTY users call 711).

Section 2: Title Page (Cover Page)

Colorado Access Choice EPO Colorado Option Bronze NA
Effective January 1, 2027, to December 31, 2027

COLORADO ACCESS CHOICE

P.O. Box #5637
Denver, CO 80237

This Member Handbook is a simple guide to help you understand your benefits. This Member Handbook serves as your Evidence of Coverage (EOC). If you have questions about your benefits, we are here to help. Call us Monday through Friday, 8:00 a.m. to 5:00 p.m. at 720-798-5704 or toll-free at 1-833-575-8033 (TTY users call 711).

If there is any conflict between the terms and conditions of this Member Handbook (including any supplements) and any other materials provided by Colorado Access Choice, the terms and conditions of this Member Handbook and its supplements will govern.

You may ask for a free copy of this Member Handbook, the Provider Directory, or any other relevant information on our website. We will send it to you within five days at no cost to you.

Section 3: Contact Information

3.1 Welcome to Your Health Plan!

Welcome! We're glad you chose ***Colorado Access Choice,*** and we look forward to supporting your health and well-being. Our mission is to partner with communities and empower people through access to quality, equitable, and affordable care.

This Member Handbook explains how your Colorado Access Choice works. It describes your benefits, how to get care, which services are covered, and what costs you may need to pay. It also explains your rights and responsibilities as a Member.

Because different sections of this Member Handbook work together, reading only part of it may not give you the full picture. We encourage you to review the entire Member Handbook, so you understand your coverage and how to use it.

This Member Handbook, along with your application, makes up the full agreement between you and us for Covered Services and supplies. By accepting coverage under this Member Handbook, you accept its terms, conditions, limitations, and exclusions You are bound by the terms of this Member Handbook.

3.2 Need Help?

You can reach Colorado Access Choice Customer Service by phone, online, or through your secure member portal. If you have questions about your Health Plan, please call Customer Service at 720-798-5704 or toll-free 1-833-575-8033 (TTY users call 711).

Hours of operation: Monday-Friday 8am-5pm Mountain Time

You can also visit www.coaccesschoice.com to find a Provider, get answers to common questions, learn more about your benefits and access wellness resources.

3.3 Understanding Key Terms

Some words in this Member Handbook have specific meanings. These terms are capitalized—such as Covered Services and Medical Necessity—and are explained in the **Definitions** section. Reviewing these definitions can help you better understand your benefits.

When this Member Handbook uses the words "we," "us," or "our," it means Colorado Access Choice, including its subsidiaries, affiliates, or partners. The words "you" and "your" mean the Member, Subscriber, and any covered Dependents.

3.4 Member Rights and Responsibilities

You have the following rights and responsibilities:

- A right to use all applicable appeals and complaint procedures available under this Member Handbook and as required by state and federal law.
- A right to receive clear, accurate, and timely information about the Plan, its services, participating practitioners and providers, and your rights and responsibilities as a Member.
- A right to receive clear explanations of coverage decisions, including the reasons for benefit determinations and information about how to appeal or file a complaint related to those decisions.
- A right to be treated with respect and recognition of your dignity, including the right to privacy and confidentiality of your medical information.
- A right to participate with your practitioners in decisions about your health care, including the ability to give informed consent, request a Second Opinion, and refuse treatment when permitted by law.
- A right to a candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- A right to timely access to covered health care services, consistent with the urgency of your medical condition and applicable access standards.
- A right to language assistance services at no cost, including interpretation and translation services, to help you understand your health care and Plan information.
- A right to voice complaints or appeals about the Plan or the care provided, without fear of retaliation or adverse treatment.
- A right to make recommendations regarding the Plan's Member Rights and Responsibilities policies.
- A responsibility to provide information, to the extent possible, that the Plan and its practitioners and providers need in order to deliver care.

- A responsibility to follow treatment plans and instructions that you agree to with your practitioners.
- A responsibility to understand your health conditions and participate in developing mutually agreed upon treatment goals, to the degree possible.

You may request a copy of your member rights and responsibilities by calling Customer Service at 720-798-5704 or toll-free at 1-833-575-8033 (TTY users call 711).

3.5 Acknowledgement of Understanding

You acknowledge and agree that this Member Handbook constitutes a contract solely between you and Colorado Access Choice. You further acknowledge and agree that this Member Handbook was not issued in reliance upon any representations made by any person or entity other than Colorado Access Choice.

No person, entity, or organization other than Colorado Access Choice is responsible or liable to you for any obligations arising under this Member Handbook. This provision does not create any obligations on the part of Colorado Access Choice other than those obligations expressly set forth elsewhere in this Member Handbook.

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Section 5: Eligibility

5.1 Who Can Enroll

To enroll in this health plan and stay enrolled you must meet all the following requirements:

- You must be a Colorado resident living within our Service Area. The Service Area is defined in Section 15: Definitions.
- You are not incarcerated (you may enroll if you are waiting for charges to be resolved).
- You meet any applicable enrollment period requirements as described below.
- You have completed and signed your application, and we have approved your enrollment.
- You must then pay your first month's premium in full in order to effectuate and activate your Plan coverage.

5.2 Who Can Enroll as Your Dependent

If you are enrolled as a Member, the following people may be eligible to enroll as your Dependents:

- Spouse or Partner, including a partner in a valid Colorado civil union.
- Your children or your Spouse's children through age 25 (coverage ends at the end of the year they turn 26). This includes:
  - biological children
  - adopted children
  - stepchildren
  - children placed with you for adoption
  - foster children
- Other Dependents, such as grandchildren, if they are under age 26, and you or your Spouse are (or were before age 18) the court appointed permanent legal guardian.
- Disabled adult children. A child aged 26 or older may stay on your plan if:
  - They are medically certified as disabled and dependent on you or your Spouse; **and**
  - The Plan receives proof of disability and dependency as required.

5.3 Adding Dependents

All eligible Dependents, such as a new Spouse and newborn, newly adopted and foster children, must meet the Plan's eligibility rules. If you enrolled via Connect for Health Colorado, please call 1-855-752-6749 to enroll Dependents during the Special Enrollment or Open Enrollment period.

If you enrolled directly through the carrier, please contact us at 720-798-5704 or toll-free at 1-833-575-8033 (TTY users call 711). If a Dependent is not enrolled within 60 days of their qualifying event, they cannot enroll until the next Open Enrollment period unless they qualify for another Special Enrollment Period.

5.3.1 Newborn Children

Your newborn child is automatically covered for the first 31 days of life. This coverage is required by state law, whether you intend to add the newborn to this Plan. Services must be provided or arranged by a Contracted Provider except for Emergency services.

If adding the newborn changes your monthly Premium, you must pay the new Premium for coverage to continue after the first 31 days. Even if the Premium does not change, you must still inform the Plan of the birth, so coverage can continue for the newborn child.

5.4 Eligibility for American Indian/Alaska Native

If Connect for Health Colorado determines you are American Indian or Alaska Native, you may qualify for zero cost sharing for all covered Essential Health Benefits under the Affordable Care Act. Connect for Health Colorado will enroll you in the corresponding plan if you qualify.

5.5 Special Enrollment

You or your Dependent may qualify for a Special Enrollment Period (SEP) if you experience a qualifying event. Examples include:

- Losing other health coverage
- A Dependent aging off the plan
- Getting married
- Having a baby or adopting a child
- Moving out of the Service Area

Most SEPs last 60 days from the date of the event. During the SEP, you may enroll your Dependent(s) in this Plan, or in certain circumstances, you may change plans (your plan choice may be limited). You may need to show proof of the qualifying event. To learn more about SEPs, deadlines, and how to enroll, visit connectforhealthco.com or call 1-855-752-6749.

If Your Income Changes: If you are enrolled directly with the Plan, and your income decreases, you may qualify for advance premium tax credits through Connect for Health Colorado. This may give you a SEP to move your coverage to Connect for Health Colorado.

5.6 Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the new

year. Except where noted otherwise, the applicant's Effective Date is determined by the Exchange based on the receipt of the completed enrollment form; the applicant's Effective Date will be no later than the first day of the following month after the application is received. Benefits will not be provided until the applicable Premium is paid to us.

Effective Dates for special enrollment periods:

1. In the case of birth, adoption or placement for adoption, placement in foster care or by court order, coverage is effective on the date of birth, adoption, placement for adoption, placement in foster care or the effective date of the order, unless the Subscriber timely requests a different Effective Date;

2. In the case of marriage or civil union, coverage is effective on the first day of the month after receipt of the application, as long as the application is received within 60 days of the event;

3. In the case where a Qualified Individual loses Minimum Essential Coverage, coverage is effective on the first day of the month following the loss of coverage if plan selection occurs before the loss of coverage; otherwise coverage is effective based on when a complete application is received, which must be within 60 days of the qualifying event; and

4. In the case of new access to an Individual Coverage Health Reimbursement Arrangement (ICHRA) or a new provision of a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA), both of which are employer-funded arrangements that reimburse employees for the cost of individual health insurance coverage, coverage effective dates are determined as follows:

- If the Plan selection is made before the day of the triggering event, coverage is effective on the first day of the month following the date of the triggering event or, if the triggering event occurs on the first day of a month, on the date of the triggering event.
- If the Plan selection is made on or after the day of the triggering event, coverage is effective on the first day of the month following the Plan selection.

5. In the case of an individual who is pregnant, coverage is effective on the first day of the month in which the individual receives written certification of pregnancy, unless the individual chooses to have coverage effective on the first day of the month following the date the individual makes a plan selection.

6. Effective Dates for special enrollment due to loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

- Legal separation, dissolution of domestic partnership or recognized civil union, or divorce;
- Cessation of Dependent status, such as attaining the maximum age;

- Death of an employee;
- Termination of employment;
- Reduction in the number of hours of employment;
- Individual who no longer resides, lives, or works in the Plan's Service Area;
- A situation in which a plan no longer offers any benefits to the class of similarly situated
- individuals that include the individual;
- Termination of employer contributions; or
- Exhaustion of COBRA or, where applicable, State continuation benefits.

Effective Dates for special enrollment due to loss of Minimum Essential Coverage do not include termination or loss due to:

- Failure to pay Premiums on a timely basis, including COBRA or State continuation Premiums prior to expiration of COBRA or State continuation coverage, or
- Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

5.7 Annual Enrollment

You may apply for coverage or make changes during Open Enrollment by submitting an application to Connect for Health Colorado or directly to Colorado Access Choice.

5.8 Members Who Are Inpatient on Effective Date of Coverage

If you are inpatient in a Hospital or Institution when your coverage with us becomes effective and you had other coverage when you were admitted, state law will determine whether we or your prior carrier will be responsible for payment for your care until your date of discharge.

5.9 Members with Medicare

This Plan is not intended for persons who are eligible for or entitled to coverage under Medicare. If you are eligible or become eligible for Medicare during the term of this Membership Agreement, you should contact Connect for Health Colorado immediately. Once Medicare Part A starts, you are not eligible for premium tax credits through Connect for Health Colorado and will have to pay the full Premium for your Plan. You remain enrolled unless you proactively end it, which is highly recommended to prevent overlap with Medicare and avoid any Premium repayment or Medicare late enrollment penalties.

Contact Connect for Health Colorado to disenroll before Medicare coverage starts and avoid paying full Premiums for two plans.

Section 6: How to Access Your Services and Obtain Approval of Benefits

6.1 How your coverage works

Understanding how your coverage works can help you get the most from your health care benefits. This Plan is an Exclusive Provider Organization (EPO), meaning it provides coverage for Covered Services received from Contracted Providers and facilities within the Plan's provider network. Except for Emergency Services, urgently needed services when required by law, and other services specifically covered under the Plan, services received from Non-Contracted Providers or facilities are not covered.

Members are not required to select a PCP and Referrals are not required to obtain Covered Services from Contracted specialists. However, your PCP should still play a key role in managing your care and coordinating services with specialists. Your PCP can also help arrange Prior Authorizations when required for certain services. Working with your PCP helps ensure you receive the right care, at the right time, and in the right place.

6.2 In an Emergency

If you have a medical emergency, **call 911** or go directly to the nearest emergency room.

6.3 Using Contracted Providers

To receive the highest level of benefits and avoid unexpected costs, it is important that you receive care from Contracted Providers. If you receive care from a provider who does not participate in your Plan, you may be responsible for paying all or a portion of the charges.

You have several ways to check whether a provider or facility is contracted with us:

- Visit the online Provider Directory at www.coaccesschoice.com which lists all Contracted Providers, and facilities for your Plan.
- Call Customer Service to help find a provider by location or specialty. Customer Service can share information such as a provider's name, address, telephone number, specialty, education, and board certification.
- Ask your health care provider directly whether they participate in the Colorado Access Choice network.

A link to the Provider Directory is available on the home page of our website and through the member portal. Our online The Provider Directory includes information about Contracted Providers, such as:

- Providers in your area, including their name, address, and telephone number
- The provider's specialty, professional qualifications, and board certification
- Languages spoken other than English (all providers speak English)
- Whether the provider is accepting new patients (please confirm directly with the

provider)

For more information about a provider's medical school or residency training, contact us or visit the provider's website. You may also contact Customer Service to help find a Contracted Pharmacy or view a list of Contracted Pharmacies online at www.coaccesschoice.com.

6.4 Federal Patient Protection and Affordable Care Act Notice

6.4.1 Choice of Primary Care Provider

You may choose a Primary Care Provider (PCP) from our network. You have the right to designate any PCP who participates in our network and is available to accept you or your covered family members.

For information on how to select a PCP, or for a list of participating PCPs, please call Customer Service at 720-798-5704 or toll-free 1-833-575-8033 (TTY users call 711), hours of operation: Monday-Friday 8am-5pm Mountain Time or visit our website at www.coaccesschoice.com.

If you are enrolling a child, you may choose a pediatrician as your child's PCP.

6.4.2 Access to Obstetrical and Gynecological (OB/GYN) Care

You do not need Prior Authorization or a Referral from a PCP to obtain obstetrical or gynecological care from a participating health care professional in our network who specializes in obstetrics or gynecology.

The health care professional may be required to comply with certain plan procedures, including obtaining Prior Authorization for specific services.

For a list of participating health care professionals who specialize in obstetrics or gynecology, please call Customer Service at 720-798-5704 or toll-free 1-833-575-8033 (TTY users call 711), hours of operation: Monday-Friday 8am-5pm Mountain Time or visit our website at www.coaccesschoice.com.

6.4.3 Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act is a federal law that requires the Plan to provide Mental Health and Substance Use Disorder (SUD) benefits in parity with Medical and Surgical benefits.

Treatment limitations, such as day or visit limits, may not be more restrictive for Mental Health or SUD benefits than those that apply to substantially all medical and surgical benefits. If no such limits apply to medical and surgical benefits, the Plan may not impose them on Mental Health or SUD benefits.

Cost sharing requirements, including deductibles, copayments, coinsurance, and out-of-pocket maximums, may not be more restrictive for Mental Health or SUD benefits than the predominant requirements applicable to medical and surgical benefits within the same classification.

6.5 Consolidated Appropriations Act of 2021 Notice and the No Surprises Act

The Consolidated Appropriations Act of 2021 (CAA) is a federal law that includes the No Surprises Act and certain provider transparency requirements. These rules are designed to protect you from unexpected medical bills in specific situations.

6.5.1 What Are Surprise Billing Claims?

Surprise Billing Claims are protected under the No Surprises Act and include:

- Emergency services provided by a Non-Contracted Provider;
- Covered services provided by a Non-Contracted Provider at a contracted facility; and
- Non-Contracted ground or air ambulance services.

6.5.2 No Surprises Act Protections

- **Emergency services** are covered under the Plan as required by federal law. No precertification is required. Coverage applies whether emergency services are provided by a Contracted or Non-Contracted Provider. When emergency services are received from a Non-Contracted Provider, those services will be covered at the Contracted benefit level, and your out-of-pocket costs will be limited to the amount you would pay if the services were provided by a Contracted Provider.

  Once a Non-Contracted Provider determines that you are stable, you may be responsible for charges for continued non-contracted care. A condition is considered stable when emergency medical services have been provided so that your condition is not expected to materially worsen and the provider determines you can safely be transferred to a Contracted Facility using non-emergency transportation.

  If, after you are stable, the Non-Contracted Provider gives you the required notice, you are able to receive and understand the information, and you provide informed consent to continue receiving non-contracted care, you will be responsible for all charges related to that care.

  These notice and consent requirements do not apply when unexpected and urgent medical needs arise during treatment that require immediate care.

  These notice and consent rules do not apply if the services are needed due to unforeseen and urgent medical needs that arise at the time care is provided.

- **Non-Contracted Providers at a contracted Facility.** If you receive Covered Services from a non-Contracted Provider at a contracted hospital or facility, those services will not be covered at the contracted benefit level if the non-Contracted Provider gives you proper notice of its charges; and You give written consent to such charges. In this case, you will be responsible for all non-contracted charges for those services.

  These notice and consent requirements do not apply to Ancillary Services such as Emergency Services and Anesthesiology. A non-Contracted Provider meets the notice and consent requirement by:
  - Obtaining your written consent at least 72 hours before the services are provided; or
  - Obtaining your written consent on the same day the services are provided if the appointment was scheduled within 72 hours.

6.5.3 Cost-Sharing for Services Under the No Surprises Act

If you receive emergency care or covered services from a Non-Contracted Provider at a Contracted facility, your cost sharing is calculated using Colorado specific Non-Contracted Provider reimbursement rate methodologies. Learn more at www.coaccesschoice.com.

Any deductibles, copayments, or coinsurance you pay for these services will count toward your Contracted out-of-pocket maximum.

6.5.4 Appeals for Claim Denials Under the No Surprises Act

If we deny a claim for services you believe are protected under the No Surprises Act, such as ground or air ambulance services, you have the right to file an appeal with us.

An appeal allows you to ask for a review of how the claim was processed and whether the No Surprises Act protections were applied correctly. We will review your appeal and notify you of our decision.

If your appeal of a Surprise Billing Claim is denied, you have the right to request an external review by an Independent Review Organization. This external review is conducted by an independent third party that is not affiliated with the Plan. Information on how to request an external review is provided in the Appeals and Complaints section of this Member Handbook.

6.5.5 Out-of-Network Care Due to Inaccurate Provider Directories

We are required to update our Provider Directory at least monthly and audit every 90 days.

If you can demonstrate that you relied on inaccurate information we provided by indicating that a Provider was participating in the network for a particular claim, you are responsible only for your usual cost-sharing amounts (such as copayments, deductibles, and/or coinsurance) for that claim.

Your cost-sharing will be calculated based on the Maximum Allowed Amount and you will only be required to pay the amount that you would have paid, had the services been delivered by an in-network provider.

6.5.6 Provider and Cost Transparency Under the No Surprises Act

We provide information about protections against surprise medical bills, including how to contact state and federal agencies if you believe a provider has violated the No Surprises Act on our website at www.coaccesschoice.com:

You may also access the following information through our website or by calling Customer Service at 720-798-5704, or toll-free at 1-833-575-8033 (TTY users call 711):

- Estimated cost-sharing information for various services; and
- A directory of all Contracted Providers.

6.5.7 Payment for Covered Services Only

The Plan pays benefits only for Covered Services, even when services are provided by your PCP or are referred or ordered by your PCP. Services that are not Covered Services are not paid by the Plan. To help ensure your care is covered and to avoid unexpected bills:

- Always present your Identification (ID) Card when you receive health care services;
- Confirm that your provider is Contracted before receiving care, except in cases of Urgent or Emergency care; and
- Contact us if you have any questions about your coverage or provider participation.

You may reach Customer Service at 720-798-5704, or toll-free at 1-833-575-8033 (TTY users call 711).

6.5.8 Non-Contracted Services

Covered Services that are not obtained from a Contracted PCP, Contracted specialist, or another Contracted Provider, or that are not approved as an Authorized Service, or that do not meet the Surprise Billing Claims criteria, are considered non-contracted services. These Non-Contracted services are not covered under your Plan. The only exceptions are:

- Emergency care;
- Ambulance services related to an emergency for transportation to a hospital; or
- Urgent care services received at an urgent care center.

6.5.9 Non-Contracted Providers and Balance Billing

We review claims before and after they are paid to help prevent fraud, waste, abuse, and other improper billing. As a result of these review processes, some claims may not be payable.

If you receive services from a Non-Contracted Provider, you may be balance billed by that Provider for any services that are not payable under the Plan. A claim may also be denied if a

provider fails to submit required medical records during the claims review process.

6.5.10 Assignment of Benefits for Direct Payment to a Non-Contracted Provider

An assignment of benefits is when you give us permission to send your payment directly to a health care provider instead of sending it to you. This usually happens when you receive care from a Non-Contracted Provider. Signing an assignment of benefits does not change what services are covered or how much the Plan pays. It only changes who receives the payment.

By signing an assignment of benefits, you are telling us:

- It is okay for the Plan to pay the provider directly for covered services; and
- You understand that the provider may bill you for any charges that are not covered by the Plan.

If you authorize it, we will pay benefits directly to a Non-Contracted Provider. We may require a copy of the assignment of benefits for our records.

Payment to a provider under an authorized assignment of benefits fulfills our payment obligation to you for those services.

6.6 Your Contracted Primary Care Providers (PCPs)

Your PCP manages and coordinates your health care. PCPs are usually family practice doctors, internal medicine doctors, general practitioners, or pediatricians, and may provide care in person or virtually.

Your PCP is your main point of contact for routine care, preventive services, and ongoing health needs. Referrals are not required to see any Contracted providers, but your PCP can help connect you with Contracted specialists when needed.

Upon enrollment in your plan, we recommend making an appointment with a PCP as soon as possible. When you visit your PCP, please bring your Member ID Card. This helps your PCP understand your benefit plan and confirm which services are covered.

Your PCP can help you:

- With checkups
- Learn how to stay healthy
- With sick visits
- Take care of any chronic conditions
- Get vaccines
- Refer you to a specialist, behavioral healthcare services, and hospital services if you need it
- Find out what is going on with your health (diagnosis)
- Take care of what is going on with your health (treatment)

6.7 Changing Your PCP

You can change your PCP at any time online via the member portal, by calling Customer Service, or by going to the Contracted PCP of your choice. You may also ask a Contracted Provider to change your PCP on your behalf via the provider portal.

Find a Contracted PCP using our online Provider directory at www.coaccesschoice.com, or call us to get help at 720-798-5704 or toll-free at 1-833-575-8033 (TTY users call 711).

6.8 Referrals

A Referral is a specific recommendation for evaluation or treatment by a particular provider or provider type. Because this plan is an EPO, you are not required to obtain a Referral from a PCP before receiving covered services from a Contracted specialist or other Contracted Provider. Prior authorization requirements, when applicable, are separate from Referral requirements. If you get a Referral from your PCP, you must make sure that the specialist is Contracted with the Plan. Your PCP may also get a Prior Authorization for those services, if needed. If there is not a specialist who is part of our network for a covered service, we will refer you to a Provider with the expertise you need.

6.9 Claims Review

We review claims before and after they are paid to help prevent fraud, waste, abuse, and other improper billing. We also review services to ensure they are Medically Necessary and appropriate. This may include Prior Authorization before services, Second Opinions, checking progress during treatment, Discharge Planning, or reviewing treatments that may be considered experimental.

These reviews follow Colorado law and help ensure you receive safe, effective care.

6.10 Prior Authorization for Health Care Services (Pre-Approval)

For some services, you must get Prior Authorization from the Plan before you receive care. This requirement applies to certain procedures, diagnostic tests, medical equipment, home health services, medications, and other services. If you are admitted to a hospital, your Contracted Provider must obtain Prior Authorization for any applicable services on your behalf. Prior Authorization is not required for emergency services.

For more information about which services require Prior Authorization, please visit www.coaccesschoice.com.

6.10.1 Your Provider Requests Prior Authorization

Your Contracted Provider is responsible for requesting Prior Authorization when they believe

you need additional services or a hospital stay. You do not need to submit the request yourself.

6.10.2 How Prior Authorization Decisions Are Made

We review all Prior Authorization requests within the timeframes required by law. During our review, we determine whether the requested service is Medically Necessary and covered under the Plan. Once a decision is made, we will notify both you and your Provider if the request is approved or denied.

6.10.3 If a Request Is Denied

If coverage for a service is denied because it is not considered Medically Necessary, your Provider may ask us to reconsider the decision. If the medical necessity denial is not reversed, you have the right to file an appeal. Your right to appeal does not depend on whether your Provider requests reconsideration. For more information, see Section 13: Appeals and Complaints.

6.10.4 Service Limits

We may authorize only a certain amount or duration of a service Prior Authorization. For example, we may approve only a certain number of visits within a specific time period. If your Provider believes you need additional visits, they may submit another Prior Authorization request.

6.10.5 Important Reminders about Prior Authorization

Receiving Prior Authorization does not guarantee payment. A claim may be denied if:

- The service is not a Covered Service; or
- The service provided differs from what was authorized.

To check the status of a Prior Authorization request or to learn the outcome, you may contact either your Provider or us. Always confirm with your Provider that any required Prior Authorization has been obtained before you receive services or supplies.

You can call us to ask if the services are covered or need Prior Authorization. Call us at 720-798-5704 or toll-free at 1-833-575-8033 (TTY users call 711) or visit our website at www.coaccesschoice.com.

6.11 Continuity of Care

We are committed to ensuring continuity of care for members who are receiving services from Non-Contracted Providers or whose current provider is no longer participating in the network.

6.11.1 New Members

For new members who are actively receiving care from a Non-Contracted Provider at the time

of enrollment, we review requests for continuity of care in accordance with state and federal requirements. When approved, members can continue receiving care from their current provider for a limited time to avoid disruption of your care. During this time, we will work with you and your Provider to support an appropriate transition to a contracted Provider, when needed.

6.11.2 Provider Network Changes

If a member's current provider leaves the Colorado Access Choice network, continuity of care provisions may allow the member to continue receiving services from that provider for a defined period of time. This is subject to the provider's agreement to comply with applicable network requirements, including reimbursement rates, quality standards, and reporting obligations. Members will be notified of the provider's change in network status and supported in either temporarily continuing care or selecting a new Contracted Provider.

6.11.3 Our Commitment to Continuity of Your Care

In all continuity of care situations, we will:

- Help coordinate care and communication between providers
- Support the transfer of medical records and treatment plans
- Assist members in selecting appropriate Contracted Providers when needed
- Prioritize uninterrupted access to medically necessary services, including ongoing courses of treatment

6.12 Identification (ID) Card

After you enroll, we will mail your ID Card directly to you. Please bring this card with you whenever you receive care.

Members who have paid their premiums under this Member Handbook are eligible to use the covered services and benefits. If you use your card to receive services or benefits you are not eligible for, you may be responsible for the cost of that care. If you have any questions about your coverage or your ID Card, we're here to help.

6.13 After-Hours Care

If you need medical care in the evening, on weekends, or on holidays and cannot wait until your provider's office reopens, please call your provider's office for instructions. Many offices have after-hours options or on-call support to guide you.

If your condition is an emergency, go to the nearest appropriate medical facility right away. You can also call **911** for emergency assistance. For immediate mental health support, you may call or text **988**, the Suicide and Crisis Lifeline.

Your coverage includes benefits for emergency care, even if services are provided by a Provider

who is not in our network, as long as the situation meets the definition of an emergency under this Member Handbook.

6.14 Obtain Approval of Benefits

6.14.1 Getting Started: How Care Reviews Work

As a new member, we want you to feel confident using your health coverage. This section explains how we review certain services to help make sure you get the care you need, in the right place, and at the right time. You'll learn when approval may be needed and what to expect if a review is required. Our goal is to support your care and make your benefits easy to understand—every step of the way.

6.15 How We Review Care

We review some health care services to make sure they are safe, appropriate, and needed. This process is called Utilization Review.

Utilization Review helps us decide:

- If a service is needed for your condition;
- If the service is covered by your plan; and
- The location where the service should be provided

Some services are also reviewed to see if they are still being studied or are considered experimental, as explained in this Member Handbook.

6.16 Where You Get Care

For care to be covered, it must be medically necessary. Sometimes, we also look at where the care is provided. If a service can be given safely in a lower-cost or lower-level setting, it may not be covered if it is done in a higher-cost setting. This does not mean the service itself is denied—only that it may not be covered in that location.

If this happens:

- The same service may be approved in a different location
- The service can be reviewed for medical necessity again
- You may need to use a different provider or facility

Examples:

- A hospital stay may not be covered, but the same care may be covered as an outpatient visit.
- A hospital outpatient test may be covered at an imaging center or doctor's office.
- Care in a skilled nursing facility may not be covered, but the same care may be covered at home.

6.17 How Coverage Decisions Are Made

Some services must be reviewed before they can be covered. Reviews are based on medical guidelines and policies. Sometimes, a service may not be covered if another option:

- Works just as well for most members
- Is safe and appropriate
- Costs less

When two treatments usually give similar results, they are called clinically equivalent.

If you have questions about these reviews, call Customer Service at 720-798-5704, or toll-free at 1-833-575-8033 (TTY users call 711).

6.18 Approval Before Care (Precertification/Prior Authorization)

Some services need approval before they start. This is called Precertification or Prior Authorization. If your service is approved:

- The approval is only valid for the specified time period
- It applies only to the service, condition, and place of care that were approved

Approval does not guarantee payment. For the service to be covered:

- You must be eligible for benefits;
- Your premium must be paid;
- The service must match what was approved;
- The service must be for the approved condition and location; and
- You must not exceed plan limits.

For a list of services that require authorization, please visit www.coaccesschoice.com. If you have questions on how to request approval, call Customer Services

6.19 Types of Reviews

6.20 Before Care Starts

Some services are reviewed before treatment or a hospital stay begins. For childbirth

- No approval is needed for the first 48 hours after a vaginal delivery
- No approval is needed for the first 96 hours after a cesarean delivery
- Longer stays are reviewed during the hospital stay

6.20.1 During Care

Some reviews happen while you are receiving care, such as during a hospital stay.

6.20.2 Urgent Reviews

Reviews are done faster when delaying care could seriously affect your health or your ability to

live independently.

6.20.3 After Care Reviews

Some reviews happen after care is provided. We may do this when approval was not required, or approval was needed but not requested on time.

Section 7: Benefits/Coverage (What Is Covered?)

Covered services are available when they are Medically Necessary and provided by Contracted Providers and facilities (unless otherwise stated in this Member Handbook). Services must meet the terms of this Member Handbook, including any Prior Authorization or other requirements. Coverage includes all Essential Health Benefits (EHBs) required for Colorado individual market plans, including ambulatory services, Emergency services, hospitalization, Maternity Services, Mental Health and Substance Use Disorder services, prescription drugs, Rehabilitation and Habilitation Services and devices, Laboratory Services, Preventive Care, and chronic disease management, and pediatric services.

We will not deny coverage for medical, surgical, Mental Health, or Substance Use Disorder care because an injury or condition resulted from self-harm, a suicide attempt, or suicide. Medically Necessary treatment for covered conditions related to self-harm or suicide is covered subject to the same terms, conditions, limitations, exclusions, and cost-sharing that otherwise apply under this EOC.

Covered services are subject to Limitations, Exclusions and Member Cost Sharing, as detailed in Section 1: Schedule of Benefits and Section 8: Limitations and Exclusions.

7.1 Provider/Professional Services

7.1.1 Office Visits (Primary Care, Specialty, and Virtual Visits)

Covered services include diagnosis and treatment in the Provider's office, during medical office consultations, in a Skilled Nursing Facility, or at home when covered under the Plan. This includes primary care visits for illness or injury, Specialist visits, follow-up visits for ongoing treatment, second opinions, and telehealth visits when available under your plan.

Benefit	Member Pays
Primary Care Provider ("PCP") office visit	First 3 visits No charge, deductible does not apply, then deductible, then $50 copay
Other Practitioner (includes nurse practitioners, physician assistants)	First 3 visits No charge, deductible does not apply, then deductible, then $50
Specialist office visit	50%

7.1.2 Preventive Services

Covered services include evidence based Preventive Care recommended by U.S. Preventive Services Task Force (UPSTF) A and B Recommendations, ACIP vaccines, and HRSA guidelines (including women's preventive services). Preventive services are covered without Deductible, Copay, or Coinsurance when provided by a Contracted Provider, as required by applicable federal and Colorado law. If you receive any other covered services during a Preventive Care

visit, you may pay the applicable cost share for those services.

The following services are covered Preventive Care Services, but this list is not exhaustive:

- Adult Preventive Care exams
- Adult preventive screenings (blood pressure, cholesterol, diabetes, Sexually Transmitted Infections)
- Cancer screenings (mammograms, colorectal, cervical)
    - An annual breast cancer screening study is covered as well as additional breast imaging that is performed, either for diagnostic or supplemental purposes for members with high lifetime risk or high breast density.
- Vaccines
- Mental health wellness exams
- Adult tobacco use screening and tobacco cessation interventions
- Well-baby and well-child exams
- Well-woman exams

This Plan covers tobacco cessation services in accordance with Colorado Insurance Regulation 4-2-81. Covered services include participation in tobacco cessation programs, including the Colorado Quitline, which provides counseling and support for tobacco cessation. Members may access the Colorado Quitline by calling 1-800-QUIT-NOW or through the program resources identified by the State of Colorado.

HIV Prevention: We cover HIV prevention drugs and services necessary for initiation and continued use of HIV prevention drugs, including office visits, testing, vaccinations, and monitoring services, consistent with task force requirements. Coverage is provided without any deductible, copayment, coinsurance, or other cost sharing for the member, and regardless of the covered person's gender.

Coverage is provided for HIV pre-exposure prophylaxis (PrEP), including baseline and monitoring services consistent with USPSTF recommendations, for federal Food and Drug Administration (FDA)-approved medications without copayment, coinsurance, or other cost-sharing.

FDA approved HIV PrEP medications listed on our formulary are not subject to step therapy or prior authorization requirements. FDA approved HIV PrEP medications not listed on our formulary are not subject to step-therapy or prior authorization when prescribed or dispensed by a pharmacist. Requests from a non-pharmacist for FDA-approved HIV PrEP medications not listed on our formulary requiring prior authorization shall be processed on an urgent basis within 24 hours of receipt.

Benefit	**Member Pays**
Preventive Care Services	No charge, deductible does not apply

7.1.3 Vision Services

Wellness and refraction exams to determine the need for vision correction and to provide a prescription for eyeglasses are covered for children ages 18 and under. Eye exams are not covered for adults age 19 and over.

7.1.4 Diagnostic Tests

Diagnostic laboratory Services, X-Rays, and special procedures such as MRI, CT and PET scans are covered. Some services may require Prior Authorization.

Benefit	Member Pays
Laboratory services	50%
Diagnostic imaging (including x-ray) services	50%
Advanced imaging (CT, SPECT, MRI, MUGA and PET)	50%

7.1.5 Abortion Services

Covered services include abortion services and related care, drugs, and supplies with no cost-sharing, as required by applicable law.

7.1.6 Anesthesia

General Anesthesia, deep Anesthesia, and monitored Anesthesia care (MAC) are covered when they are Medically Necessary and provided as part of a covered procedure. These services must be provided by a qualified Provider who specializes in Anesthesia or by a certified nurse anesthetist.

7.1.7 Infertility Services

Covered infertility services include the diagnosis and treatment of involuntary Infertility, including X-Ray, Laboratory Services, and artificial insemination, except for donor semen, donor eggs, and services related to their procurement and storage. Services must adhere to established medical standards—for example, treatment guidelines from the American College of Obstetricians & Gynecologists (ACOG) or the American Society for Reproductive Medicine (ASRM). Prior Authorization is required – refer to www.coaccesschoice.com for the Plan's current Prior Authorization list.

Note: Services to reverse voluntary, surgically induced Infertility and all services and supplies, other than artificial insemination, related to conception by artificial means are not covered. Prescription drugs related to such services and donor semen and donor eggs used for such services, including but not limited to in vitro fertilization, ovum transplants, gamete intrafallopian transfer, and zygote intrafallopian transfer are not covered. These exclusions

apply to fertile as well as infertile individuals or couples.

7.1.8 Temporomandibular Joint (TMJ) Services

Diagnostic exams and treatment for TMJ disorders are covered when ordered by your Provider and Medically Necessary. Services may require Prior Authorization. Coverage includes diagnostic exams, X-Rays and Laboratory Services, surgical procedures, and non-surgical treatments such as Physical Therapy.

7.1.9 Telehealth

Covered services may be delivered by Contracted Providers through telehealth, including video visits or audio-only visits when appropriate and allowed under the Plan. Telehealth services are covered on the same basis as in-person care as required by Colorado law. Services may require Prior Authorization.

7.2 Facility Services

7.2.1 Inpatient Hospitalization

Inpatient Hospital care, including acute care, Skilled Nursing Facility, and Private-Duty Nursing, when ordered by your Provider, are covered under the Plan. Covered services include room and board, professional services of Providers and other health care professionals during a Hospital stay, general nursing care, meals and special diets, and other Hospital services and supplies. Services may require Prior Authorization.

Private rooms: If a private room is Medically Necessary, such as for isolation, it is covered. If you choose a private room when a semi-private room is available and a private room is not Medically Necessary, you are responsible for any difference in cost, unless the Hospital only offers private rooms, or a private room is the only room available.

Benefit	Member Pays
Inpatient Hospital Services (e.g., Hospital Stay)	50%
Inpatient Physician and Surgical Services	50%
Room and board in a semi-private or private room or special care unit including ancillary (additional) services	50%
Mental Health Physician visit to Hospital, Behavioral Health Facility or Residential Treatment Center	50%
Inpatient Services at a Hospital, Behavioral Health Facility or Residential Treatment Center	50%

Detoxification	50%

7.2.2 Outpatient Facility/Ambulatory Surgery Center Services

Outpatient surgery and services provided in a Hospital or ambulatory surgery center when ordered by your Provider, including professional services of Providers and other health care professionals are covered. Some services may require Prior Authorization.

Benefit	Member Pays
Outpatient surgery facility (surgery performed in a hospital outpatient setting or Outpatient Surgical Center)	50%
Outpatient facility services (other than surgery)	50%
Outpatient Surgery Physician/Surgical Services	50%

7.2.3 Maternity Services

Prenatal and postnatal visits, labor and delivery (vaginal or cesarean) in a Hospital or birthing center, complications of pregnancy, and inpatient Hospital care for the mother and newborn are covered. Covered services also include minimum 48-hour (vaginal) or 96-hour (cesarean) Hospital stays unless early discharge is appropriate based on the attending clinician's judgment and patient preference, newborn screenings and immunizations, breastfeeding support and counseling, and breast pump equipment. One standard-issue breast pump is covered at $0 per pregnancy under the preventive care benefit. Some services may require Prior Authorization.

This Plan provides coverage for prenatal and postnatal visits in accordance with Colorado Insurance Regulation 4-2-81. Covered benefits include Medically Necessary prenatal visits during pregnancy and postnatal visits following delivery when provided by an In-Network Provider, including physicians or Certified Nurse Midwives, subject to the cost-sharing described in this Evidence of Coverage

Benefit	Member Pays
Preventive Prenatal and Postpartum care office visits	No charge, deductible does not apply
Non-Preventive Prenatal and Postpartum care office visit	First 3 visits No charge, deductible does not apply, then deductible, then $50
Newborn care office visit (birth through 30 days)	No charge, deductible does not apply
Physician visit to the mother or newborn at a Hospital	First 3 visits No charge, deductible does not apply, then deductible, then $50

Professional Services for Normal delivery, including Cesarean section	50%
Other services for Normal delivery, including Cesarean section	50%
Genetic testing of fetus	50%
Circumcision of newborn (birth through 30 days)	50%

7.2.4 Skilled Nursing Facility

Skilled inpatient services are covered up to 100 days per year in a licensed Skilled Nursing Facility. Covered services include those usually provided by Skilled Nursing Facilities, such as room and board, nursing care, medical social services, medical and biological supplies, and blood, blood products, and their administration.

Benefit	Member Pays
Room and board in a semi-private or private room with ancillary (additional) services	50%

7.2.5 Hospice Care

Supportive care is covered when ordered by your Provider for individuals with a life expectancy of six months or less. Services must be provided by a licensed hospice program and may require Prior Authorization. Care may be provided at home or in an inpatient hospice facility. Hospice Care focuses on comfort and quality of life rather than curative treatment and includes pain management, counseling, and support for you and your family.

Benefit	Member Pays
Hospice Care	50%

7.2.6 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 choose Hospice Care, you are eligible for the Special Services Program. This Program allows you to receive up to 15 home health visits per lifetime. These 15 visits are without charge until you choose Hospice Care coverage. 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.

7.3 Emergency and Urgent Care Services

7.3.1 Emergency Services

If you think you are having a medical Emergency, call 911 or go to the nearest Emergency room. You do not need to contact us first, and do not need Prior Authorization for Emergency Care.

An Emergency medical condition is one that a prudent layperson with an average knowledge of health and medicine could reasonably believe needs immediate medical attention to avoid serious harm to health, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

Emergency services are covered in the United States from Contracted and Non- Contracted Providers as required by law. Coverage outside the United State is not provided unless otherwise stated under this EOC.

If you are admitted to a Hospital directly from the Emergency room, the Emergency room facility Copayment will not apply as part of your cost share.

If Emergency services are received at a Non- Contracted facility, coverage for Emergency services and any related post-stabilization services will be provided in accordance with applicable federal and state law, including surprise billing protections. Once you are stabilized, additional services may be subject to Plan requirements, including transfer to a Contracted facility when medically appropriate and permitted by law.

Benefit	Member Pays
Emergency room facility	50%
Emergency room physician	50%

Cost-sharing for Emergency services is applied as if the services were received In-Network. If you are admitted for the same condition, any Emergency room Copayment is waived. Other covered services you receive may still be subject to the cost-sharing that applies under other parts of this EOC.

7.3.2 Ambulance

Emergency transportation by a licensed Ambulance is covered when your condition requires care that only an Ambulance can provide. Transportation is to the nearest facility equipped to treat your condition. Coverage includes ground or air Ambulance for emergencies. Non-emergent transportation is covered with Plan authorization.

Benefit	Member Pays
Ground ambulance	50%
Air ambulance	50%

7.3.3 Urgent Care

Covered urgent care services include Medically Necessary medical or surgical care you receive in an urgent care center or in a Provider's office for an unexpected illness or injury that required prompt attention but is not life-threatening. Cost-sharing is applied as if the care were received In-Network.

If you receive care from an urgent care center owned and operated by your PCP, the Urgent Care cost share will apply.

Additional cost-sharing may apply for other covered services provided during the urgent care visit, such as laboratory or radiology services.

Benefit	Member Pays
Urgent care center or facility	50%

7.4 Behavioral Health, Mental Health, and Substance Use Disorder Services

Behavioral Health, Mental Health, and Substance Use Disorder Services: Your Plan covers Medically Necessary behavioral health, mental health, and Substance Use Disorder services in accordance with federal and Colorado law, including mental health parity requirements. Coverage is subject to the terms of this EOC, including Medical Necessity, Prior Authorization when required (refer to www.coaccesschoice.com for the Plan's current Prior Authorization list), and any applicable cost-sharing, limitations, and exclusions. Covered conditions include those listed in standard diagnostic manuals, including Autism Spectrum Disorders.

The Plan cover treatments that are standard for your condition, such as:

- Outpatient therapy and counseling (individual, group, and family sessions)
- Inpatient mental health care in a Hospital or residential treatment facility
- Partial hospitalization
- Substance Use Disorder treatment, including detoxification and rehabilitation
- Medication management for mental health and substance use conditions
- Crisis intervention and stabilization services
- Telehealth visits for behavioral health when available under the Plan

Medication-Assisted Treatment (MAT), the use of an FDA-approved medication alone or in combination with evidence-based behavioral therapies to treat a substance use disorder (SUD) or withdrawal or treat or prevent the relapse of a substance use disorder, is a covered benefit. This coverage includes services provided by Opioid Treatment Programs (OTPs) for methadone administration and maintenance for the treatment of opioid use disorder (OUD).

Benefit	Member Pays
Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, medication management, and drug therapy monitoring)	No charge, deductible does not apply
Outpatient group therapy session	50%
Outpatient services other than an office visit/professional consultation (psychological and neuropsychological testing, other outpatient procedures, outpatient detoxification, intensive outpatient care program, day treatment and partial hospitalization)	50%

7.4.1 Substance Use Disorder

Coverage is provided for treatment of a Substance Use Disorder regardless of whether the treatment is voluntary or court-ordered as a result of contact with the criminal justice or legal system. Coverage includes, at a minimum, benefits that are medically necessary and otherwise covered under the Plan. Such coverage is subject to Copayment, Deductible, and any applicable Plan limitations.

7.4.2 Treatment of Eating Disorders

The use of Body Mass Index (BMI) or Ideal Body Weight (IBW) or any other standard requiring an achieved weight will not be utilized to determine medical necessity or level of care appropriateness of the treatment of eating disorders, including but not limited to bulimia nervosa, atypical anorexia nervosa, binge-eating disorder, avoidant restrictive food intake disorder, and other specified feeding and eating disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

BMI or IBW will not be a determining factor when assessing medical necessity or level of care appropriateness for treatment of anorexia nervosa, restricting subtype, or binge-eating/purging subtype as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

7.4.3 Serious Mental Illness (SMI)

For the treatment of serious mental illness (SMI), when step therapy is mandated, a covered individual is required to try only one (1) alternative prescription drug before receiving coverage for the medication prescribed by their healthcare provider. SMI, as defined by the American Psychiatric Association in the latest Diagnostic and Statistical Manual of Mental Disorders,

includes the following:

7.4.4 Bipolar disorders (hypomanic, manic, depressive, and mixed),

7.4.5 Depression in childhood and adolescence,

7.4.6 Major depressive disorders (single episode or recurrent),

7.4.7 Obsessive-compulsive disorders,

7.4.8 Paranoid and other psychotic disorders,

7.4.9 Schizoaffective disorders (bipolar or depressive), and

7.4.10 Schizophrenia.

7.4.11 Medication-Assisted Treatment (MAT)

A combination of behavioral therapies and FDA-approved medications to treat Substance Use Disorders is a covered benefit. This includes services provided by opioid treatment programs (OTPs) for methadone administration and maintenance for the treatment of opioid use disorder (OUD), when otherwise covered under the Plan.

7.5 Rehabilitation and Habilitation Services

7.5.1 Rehabilitation Therapy:

Physical Therapy, Occupational Therapy, and Speech Therapy are each covered up to 20 visits per therapy type per Calendar Year when Medically Necessary and when improvement or maintenance of function is reasonably expected. Visit limits for Physical Therapy, Occupational Therapy, and Speech Therapy do not apply when the services are Medically Necessary to treat Autism Spectrum Disorder or when the primary diagnosis is Behavioral Health, Mental Health, or Substance Use Disorder.

7.5.2 Habilitation Services

Habilitation Services are covered at the same level as rehabilitation therapy to help a Member keep, learn, or improve skills and functioning. Habilitation Services are in parity with, and in addition to, rehabilitation services for Physical Therapy, Occupational Therapy, and Speech Therapy. Visit limits for Physical Therapy, Occupational Therapy, and Speech Therapy do not apply when the services are Medically Necessary to treat Autism Spectrum Disorder or when the primary diagnosis is Behavioral Health, Mental Health, or Substance Use Disorder.

7.5.3 Inpatient Rehabilitation

Physical Therapy, Occupational Therapy, and Speech Therapy are covered up to 60 days per condition per Calendar Year as part of your inpatient Hospital care.

7.5.4 Autism Spectrum Disorder

Covered services include evaluation and assessment for treatment of Autism Spectrum Disorders, behavior training, behavior management, and Applied Behavioral Analysis, psychiatric care, psychological care, including family counseling and therapeutic care, and habilitative or rehabilitative care, including Physical Therapy, Occupational Therapy, and Speech Therapy. Visit limits for physical therapy, occupational therapy, and speech therapy do not apply to therapies that are Medically Necessary to treat Autism Spectrum Disorder.

7.5.5 Cardiac and Pulmonary Rehabilitation

Medically Necessary pulmonary rehabilitation and Phase II cardiac rehabilitation are covered on an outpatient basis after you have been diagnosed with a qualifying heart condition and discharged from the Hospital. Phase II programs are Hospital-based, supervised by a doctor, and include active treatment with heart monitoring. Phase III and Phase IV cardiac rehabilitation programs are not covered.

Benefit	Member Pays
Physical therapy	50%
Occupational therapy	50%
Speech therapy	50%
Pulmonary therapy	50%
Cardiac therapy	50%
Habilitation therapy	50%

7.6 Durable Medical Equipment (DME), Prosthetic and Orthotic Devices

Equipment and devices are covered when prescribed by a Provider and Medically Necessary for a covered condition. Coverage for rental or purchase of equipment and devices will be determined based on Medical Necessity and cost-effectiveness. Features or upgrades that are primarily for comfort or convenience and are not Medically Necessary and are not covered. Some equipment or devices may require Prior Authorization. Coverage includes:

- **DME:** Items like wheelchairs, hospital beds, oxygen equipment, and insulin pumps.
- **Prosthetic Devices:** Artificial devices that replace a missing body part or restore normal body function. Examples include internal prostheses such as artificial joints, heart valves, cochlear implants, and intraocular lenses, and external

prostheses such as artificial limbs, post-mastectomy breast forms, and Cosmetic facial prostheses. This includes Prosthetic Devices required for physical and recreational activities if your Provider determines that the device is necessary for your health, function, or activity level.

- **Orthotic Devices:** Braces and supports prescribed by your Provider.

Note: Coverage does not include replacement of lost equipment, repairs, or replacements due to misuse, or more than one item serving the same function. Spare or alternate-use equipment is not covered. Additional exclusions may apply as listed in Section 8: Limitations and Exclusions.

Benefit	Member Pays
Durable Medical Equipment, nebulizers, face masks, and tubing	50%
Orthotics (such as bracing, supports and casts)	50%
Diabetic Supplies	No charge, deductible does not apply
Skin grafts and tissue replacement	50%
Prostheses (internal or external)	20%
Prosthetic Limbs	20%; deductible does not apply
Blood or blood products, including blood factors not obtained through Prescription Drug benefit.	50%

7.7 Pediatric Services

7.7.1 Pediatric Vision Services (through age 18)

Wellness and refraction exams to determine the need for vision correction and to provide a prescription for eyeglasses.

One pair of prescription eyeglasses (frames and lenses) or one set of contact lenses is covered every two years, up to $120. Coverage applies when prescribed by an eye care professional. Additional hardware beyond this limit is not covered unless Medically Necessary and Preauthorized.

7.7.2 Early Intervention Services:

Therapies and supports designed to help your child develop skills for daily living are covered for children up to age 3 who have significant developmental delays or a diagnosed with a physical

or mental condition likely to cause delays. These services must be provided by a qualified Provider and included in a written Individualized Family Service Plan (IFSP). Services in the IFSP are considered Medically Necessary.

Note: Coverage does not include non-Emergency transportation, respite care, service coordination (except case management), and assistive technology devices unless covered under the plan as DME. Additional exclusions may apply as listed in Section 8: Limitations and Exclusions.

7.7.3 Cleft Lip/Palate:

For newborn children born with a cleft lip, cleft palate, or both, there is no age limit on benefits related to these conditions. Coverage includes all Medically Necessary care and treatment, such as oral and facial surgery, surgical management, and follow-up care by plastic and oral surgeons. It also includes Prosthetic Devices such as feeding appliances, obturators, and speech appliances, Orthotic Devices, and prosthodontic services, habilitative Speech Therapy, otolaryngology services, and audiology assessments and treatment are also covered when Medically Necessary. (C.R.S. § 10-16-104 (1)(c)(II))

7.8 Prescription Drug Benefits

Your Plan covers Medically Necessary prescription medications when prescribed by an authorized provider for a covered condition and obtained from a Contracted Pharmacy, unless otherwise stated in this EOC. To find a Contracted Pharmacy, please visit www.coaccesschoice.com or contact us. To fill a prescription, present your written prescription, if required, and your ID Card to the Contracted Pharmacy.

Prescribed covered drugs are provided at the applicable prescription drug Copayment or Coinsurance for each tier of drug coverage. This will include:

- Tier 1 Preventive Drugs – zero-cost-share drugs used for preventive purposes;
- Tier 2 Preferred Generic – for lowest-cost prescription drugs;
- Tier 3 Preferred Brand – for medium cost prescription drugs, including medications not having a generic or a generic equivalent;
- Tier 4 Non-Preferred – for higher-cost prescription drugs; and
- Tier 5 Specialty – for highest-cost prescription drugs.

Prescription drugs are assigned to formulary tiers based on usage, cost, and clinical effectiveness, in compliance with applicable federal and Colorado law.

Your cost for prescription medications depends on the drug tier and the cost-sharing shown in Section 1: Schedule of Benefits. Each covered prescription or supply requires its own Copayment or Coinsurance. If the retail price of the drug is lower than your Copayment, you

pay the retail price. We cover up to a 30-day supply per fill unless a medication qualifies for an extended supply. Some medications taken daily may qualify for up to a 90-day supply when allowed by the Plan. Quantity limits are set for safety, medical appropriateness, and regulatory compliance. Any amount dispensed beyond the permitted day-supply limit is not covered, and you will be responsible for the full cost.

Certain medications or quantities may require Prior Authorization. When Prior Authorization is required, the prescribing Provider must submit supporting information showing why the medication is Medically Necessary. If coverage is denied, you have the right to Appeal. Please refer to Section 13: Appeals and Complaints of this EOC. If you attempt to fill a prescription that requires Prior Authorization, the pharmacist will advise you that approval is needed, and you will need to contact your prescribing Provider.

FDA-approved prescription medications listed on our formulary for the treatment of a substance use disorder (SUD) are not subject to step therapy or prior authorization requirements.

FDA approved HIV treatment and prevention medications listed on formulary are not subject to prior authorization or step-therapy.

We cover at least one FDA-approved prescription medication on the lowest-cost tier of our formulary for each DSM-5 defined substance use disorder category, including: alcohol; caffeine; cannabis; hallucinogens (with separate categories for phencyclidine and other hallucinogens); inhalants; opioids; sedatives, hypnotics, or anxiolytics; stimulants (amphetamine-type substances, cocaine, and other stimulants); tobacco; and other (or unknown) substances.

As specified in § 10-16-161, C.R.S., effective for all health benefit plans issued or renewed on or after January 1, 2025, all carriers shall include any amount paid by the covered person and/or by another person on behalf of the covered person for a prescription drug when calculating the covered person's overall contribution to an out-of-pocket maximum or cost-sharing requirement.

This requirement applies whether the prescription drug is covered under the plan's medical benefit or pharmacy benefit. It also applies regardless of the source of payment, including amounts paid through manufacturer copay assistance, discount card programs, charitable organizations, or any other third-party payers acting on behalf of the covered person.

Health benefit plans and PBMs may not implement benefit designs that exclude such third-party payments from counting toward the covered person's cost-sharing obligations unless expressly permitted by state or federal law.

7.8.1 Specialty Drugs

Prescribed specialty drugs, including self-administered injectable drugs, are provided at the specialty drug Copayment or Coinsurance cost up to the maximum amount per drug dispensed. Specialty Drugs must be filled at the Plan's preferred specialty pharmacy.

7.8.2 Step Therapy

The Plan may use step therapy for certain medications when allowed by law. This means you may need to try one drug before another drug is covered. Exceptions to step therapy will be handled in accordance with applicable law and Plan procedures. Prior Authorization may still apply when permitted under the Plan.

The Plan does not require step therapy for treatment of stage four advanced metastatic cancer or atypical opioid medications approved by the FDA for pain treatment, to the extent required by law.

Your Provider may request that step therapy be skipped if the recommended drug is Medically Necessary. Prior Authorization may be required for the drug even when step therapy is not.

Prior Authorization and step therapy are not required or applied to any FDA-approved prescription drug listed on our formulary for the treatment of SUD, including alcohol use disorder, opioid use disorder, and tobacco use disorder, to the extent required by law. At least one FDA-approved medication for the treatment of each DSM-5 defined SUD condition is available on the lowest-cost tier of the formulary.

7.8.3 Formulary List (Covered Drug List)

We use a Formulary, which is a list of preferred and covered medications. The Formulary is available online at www.coaccesschoice.com or by request. A drug's inclusion on the Formulary does not guarantee coverage in all cases, because coverage is still subject to Medical Necessity and other Plan requirements. Non-formulary drugs may require Prior Authorization or may not be covered unless otherwise required by law. Under Colorado law, we cannot make mid-year Formulary changes that increase your cost-sharing or remove covered drugs, except for limited reasons such as FDA safety warnings or when a drug becomes available over the counter.

7.8.4 Off-Label Drugs

Your plan covers certain cancer medications even when prescribed for a type of cancer that the FDA has not specifically approved the drug to treat. The drug must already be FDA-approved to treat cancer and must be recognized as an effective treatment for your type of cancer in nationally accepted medical reference guides used by the U.S. Department of Health and Human Services. The treatment must also be for a condition otherwise covered under your Plan.

7.8.5 Diabetic Supplies

Equipment and supplies for management of Type 1, Type 2, and gestational diabetes, such as glucose meters, test strips, continuous glucose monitors, insulin pumps, syringes, lancets, infusion sets and other DME, are covered when prescribed by your Provider. Certain diabetic supplies and DME are covered with no cost-sharing even if your Deductible has not been met, in accordance with Colorado Insurance Regulation 4-2-81. Members can find a list of diabetic supplies with $0 cost sharing on our website at www.coaccesschoice.com.

7.8.6 Prescription Insulin Drug Cost-Sharing and Limitations

Your Plan covers prescription insulin drugs with limits on the amount you may be required to pay, as required by law. Under state law, you will not pay more than $100 total for all covered insulin you receive in a 30-day supply, no matter the type or amount of insulin prescribed. We are allowed to charge less than this amount but cannot exceed the required state cap. If you receive a 90-day supply of insulin, your cost will not exceed $300 total for that supply.

7.8.7 HIV Pre-Exposure Prophylaxis (PrEP)

Coverage is provided for HIV pre-exposure prophylaxis (PrEP), including baseline and monitoring services, as required by applicable law for (FDA)-approved medications and services consistent with USPSTF recommendations.

FDA- approved HIV PrEP medications listed on our formulary are not subject to step therapy or Prior Authorization where prohibited by law**.** Non-formulary FDA-approved HIV PrEP medications are handled in accordance with applicable law and Plan procedures.

7.8.8 Epinephrine Auto-Injectors

The amount you pay for covered prescription epinephrine auto-injectors is capped at no more than $60 for a two-pack, as required by law.

7.8.9 Oral Anticancer Medications

Orally administered anticancer medications covered at cost sharing no greater than the coinsurance/copay applied to IV or injectable anticancer medications prescribed for the same purpose, as required by Colorado law.

7.8.10 Reimbursement for Out-of-Pocket Medication Costs

If you paid out-of-pocket for a medication covered under this Plan, such as when you did not have your ID Card or unintentionally used a Non-Contracted Pharmacy, you should return to the pharmacy and request that the pharmacist reprocess (re-run) the prescription through the Plan for proper claim adjudication. If the claim is successfully reprocessed, the pharmacy may refund the amount you paid, less any applicable cost-sharing.

7.9 Contraception Coverage

We cover all FDA-approved, cleared, or granted exception, emergency and preventive contraceptives approved by the FDA, whether or not specifically listed in the FDA Birth Control Guide, and as included in the Health Resources and Services Administration (HRSA) Women's Preventive Services Guidelines, without any deductible, copayment, coinsurance, or other cost sharing for the member. These include tubal ligation, various intrauterine devices (IUDs), implants, shots, oral contraceptives (sometimes known as "the pill"), patches, vaginal rings, diaphragms, sponges, cervical caps, female condoms, spermicide, and emergency contraceptives (sometimes known as "Plan B"). The no-cost coverage also includes contraceptive counseling, initiation of contraceptive use, and follow-up care (e.g., office visits, management, evaluation, associated laboratory testing, as well as changes to and removal or discontinuation of the contraceptive method). Over the counter and emergency contraception is also covered at no-cost, with or without a prescription.

We cover and reimburse for the single dispensing or furnishing of a contraceptive intended to last for twelve (12) months when dispensed at one time.

We do not apply prior authorization, step therapy, fail-first requirements, age limitations, or other utilization management practices to contraceptive coverage, including alternative or non-formulary contraceptives determined medically necessary by your provider. No plan enrollees will be subject to denials of coverage for all or a particular brand name of contraceptives if deemed medically necessary by your provider.

If your provider determines that a specific contraceptive is medically necessary for you, that determination is final, and we will cover the contraceptive without prior authorization or step therapy for no cost to the member. To request an alternative or non-formulary contraceptive, your provider should complete the Standard Exemption Form for Contraceptive Products found at www.coaccesschoice.com and return it to our Pharmacy Benefit Manager via fax at 855-668-8551. Requests for alternative or non-formulary contraceptives will be treated as expedited exception requests and will be resolved within 24 hours of receipt.

Male and female sterilization is covered.

7.10 Gender-Affirming Care

Treatment for gender dysphoria and gender-affirming health care is covered for office visits, counseling, preventive health, prescription drugs, Laboratory Services, and surgical procedures, including pre- and post-operative care. The Plan will not deny, exclude, or otherwise limit gender affirming care coverage for Medically Necessary services, in accordance with generally accepted professional standards of care, based upon sexual orientation or gender identity. Coverage includes the following, or any combination of the following:

a. Hormone therapy
b. Laser or electrolysis hair removal
c. Breast/ Chest Surgery (Male to Female)
    - Augmentation Mammoplasty
    - Implants/Lipofillings
    - Breast/chest augmentation, reduction, construction
d. Genital Surgery (Male to Female)
    - Penectomy
    - Orchiectomy
    - Vaginoplasty
    - Dilator (Medical Equipment)
    - Clitoroplasty
    - Vulvoplasty
    - Labiaplasty
    - Prostatectomy
    - Urethroplasty
    - Vagina/Perineum reconstruction
e. Non-Breast/Chest Surgical Interventions (Male to Female)
    - Facial Feminization Surgery
    - Blepharoplasty (eye and lid modification)
    - Face/forehead and/or neck tightening
    - Facial bone remodeling for facial feminization
    - Genioplasty (chin width reduction)
    - Rhytidectomy (cheek, chin, and neck)
    - Cheek, chin, and nose implants
    - Lip lift/augmentation
    - Mandibular angle augmentation/creation/reduction (jaw)
    - Orbital recontouring
    - Liposuction
    - Lipofilling
    - Voice Surgery
    - Thyroid Cartilage Reduction/Reduction thyrochondroplasty
    - Gluteal Augmentation (Implants/Lipofilling)
    - Hair Reconstruction
    - Rhinoplasty (nose reshaping)
f. Breast/Chest Surgery (Female to Male)
    - Subcutaneous Mastectomy (for Creation of Male Chest)

- Simple/Total Mastectomy
- Partial Mastectomy
- Modified Radical Mastectomy
- Radical Mastectomy
- Breast reduction (reduction mammoplasty)
- Breast/chest augmentation, reduction, construction

g. Non-Genital, Non-Breast/Chest Surgical Interventions (Female to Male)
- Voice Surgery
- Liposuction
- Lipofilling
- Pectoral Implants
- Calf Implants
- Nipple reconstruction following mastectomy
- Voice Therapy Lessons

h. Genital Surgery (Female to Male)
- Hysterectomy
- Ovariectomy/Oophorectomy
- Salpingectomy
- Metoidioplasty
- Phalloplasty
- Vaginectomy
- Vulvectomy
- Scrotoplasty
- Urethroplasty
- Trachelectomy
- Penis/perineum reconstruction
- Implantation of Erection and/or Testicular Prosthesis

7.11 Additional Covered Services

7.11.1 Acupuncture Services

Licensed providers may offer up to 6 sessions per plan year for pain management. Each visit has the same cost-sharing as a specialist care office visit (for non-Preventive Care).

7.11.2 Allergy, Immunizations, and Medical Injections

Medicines, injections, and supplies needed for allergy evaluations and testing. Vaccines that are approved by the FDA are also included.

Benefit	Member Pays

Allergy testing	50%
Allergy serum	50%
Allergy injection services	First 3 visits No charge, deductible does not apply, then deductible, then $50
Immunizations for occupational purposes or foreign travel	Not Covered
Medical Injections (excluding injections for Infertility) and office-based injectable medications (per dose)	50%

7.11.3 Bariatric Surgery

Weight-loss surgery is covered when it is Medically Necessary and meets all Plan requirements for Prior Authorization. The surgery must be performed at a facility that is accredited by a nationally recognized bariatric surgery quality program to ensure safety and quality standards.

7.11.4 Care Management

Outpatient self-management training and education for chronic conditions such as asthma, diabetes, heart disease, COPD, hypertension, and other serious illnesses is covered when recommended by a Provider and led by qualified professionals. Includes teaching self-care on topics such as stress management and nutritional counseling. These services help you understand your condition, monitor symptoms, manage medications, follow a healthy lifestyle, and reduce complications.

7.11.5 Chiropractic Services

Evaluation and spinal manipulation for and treatment of musculoskeletal disorders is covered. Coverage is limited to 20 visits per year.

7.11.6 Clinical Trials

If you join an approved clinical trial, we cover the routine patient care costs related to the trial. This means the regular medical services you would normally receive even if you were not on a trial, such as doctor visits, Laboratory Services, and Hospital stays.

We do not cover the investigational items or services themselves (for example, the experimental drug or device being studied).

Coverage applies when:

- The trial is for the prevention, detection, or treatment of cancer or another life-threatening condition;
- The trial is federally approved or funded (such as by the National Institutes of Health, the Department of Defense, or the Department of Veterans Affairs);
- You are eligible for the trial and enrolled according to its rules; and

- The trial is not just for data collection or observational purposes.

You cannot be denied participation in a clinical trial based on your health plan, and you will not lose coverage for routine care because you are in a trial.

7.11.7 Diabetic and Prediabetic Education

Outpatient diabetes and prediabetes education is covered in accordance with Colorado Insurance Regulation 4-2-81. Covered Services include Outpatient self-management education and training for Members with diabetes or prediabetes when prescribed or recommended by a Provider. Prediabetes education must be provided through CDC-recognized diabetes prevention programs.

7.11.8 Dialysis

Services related to acute renal failure and end-stage renal disease.

7.11.9 Hearing Services and Hearing Aids

Hearing exams and tests to determine the need for hearing correction are covered when provided by a licensed audiologist or qualified hearing professional. For children up to age 18 with verified hearing loss, coverage includes hearing aids, initial fitting and replacements no more than once every five years or when alterations to the existing hearing aid cannot adequately meet the needs of the Member. Coverage also includes adjustments, repairs, related supplies, and newborn hearing screening with follow-up testing. Some devices may require Prior Authorization. Hearing aids for adults are not covered.

7.11.10 Home Health Services

Skilled nursing care by a registered nurse (RN) or licensed practical nurse (LPN), home health aide services and medical social services when you are confined to your home, your Provider orders the care and it helps you recover from an illness, injury, or surgery or manage a chronic condition. These services allow you to receive care at home instead of in a Hospital or Skilled Nursing Facility and may require Prior Authorization.

Coverage is limited to part-time or intermittent care. Services must be Medically Necessary and cannot exceed 60 visits per year.

Benefit	Member Pays
Home Health Care Services	50%

7.11.11 Infusion Therapy and Radiation Therapy

All Medically Necessary infusion and Radiation Therapy including Chemotherapy are covered with Contracted Providers. You can receive these services in inpatient or outpatient settings, depending on what your Provider recommends.

7.11.12 Mastectomy and Breast Reconstruction

Mastectomy and related services are covered when ordered by your Provider. Coverage includes Reconstruction Surgery and related procedures as required by federal law (Women's Health and Cancer Rights Act) and Colorado regulations. Following Medically Necessary removal of all or part of a breast, we also cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas. Plastic surgery or other Cosmetic Services and supplies primarily to change your appearance are not covered except services for medically necessary gender affirming care. Services unrelated to the mastectomy or its complications are also not covered.

7.11.13 Medical Foods

Diagnosis and treatment of inherited enzymatic disorders are covered. Coverage includes, when Medically Necessary, Physician-prescribed medical foods for home use obtained through a Contracted Pharmacy, including prescription metabolic Formulas, modular counterparts, and amino acid-based elemental Formulas specifically manufactured for these conditions.

7.11.14 Medical Supplies:

Plan covers Medically Necessary Medical Supplies when ordered by your Provider for the diagnosis, treatment, or management of a covered condition. Supplies may require Prior Authorization. Coverage includes:

- Disposable supplies needed for a covered medical condition (e.g., wound care, ostomy supplies);
- Oxygen and related delivery equipment; and
- Supplies necessary for Home Health Services or skilled nursing services.

7.11.15 Organ and Tissue Transplant Services

Plan covers Medically Necessary organ and tissue Transplants when they are ordered by your Contracted Provider, meet our medical criteria, and are performed at an approved transplant center. Services may require Prior Authorization

This includes the tests you need to see if you can get a Transplant, the surgery and Hospital stay, and the care you need after the Transplant. We cover Transplants for kidneys, hearts, heart-lung, liver, small bowel, small bowel–liver, lungs, corneas, and combined kidney-pancreas. We also cover pancreas-only Transplants when you meet certain medical rules. Bone marrow and stem cell Transplants are covered for certain conditions, such as leukemia, severe immune problems, aplastic anemia, and specific childhood cancers. Plan will cover the services needed for your donor, even if your donor is not a Member of our Plan.

Prescribed drugs you need after a Transplant, including the medication that helps your body

accept the new organ, are covered under your prescription drug benefit, and you may pay the Copay or Coinsurance listed in your Plan. Refer to Section 1: Schedule of Benefits for cost-shares.

Note: Your Plan and its Providers cannot guarantee the availability of a donor organ, tissue, bone marrow, or cornea.

7.11.16 Reconstructive Surgery

When a Contracted Provider determines surgery will correct significant disfigurement resulting from an injury or Medically Necessary surgery, will correct a Congenital Defect, condition, disease or anomaly to produce major improvement in physical function or will treat congenital hemangioma (port wine stains) on the face and neck of Members under age 18 it is covered.

Note: Plastic surgery or other Cosmetic Services and supplies primarily to change your appearance are not covered except services for medically necessary gender affirming care. This includes Cosmetic surgery related to bariatric surgery.

7.11.17 Routine Foot Care:

Routine foot care services are covered when Medically Necessary.

Section 8: Limitations and Exclusions (What Is Not Covered?)

The following exclusions and limitations apply to all benefits under this Plan. This list describes services, supplies, and circumstances that are not covered. It is not exhaustive. Additional exclusions specific to certain benefits may appear in the corresponding benefit sections of this Evidence of Coverage (EOC). Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary.

If you have questions about what is or is not covered, please call us at 720-798-5704 or toll-free at 1-833-575-8033 (TTY users call 711).

8.1 Important Information About Payment for Non-Covered Services

You may be billed for any service that is not a covered benefit, even if recommended by a Provider or referred by your PCP.

If a service is not covered, then any services performed in conjunction with that service are also not covered.

We are the final authority for determining Medical Necessity for purposes of coverage and payment, consistent with applicable federal and Colorado regulations.

8.2 Non-Covered- Services

We do not cover the following services, supplies, treatments, or related charges. Examples are provided for clarity, but the list is not all-inclusive.

8.2.1 Administrative, Membership, or Access Fees

Charges that are administrative, contractual, or access-based in nature rather than for direct medical care. This includes, but is not limited to, concierge fees, membership or retainer fees, access or participation fees, administrative processing fees, costs associated with completing or transmitting forms, reports, or medical records, and similar non-clinical charges.

8.2.2 Adoption and Surrogacy Expenses

All medical and non-medical expenses related to adoption, surrogacy, or gestational carrier arrangements. This includes fertility services, donor services, medical screening, counseling, agency or legal fees, procurement of donor materials, and services provided to donors or carriers.

8.2.3 Affiliated Providers

Services furnished by a medical clinic, department, or facility that is operated, sponsored, or maintained by an employer, labor organization, trust, mutual benefit association, educational

institution, or other similar entity.

8.2.4 After-Hours or Holiday Charges

Additional fees charged solely because services are rendered outside normal business hours, on weekends, or on holidays, when such charges exceed the Plan's allowable reimbursement for the underlying service.

8.2.5 Aids for Non-Verbal Communication

Devices, computers, or related technology designed to support communication or speech for individuals who are unable to communicate verbally, excluding approved speech-generating devices and trachea-esophageal voice devices authorized by the Plan.

8.2.6 Alternative or Complementary Care

Services, supplies, or products considered outside generally accepted medical practice, regardless of provider credentials. This includes, but is not limited to, naturopathy, homeopathy, acupuncture (unless otherwise covered), massage therapy, aromatherapy, Reiki, hypnosis, herbal remedies, nutritional or vitamin therapies, holistic or integrative medicine, neurofeedback, and similar modalities.

8.2.7 Ambulance Services Not Medically Necessary

Ground or air ambulance transportation that is not medically necessary, including transportation used for convenience, preference for a specific provider or facility, or when other forms of transportation could be used safely without endangering the member's health.

8.2.8 Applied Behavioral Treatment

Applied behavioral therapies, including Applied Behavior Analysis (ABA) or intensive behavioral interventions, when provided for indications not expressly covered under the Plan or not required by applicable law.

8.2.9 Autopsies and Post-Mortem Services

Autopsies, post-mortem examinations, and related testing performed after death.

8.2.10 Biofeedback

Biofeedback services, training sessions, monitoring activities, and related equipment or supplies used to teach physiological self-regulation.

8.2.11 Charges Not Supported by Medical Records

Charges for services, supplies, or procedures that are not documented in the Member's medical records or otherwise supported by appropriate clinical documentation.

8.2.12 Charges Exceeding the Maximum Allowed Amount

Any portion of charges billed in excess of the Plan's Maximum Allowed Amount for Covered Services, except where prohibited by applicable surprise billing laws.

8.2.13 Chelation Therapy

Chelation therapy, except when determined to be medically necessary for the treatment of documented heavy metal poisoning.

8.2.14 Chronic Pain Programs

Pain management programs that are primarily educational, behavioral, supportive, or maintenance-oriented in nature, rather than focused on active medical treatment, unless otherwise specified as covered.

8.2.15 Clinical Trial–Related Non-Covered Services

Items or services provided in connection with clinical trials that are not required to be covered under federal law. This includes investigational drugs or devices, services provided solely for research or data collection, costs associated with managing the research, sponsor-paid services, and services that would not otherwise be covered outside of a clinical trial.

8.2.16 Comfort, Convenience, or Luxury Items

Items or services primarily intended for personal comfort or convenience rather than direct medical care, including private rooms when not medically necessary, televisions, telephones, guest meals, personal comfort items, and equipment with upgraded features beyond what is clinically required.

8.2.17 Complications from Non-Covered, Experimental, or Non-Medically Necessary Services

Services, treatment, or supplies required as a direct result of a service that is excluded under the Plan, experimental, or not medically necessary. A complication is considered directly related if it would not have occurred in the absence of such a service, unless coverage is otherwise mandated.

8.2.18 Compound Drugs

Medications prepared by compounding, unless specifically covered by the Plan or required by law.

8.2.19 Convalescent or Rest Care

Care provided primarily for rest, recovery, or assistance with activities of daily living when no active medical treatment is being rendered.

8.2.20 Corrective Eye Surgery

Surgical procedures performed to correct refractive vision errors, including myopia, hyperopia, or astigmatism. This includes, but is not limited to, LASIK, radial keratotomy, keratomileusis, and excimer laser refractive procedures.

8.2.21 Cosmetic Services

Procedures or treatments performed primarily to improve, alter, or enhance appearance rather than to restore bodily function or treat illness or injury. This includes cosmetic surgery and related complications, except for medically necessary reconstructive services or medically necessary gender-affirming care.

8.2.22 Court-Ordered Services

Testing, treatment, or evaluations required solely by court order, unless the service otherwise meets coverage criteria.

8.2.23 Custodial Care, Convalescent care, Assisted Living, or Rest Cures

Non-skilled care that assists with activities of daily living such as bathing, dressing, eating, ambulation, toileting, or medication reminders. Custodial care does not require licensed clinical training and is not considered medical treatment.

8.2.24 Dental Services

All dental care for adults and children, including dental services following injury to teeth.

8.2.25 Directed Blood Donations

Costs related to donor-designated blood, including collection, processing, testing, storage, or associated administrative fees.

8.2.26 Disposable Supplies

Disposable or routine household medical supplies intended for home use, such as bandages, dressings, gauze, tape, antiseptics, or adult diapers, unless specifically listed as covered.

8.2.27 Domiciliary or Residential Facility Care

Care provided in facilities that are not licensed to deliver medical or acute care services.

8.2.28 Durable Medical Equipment

Equipment, devices, or supplies that do not meet Plan criteria for covered durable medical equipment, including comfort, convenience, or lifestyle items. Examples include exercise equipment, humidifiers, stockings, hygiene supplies, pools/spas, elevators, supplies for comfort, hygiene or beautification, etc.

8.2.29 Education or Vocational Training

Programs, services, or facilities where the primary purpose is education, instruction, or vocational training rather than medical treatment.

8.2.30 Employer-Provided Services

Services or expenses that an employer is legally obligated to provide outside of the health Plan.

8.2.31 Experimental or Investigational Services

Services, procedures, drugs, or devices determined to be experimental or investigational based on regulatory approval status, clinical trial involvement, research protocols, lack of sufficient evidence of safety or effectiveness, or expert consensus. If any component of a treatment plan is experimental or investigational, all related services are excluded.

8.2.32 Eyeglasses or Contact Lenses (Adults)

Vision hardware not covered for adults aged 19 and over.

8.2.33 Foot Care and Foot-Related Surgical Services

Services are not covered for routine, preventive, or maintenance care of the feet, including nail trimming, cutting or debriding nails, removal of corns or calluses, cleansing or soaking of the feet, application of skin creams, or similar hygiene-related services when there is no specific illness, injury, or localized medical condition. Surgical treatment of foot conditions such as flat feet, foot instability, subluxation, strain, tarsalgia, metatarsalgia, hyperkeratosis, or comparable conditions is also excluded unless otherwise specified as covered under the Plan.

8.2.34 Free or No-Charge Services

We do not cover services that are available to you at no charge even without this Plan. This includes, but is not limited to, services provided through government programs, care received while incarcerated or detained, services covered under workers' compensation laws, and services furnished by free or charitable clinics.

8.2.35 Genetic Testing and Gene Therapy

Genetic testing, counseling, or gene-based therapy unless specifically covered and determined to be medically necessary under applicable law.

8.2.36 Government-Provided Services

Services for which a federal, state, or local governmental agency is financially responsible.

8.2.37 Hair Loss or Growth Treatments

Items or services intended to prevent, treat, or restore hair growth, except where required by

law or for treatment of specific medical conditions, such as for medically necessary gender affirming care.

8.2.38 Health Club Memberships and Fitness Services

Expenses for health club or gym memberships, exercise or fitness equipment, personal training services, or charges for facilities or activities intended for physical conditioning or fitness are not covered, even when recommended or prescribed by a provider. This exclusion also includes services or charges related to health spas or similar facilities.

8.2.39 Hearing Aids (Adults)

Hearing aids and related evaluations, fittings, molds, repairs, and batteries for individuals age 18 and older.

8.2.40 Hospice Care

The following services, supplies or care are not covered:

- Services or supplies for personal comfort or convenience, including homemaker services
- Food services, meals, formulas and supplements other than listed even if the food, meal, formula or supplement is the sole source of nutrition
- Services not directly related to the medical care of the Member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
- Services provided by volunteers.

8.2.41 Human Growth Hormone

8.2.42 Hyperhidrosis

Treatment of hyperhidrosis (excessive sweating) is not covered unless medically necessary.

8.2.43 Impotency

Services and supplies related to male or female sexual or erectile dysfunctions or

inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling are not covered. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing, except as authorized by us in connection with infertility services or gender affirming surgery noted in this Member Handbook.

8.2.44 Hypnosis

Hypnotherapy or hypnosis-based treatments.

8.2.45 Illegal Acts

Services required to treat conditions resulting from participation in illegal acts, consistent with nondiscrimination rules.

8.2.46 Infertility Services

Evaluation, diagnosis, or treatment of infertility, including assisted reproductive technologies and infertility medications, unless specifically included as a covered benefit or required by law.

8.2.47 Incarceration

For care required while incarcerated in a federal, State or local penal institution or required while in custody of federal, State or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

8.2.48 Intermediate Care

Services provided in intermediate care facilities.

8.2.49 Long-Term or Custodial Nursing Home Care

Extended care provided in nursing homes or similar facilities when the primary purpose is assistance with daily living, supervision, or maintenance rather than active medical or skilled nursing treatment.

8.2.50 Maternity and Newborn Care

Benefits are not provided for certain maternity or pregnancy-related services, supplies, equipment, or charges, including the following:

- Non-emergency maternity services or childbirth occurring outside the Plan's Service Area.
- Services related to family planning or pregnancy that are not part of covered maternity care, such as preconception counseling; paternity determination; genetic counseling or testing; screening for inherited or fetal conditions; or consultations or testing performed solely to identify the sex or physical traits of an unborn child.
- Costs associated with the collection, storage, or preservation of umbilical cord blood or tissue.

8.2.51 Maintenance Therapy

Therapy services provided primarily to preserve current functional status or prevent decline, when no measurable improvement is expected.

8.2.52 Medical Devices and Services

Medical technologies, devices, or services not classified as covered under applicable national coverage determinations or Plan provisions. If an expense exceeds the Maximum Allowed Amount for the standard covered item, then it is Your responsibility.

8.2.53 Missed or Cancelled Appointments

Fees for missed or cancelled appointments or services.

8.2.54 Non-Medical Expenses

Expenses that are not directly related to medical diagnosis or treatment, including home or vehicle modifications, personal services, and membership fees.

8.2.55 Not Medically Necessary

Any service or supply that is not medically necessary.

8.2.56 Nutritional and Dietary Supplements.

For nutritional and dietary supplements, except as specified as a Covered Service in this Member Handbook or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either the written Prescription or dispensing by a licensed pharmacist.

8.2.57 Off Label Use

Off label use, unless prior authorized by the Plan or required by law.

8.2.58 Orthotics

Foot orthotics, such as shoes or shoe inserts and other orthotic devices that do not meet medical necessity criteria.

8.2.59 Out-of-Country Services

Medical services or supplies received outside the United States.

8.2.60 Over-the-Counter Products

Drugs, devices, or supplies available without a prescription, unless specifically covered or required by law.

8.2.61 Post-Termination Services

Services received after coverage ends, except as permitted under continuity-of-care or transition-of-care rules.

8.2.62 Prescription Drugs

Prescription drugs are not covered if they are prescribed, dispensed, or used in a manner that does not conform to accepted medical or professional standards of practice; not FDA approved; exceed quantity, dosage, refill, or age limits established by the Plan; are provided in quantities greater than prescribed or refilled more than one year after the original prescription date; are prescribed by a provider who lacks the required licensure, certification, registration, or other credentials; or are not required to be dispensed by prescription under federal law.

8.2.63 Private Duty Nursing

Continuous one-to-one nursing services provided outside of covered inpatient, home health, or hospice benefits.

8.2.64 Residential Accommodations.

Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, hospice, Skilled Nursing Facility, or Residential Treatment Center. This exclusion includes procedures, equipment, services, supplies or charges for the following:

- Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care Facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar Facility or institution.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.

8.2.65 Reversal of Sterilization

8.2.66 Services Not Available in Plan Service Area

Non-emergency services not generally available within the Plan service area without Prior Authorization.

8.2.67 Services Received Before Coverage Begins

Services received prior to the effective date of coverage are not covered.

8.2.68 Services Related to Non-Covered Care

Services directly related to a service that is excluded under the Plan, except otherwise covered treatment of complications.

8.2.69 Sexual Dysfunction Treatment

Services and supplies for treatment of sexual or erectile dysfunction unless required by mandated gender-affirming care.

8.2.70 Shock Wave Treatment.

Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions.

8.2.71 Spinal Decompression Devices

Spinal decompression devices. This includes, but is not limited to, vertebral axial decompression (Vax-D) and DRX9000.

8.2.72 Temporary Billing Codes

8.2.73 TMJ or Orthognathic Surgery

Surgical treatment of temporomandibular joint disorders or corrective jaw surgery unless medically necessary and specifically covered.

8.2.74 Taxes and Surcharges

Taxes, assessments, or regulatory surcharges applied to medical services.

8.2.75 Third-Party Liability Services

Services, examinations, documentation, or reports required by employers, insurers, courts, licensing bodies, or other third parties.

8.2.76 Travel and Lodging Expenses

Transportation, meals, lodging, and related travel expenses incurred to obtain medical care, except when prior authorized under limited circumstances.

8.2.77 Other Therapy

We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Gastric electrical stimulation
- Hippotherapy
- Intestinal rehabilitation therapy
- Prolotherapy
- Recreational therapy
- Sensory integration therapy (SIT)
- Home programs, on-going conditioning, or maintenance care

8.2.78 Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood Exclusions.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Child care.
- Mileage within the medical transplant Facility city.
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by us.
- Frequent flyer miles.
- Coupons, vouchers, or travel tickets.
- Prepayments or deposits.
- Services for a condition that is not directly related, or a direct result, of the transplant.
- Telephone calls.
- Laundry.
- Postage.
- Entertainment.
- Travel expenses for donor companion/caregiver.
- Return visits for the donor for a treatment of a condition found during the evaluation.

8.2.79 Vein Treatment

Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

8.2.80 Vision Therapy

Programs designed to train or improve visual skills rather than treat disease.

8.2.81 War-Related Conditions

Treatment for illness or injury resulting from war or armed conflict unless coverage is required by law.

8.2.82 Weight Loss Programs

Commercial or behavioral weight loss programs, products, or memberships unless part of a covered obesity benefit.

8.2.83 Weight Management Facilities

Services provided in residential or outpatient weight management facilities.

8.2.84 Workers' Compensation

Services for illness, injury, or conditions for which benefits are available under workers' compensation or employer liability laws, subject to Plan recovery rights.

Section 9: Member Payment Responsibility (Cost-Sharing)

Information on your Cost-Sharing responsibilities including applicable Deductibles, Copayments, Coinsurance, and your annual Out-of-pocket Maximum can be found in Section 1: Schedule of Benefits. If you have additional questions about how your Cost-Sharing works, please contact us.

The contracts we have with Contracted Providers prevent them from billing you more than your required Cost-Share. Contracted Providers also file claims for you and request Prior Authorization when required. If a Contracted Provider bill you for more than your Copayment, Deductible, or Coinsurance for an approved and covered service, please call us at 720-798-5704 or toll-free at 1-833-575-8033 (TTY users call 711).

9.1 Services from Non-Contracted Providers

Non-Contracted services are not covered unless they are Emergency Services or Urgent Care received when you are away from home, or services you received Prior Authorization for. If Non-Contracted services are authorized, your Cost-Sharing will be the same as if you had received care from a Contracted Provider. If we do not have a Contracted Provider with the appropriate specialty, skills, or availability to provide a covered benefit, we will arrange care with a Non-Contracted Provider and ensure you pay no more than your Contracted Cost-Share.

It is your responsibility to confirm whether a Provider is Contracted before receiving non-Emergency or Urgent Care services. Call us if you need help finding a Contracted Provider.

9.2 Surprise Billing (No Surprises Act Protections)

Both federal and Colorado law protects you from receiving unexpected medical bills from Non-Contracted Providers in certain situations. A “surprise bill” (also called “balance billing”) happens when a Provider bills you for the difference between the amount your Plan pays and the Provider’s full charge. Under federal and state law, you are protected from these bills in specific circumstances, and you are only responsible for your Contracted Cost-Sharing. Federal surprise billing protections do not apply outside the U.S.

You cannot be balance-billed for:

- Emergency Services: You are protected from balance billing for all emergency services, whether you receive care at a Contracted or Non-Contracted facility. You only pay your Contracted cost share. This protection also applies to post stabilization services until you can safely transfer to a Contracted facility or agree in writing to use Non-Contracted Providers. Members don’t lose surprise-billing protections after stabilization unless they choose, in writing, to receive Non-Contracted care.
- Non-Contracted Ground or Air Ambulance Services: If you require Non-Contracted

Ambulance transport, you only pay Contracted Cost-Sharing.

- Certain Non-Emergency Services at Contracted Facilities: You cannot be balance billed for non-emergency services provided by Non-Contracted Providers who treat you at a Contracted Hospital or ambulatory surgical center, including:
  - Anesthesiologists
  - Radiologists
  - Pathologists
  - Neonatologists
  - Assistant surgeons
  - Hospitalists and intensivists
  - Other Ancillary Service Providers you cannot choose in advance

In these situations, you only pay your Contracted Cost-Share, even if the Provider is not in our network.

If you believe you were incorrectly billed contact us immediately so we can help resolve the issue. You can also contact the No Surprises Help Desk at 1-800-985-3059 or file a Complaint online.

9.3 How Your Payments Count Toward Your out-of-pocket Maximum

Colorado law requires that certain payments made by you or on your behalf count toward your Deductible and Out-Pocket Maximum. This includes payments made using manufacturer coupons, Copay assistance programs, discounts, rebates, or similar financial assistance for a prescription drug when:

- The drug does not have a Generic equivalent, or for biologics, does not have a biosimilar or interchangeable product; or
- The drug does have a Generic or biosimilar, but you are using the brand name drug because you received Prior Authorization, completed step therapy, or otherwise received plan approval for its use.

This means these payments will count toward your Deductible and Out-of-Pocket Maximum if the drug meets the criteria above. You will not be required to “pay twice” due to Copay accumulator programs, and your progress toward your Out-of-Pocket Maximum will not reset because financial assistance was used.

9.4 Grace Periods

This grace period does not apply to the first month’s Premium payment. The first month’s Premium must be paid in full before the member is considered effectuated and coverage starts.

We will send written notice stating when the grace period begins. We will pay for Covered

Services you receive during the first month of the grace period. If applicable, for the second and third months of the grace period, we are not required to pay for any Services unless we receive all outstanding Premiums (including your portion of any Premiums for the grace period months that are already due on the date you make your payment) by the end of the grace period. If we do not receive your portion of all outstanding Premiums (including any Premiums for the grace period months that are already due on the date you make your payment) by the end of the grace period, we will terminate your membership. Membership will end at 11:59 pm on the last day of the first month of the grace period.

9.4.1 Grace Period if You Get a Premium Tax Credit

You have a three-month grace period to pay overdue Premiums, but only if:

- We have previously received the full monthly Premiums for you (including advance payment of the premium tax credit) during the immediately preceding policy year; OR
- We receive or will receive advance payment of the premium tax credit on your behalf for the month for which we do not receive your portion of the Premiums on time during this policy year if you were not enrolled in Plan during the preceding policy year.

During the first month of the grace period, your Plan will pay for Covered Services. During the second and third months, your Plan will not pay for services unless you pay all overdue Premiums by the end of the grace period.

If you do not pay by the end of the grace period, your coverage ends at 11:59 PM on the last day of the first month of the grace period.

9.4.2 Grace Period If You Do NOT Get a Premium Tax Credit

If you do not get a premium tax credit, you have a 31-day grace period to pay overdue Premiums (except the first month's premium) and your Plan will pay for Covered Services. If you do not pay by the end of the grace period, your coverage ends at 11:59 PM on the last day of the grace period.

Section 10: Claims Procedure (How to File a Claim)

Contracted Providers submit claims for payment for Covered Services directly to the Plan. Show your ID Card and pay any required copayment at time of service. The Provider will handle filing the claim for you.

10.1 How to File a Claim for Medical Services

When you receive health care services, show your provider your ID card. The card includes important information about your benefits and cost-sharing, where to call for Prior Authorization, and how the provider should bill Colorado Access Choice for your care.

In most cases, your provider will bill Colorado Access Choice directly. You are responsible for any applicable cost share and should pay those amounts directly to your provider.

In some situations, you may need to file a claim yourself. For example, if you receive emergency or urgent care from a provider outside the Colorado Access Choice network, you may have to pay all or part of the bill at the time of service (and in some cases, the full amount). Colorado Access Choice will reimburse you up to the limits shown in the Schedule of Benefits. If you pay at the time of service, mail your receipt and include your name, mailing address, and member ID number to:

Colorado Access Choice
P.O. Box 5637
Denver, CO 80217

Colorado Access Choice will mail the reimbursement check to the Subscriber's address on file. Reimbursements are paid up to the eligible amount, not to exceed the benefit maximum. Claims submitted more than 120 days after the date of service may be denied for late filing.

Authorized claims that were part of a Utilization Management review will be paid within 30 days of receipt. Applicable cost sharing will apply.

Section 11: General Policy Provisions

11.1 Colorado Division of Insurance Required Disclosures

This health plan is regulated by the Colorado Division of Insurance. You may contact the Division of Insurance for consumer assistance or complaints at:

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

303-894-7490 (Denver Metro)
1-800-930-3745 (Toll-Free)

doi.colorado.gov

This Plan isan Exclusive Provider Organization (EPO), meaning it provides coverage for Covered Services received from Contracted Providers and facilities within the Plan's provider network. Except for Emergency Services, urgently needed services when required by law, and other services specifically covered under the Plan, services received from non-participating providers or facilities are generally not covered. Members are not required to select a PCP and Referrals are not required to obtain Covered Services from Contracted specialists.

11.2 The Contract

This Evidence of Coverage (EOC), including your Schedule of Benefits and any amendments or notices we provide, is the entire contract between you and Colorado Access Choice. When you enroll and pay your monthly Premium, we agree to provide the benefits described in this Member Handbook. If any other materials conflict with this EOC, the terms of this EOC and its supplements apply.

11.3 Entire Agreement

No change to this contract is valid unless it is approved by Colorado Access Choice and issued in writing. We will administer the contract in strict accordance with its terms as written. No agent or representative has authority to change or waive any part of this contract.

11.4 Conformity With Law

If any part of this Contract conflicts with federal or Colorado law, it is automatically amended to meet the minimum legal requirements.

11.5 Third Party Liability and Recovery

If another person or company caused your injury or illness, they may be responsible for your costs. Your plan will still cover your care. However, under Colorado law the plan may be paid

back for covered services only after you have been fully compensated ("made whole") for all damages related to your injury. The plan cannot recover money that is meant for pain and suffering or other non-economic damages, unless permitted by law.

11.5.1 When the Plan Can Be Paid Back

We have subrogation and reimbursement rights when a third party is or may be liable for the costs of covered expenses payable to you or on your behalf. This means that we may pursue recovery for the benefits we paid related to your injury or illness. Any recovery by the plan may occur only after you have been fully compensated for all damages arising out of the claim. The plan will not seek or accept repayment that would leave you less than fully compensated.

11.5.2 Your Responsibilities When There Is Third Party Liability

You have an obligation to help us ensure that the correct party pays your claims. If a third party is or may be liable (responsible) to make payments to you or on your behalf for any benefits that are available under the plan:

- You must promptly notify us, in writing, of your claim against the third party.
- You and your attorney must account for benefits paid by Colorado Access Choice when negotiating any settlement with the third party of the third party's insurance carrier.
- If you get money for the claim by suit, settlement, or otherwise you must reimburse us for benefits given to you under this plan, but only after you are fully compensated ("made whole").
- You may not structure a settlement in a way that improperly excludes repayment of benefits the plan is legally entitled to recover, consistent with Colorado law.
- You must cooperate in every way necessary to help us enforce our rights.
- You have the responsibility to follow any process of a liable third-party payer before you get non-emergency services.

If the plan benefits from your attorney's efforts in obtaining a recovery, the plan will pay its proportionate share of attorney fees, as required by Colorado law.

If we must take legal action to uphold our rights, and if we prevail in that action, you will be required to pay our legal expenses. This includes attorneys' fees and court costs.

11.6 Assignment/Non-Assignment

You may not transfer or assign your rights, benefits, or obligations under this Plan unless we give you written permission. However, you may assign payment for covered services to a licensed hospital, licensed health care provider, occupational therapist, or massage therapist by giving them a written assignment. This assignment allows us to pay the provider directly for covered services you received.

We pay Contracted Providers directly for covered services, whether or not you have assigned benefits, unless you have already paid the provider in full. In that case, we will reimburse you. If you assign benefits to a Non-Contracted Provider, we may pay you instead of the Provider. If we pay you directly, you are responsible for paying the Provider, and our payment to you will be considered full satisfaction of our obligation for that claim.

Any other assignment or transfer of rights under this Plan that does not meet these requirements is not valid without our prior written approval.

11.7 Notices

We may send required notices to the most recent mailing address, email address, or member portal address you have provided. Notices delivered electronically are sufficient when you have consented to such deliveries. You are responsible for keeping your contact information up to date. Notice is considered delivered when sent.

11.8 Non-Waiver

If we do not enforce a provision of this contract at any time, it does not mean the requirement is waived or that we cannot enforce it later.

11.9 Identification (ID) Card

Your ID Card is for identification purposes only. Possession of an ID Card does not guarantee coverage or eligibility for benefits at the time services are received. To be entitled to coverage, you must be enrolled and eligible at the time of service.

11.10 Independent Provider Relationships

Providers in our network are independent contractors. We have contracts with Providers that allow the Providers to offer treatment to you. They are not employees or agents of Colorado Access Choice, and we do not have control over any diagnosis, treatment, care or other service given to you by any Provider. We are not responsible for any claim connected with any injuries suffered by you while you get care from any Provider.

11.11 Reinstatement

If your coverage ends because Premiums were not paid on time, you may request reinstatement. Approval is at our discretion and subject to Colorado law, including protections for members called to active military duty. In order to be reinstated, you must pay all applicable outstanding premiums. If your coverage is reinstated, you will have the same rights and benefits that applied before coverage ended, unless otherwise required by law.

Section 12: Termination/Non-Renewal/Continuation

12.1 How You Can End Coverage

You can cancel your coverage anytime by giving written notice to us if you enrolled directly with Colorado Access Choice or, if you enrolled through Connect for Health Colorado, by calling Connect for Health Colorado at 1-855-752-6749.

12.2 When We May End Coverage

We may terminate your coverage for:

- Non-payment of Premiums: If you do not pay your Premium within the grace period, coverage may end. We may recover costs for benefits paid after your termination date.
- Fraud or Misrepresentation: If you or your dependents commit fraud or intentionally provide false information. Coverage may be rescinded retroactively to the date of fraud. We will provide at least 30 days' written notice before rescission takes effect.
- Loss of Eligibility: If you or your dependents no longer meet eligibility requirements, including moving outside the service area. We will provide at least 30 days' written notice.
- Other Situations:
    - If you enroll in another health plan.
    - If the Plan or product is discontinued. We will provide 90 days' notice if we stop offering this product and 180 days' notice if we withdraw from the market.
    - If the Plan loses certification as a Qualified Health Plan.

Except for fraud or intentional misrepresentation, federal law prohibits retroactive terminations. All other terminations will be prospective with required advance notice.

If your coverage ends for reasons other than nonpayment, fraud, or abuse while you are hospitalized, your coverage will continue until you are discharged. All benefits stop on the termination date, and any services received after that date are your responsibility. Premiums paid beyond the termination date may be refunded, and any claims owed to you will be paid within 30 days, minus any amounts you owe.

You have the right to Appeal a termination by contacting Customer Service or the Colorado Division of Insurance.

12.3 When Coverage Ends

Coverage ends:

- On the last day of the month in which a termination request is received.
- The day before new coverage starts if you become eligible for Medicaid, Child Health Plan Plus (CHP+), or another health plan.
- On the date specified by the Marketplace.

- When a dependent child turns 26, their coverage ends at year-end.

All plans end at the end of each Calendar Year unless renewed.

12.4 Guaranteed Renewability

Under federal law, Plans are guaranteed renewable if you pay your Premiums on time, and you continue to meet eligibility requirements. We cannot refuse to renew your Plan based on your health status or claims history.

Section 13: Appeals and Complaints

We want to resolve any concerns you have about how your plan operates, your benefits, or the quality of care you receive. Depending on your concern, we offer:

- Internal Inquiry (informal)
- Internal Grievance
- Internal Appeals (including an Expedited Appeal for urgent situations)
- External Review through the Colorado Division of Insurance, when applicable

You may ask us which process applies, and we will route your concern accordingly.

13.1 Internal Inquiry Process

An inquiry is an informal request or question about a Plan action, policy, procedure, benefit, or claim. Inquiries are not formal grievances or appeals.

Concerns about the quality of care or provider services are handled through the grievance process. Concerns involving an Adverse Determination are handled through the appeals process.

To make an inquiry, contact Customer Service at 720-798-5704 or toll-free at 1-833-575-8033 (TTY users call 711), Monday to Friday, 8:00 a.m. to 5:00 p.m.

We will attempt to resolve most inquiries informally within three (3) business days. If we are unable to resolve your concern or if you are not satisfied with the outcome, we will explain your options to file a formal grievance or appeal, as appropriate.

13.2 Grievance Process

A Grievance is a formal complaint that does not involve an Adverse Determination. Grievances generally involve:

- Plan administration or customer service
- Access to care or network issues
- Dissatisfaction with services provided by a Contracted Provider
- Concerns about the quality of care received

You may submit a grievance within 180 days of the event giving rise to your concern. Grievances may be submitted by phone, online, or in writing.

How to File a Grievance

- Call Customer Service at 720-798-5704 or 1-833-575-8033 (TTY users call 711);
- Submit online (including through the member portal) or obtain assistance at www.coaccesschoice.com; or
- Mail your name, address, ID number, daytime phone number, a description of your

concern (including provider name and date(s) of service), any supporting documents, and the outcome you are requesting to:

Colorado Access Choice
P.O. Box 5637
Denver, CO 80217

We will acknowledge receipt of your grievance and begin our review. Depending on the nature of the issue, a grievance coordinator and/or appropriate clinical staff may be involved.

We will provide you with a written response within 90 days of receiving your grievance. If additional time is needed, we will notify you and keep you informed. If your grievance raises issues that are more appropriately addressed through the appeals process, we will notify you and process it as an appeal.

13.3 Appeals Process

An Appeal is a formal request for review of an Adverse Determination, which is a decision that affects coverage or payment of services. Adverse Determinations may include, but are not limited to:

- Denial, reduction, suspension, or termination of a covered service
- Denial of a Prior Authorization request
- Denial based on medical necessity, appropriateness, setting, or level of care
- Denial of coverage because a service is considered experimental or investigational
- Denial or reduction of payment for a service that is otherwise covered

Appeals may involve clinical/coverage determinations or claims/payment determinations, as described below.

13.3.1 Filing an Internal Appeal

You or your authorized representative may file an appeal within 180 days of the date of the Adverse Determination. To submit an appeal:

- Call Customer Service at 720-798-5704 or 1-833-575-8033 (TTY users call 711); or
- Mail your name, address, ID number, daytime phone number, a description of the decision you are appealing (including provider name and date(s) of service), and any supporting documents to:

  Colorado Access Choice
  P.O. Box 5637
  Denver, CO 80217

If your appeal requires review of medical records, you may be asked to provide a signed authorization allowing us to obtain records from your Providers.

13.3.2 Review of Appeals

Appeals are reviewed by individuals who were not involved in the initial decision.

Clinical or coverage appeals (including medical necessity or appropriateness determinations) are reviewed by a Physician who consults with a clinical peer in the same or similar specialty.

Claims or payment appeals are reviewed under the Plan's claims and payment procedures and do not involve medical judgment unless clinical issues are raised.

We will notify you in writing of our decision within 30 days for appeals involving pre-service requests and within 60 days for appeals involving post-service requests.

We will consider any information you submit, even if it was not part of the initial review.

13.3.3 Expedited Internal Appeals

If waiting for a standard appeal decision could seriously jeopardize your life or health, your ability to regain maximum function, or if you are currently hospitalized, you or your Provider may request an expedited appeal.

Expedited appeals may be requested by phone at 720-798-5704 or toll-free at 1-833-575-8033 (TTY users call 711). We will issue a decision as quickly as your medical condition requires, but no later than 72 hours after receiving the request.

For concurrent care appeals, coverage for the disputed services will continue until you are notified of the expedited appeal decision.

13.4 External Review (Colorado Division of Insurance)

If your final internal appeal upholds an Adverse Determination involving medical judgment or coverage, you may request an independent external review through the Colorado Division of Insurance (DOI).

Your request must be submitted within four (4) months of the date you receive our final internal appeal decision. In urgent situations, an expedited external review may be requested at the same time as an expedited internal appeal.

The DOI assigns an Independent Review Organization (IRO) to review your case.

- Standard external review decisions are issued as soon as possible, but no later than 45 days after receipt of the complete case.
- Expedited external review decisions are issued as quickly as the medical condition requires, but no later than 72 hours.

External review is not available for disputes involving claims or payment issues that do not

involve medical judgment or coverage determinations.

Our denial letters include instructions on how to request an external review. You may also contact the Colorado Division of Insurance Consumer Services Team at 303-894-7490 or 800-930-3745 (outside the Denver Metro area) or visit www.doi.colorado.gov.

13.5 Authorized Representatives

You may appoint another person to act for you as an authorized representative. For urgent requests, your treating provider may act as your representative. To appoint a representative, send us a signed written authorization. If you are unable to consent, a person authorized by law may act on your behalf.

13.6 Access to Information Used in Your Appeal

Upon request and at no cost to you, we will provide reasonable access to, and copies of, all documents, records, and information relevant to your appeal, including any clinical review criteria used and any new or additional evidence or rationales considered in making our decision. We will provide this information sufficiently in advance of the decision due date, so you have a reasonable opportunity to respond.

13.7 Coverage During an Appeal

If you request an expedited appeal for a concurrent review of ongoing treatment and an Adverse Determination is made, coverage for that course of treatment will continue until we notify you of our expedited decision. Other continuation-of-coverage rules may apply under federal or state law. Call Customer Service if you have questions about your situation.

If you need assistance at any point, call Customer Service at 720-798-5704 or toll-free at 1-833-575-8033 (TTY users call 711), Monday to Friday, 8:00 a.m. to 5:00 p.m. You may also contact the Colorado Division of Insurance Consumer Services Team for help understanding your rights or to file a complaint: 303-894-7490 or 800-930-3745 (outside the Denver Metro area), or doi.colorado.gov (select “File a Complaint”).

Section 14: Information on Policy and Rate Changes

14.1 Payment of Premiums

Premiums must be paid and received in advance of coverage. You must then pay the correct amount before the beginning of the month to have coverage for that month. If you do not pay on time, we will send you a notice that you are in default. You then have a grace period in which to pay your Premiums without loss of membership. If you do not pay within the grace period, we will terminate your membership. After termination of your enrollment for nonpayment of Premiums, the Plan may require payment of any outstanding Premiums for prior coverage if permitted by applicable law. Only Members for whom we have received the correct amount are entitled to benefits under this Membership Agreement.

14.2 Premiums Subject To Change

Your Premiums may change for any of the following reasons:

- If you choose a new Plan;
- If you switch to coverage other than self-only by adding new Dependents or add Dependents to your current family coverage;
- If you reduce the number of your Dependents; or
- If you move to another rating/service area.

14.3 Premium Due Date

Premiums are due by the 23rd of the month prior to the month of coverage. Visit www.coaccesschoice.com to set up autopay through your member portal or make a one-time payment. You can also make a payment by phone (833-575-8033) or mail. See www.coaccesschoice.com for information about mailing your payment.

14.4 Premium Payments from Third Parties

We will accept third-party Premium payments from the following entities as required by state and federal law:

- Ryan White HIV/AIDS Program:
- Indian tribes, tribal organizations, or urban Indian organizations: and
- Local, state, or federal government programs, including grantees directed by a government program to make payments on its behalf.
- Not-for-profit organization, under state law, qualifies as a tax-exempt nonprofit under section 501(c)(3) of the Internal Revenue Code and is using objective, publicly available criteria without considering health status.

Section 15: Definitions

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

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

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

Advance Payments of the Premium Tax Credit (APTC) - Payment of the tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an Exchange.

Adverse Determination - decision made by Us to deny, reduce, modify, or terminate a requested health care service or coverage based on Medical Necessity, appropriateness, level of care, setting, effectiveness, or experimental/investigational status.

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

Affordable Care Act (ACA) - the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010 and associated regulations.

After-Hours Care – office services requested after a Provider's normal or published office hours or services requested on weekends and holidays.

Alternative or Complementary Care – therapeutic practices of healing or treating disease that are not currently considered an integral part of conventional medical practice. Therapies are termed complementary when used in addition to conventional treatments and when they are used as alternatives instead of conventional treatments. Alternative medicine includes, but is not limited to, eastern medicines such as Chinese or Ayurvedic, herbal treatments, vitamin therapy, homeopathic medicine, naturopathy, faith healing, and other non-traditional remedies for treating diseases or conditions.

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

licensed as an Ambulance.

American Indian – An individual who is a member of a federally recognized Indian tribe. A tribe is defined as any Indian tribe, band, nation, or other organized group or community, including any Alaska native village or regional or village corporation which is recognized as eligible for the special programs and services provided by the United States because of their status as Indians.

Ancillary Services – services and supplies (in addition to room expenses) that Hospitals and other facilities bill for. Such services include, but are not limited to:

- Use of an operating room, recovery room, Emergency room, treatment room, and related equipment; intensive and coronary care units.
- Drugs/medication and medicines, biologics (medicines made from living organisms and their products) and pharmaceuticals.
- Medical Supplies (dressings and supplies, sterile trays, casts, and splints used instead of a cast).
- DME owned by the facility and used during a covered admission.
- Diagnostic and therapeutic services.
- Blood processing and transportation and blood handling costs and administration.

Anesthesia – there are two types of Anesthesia:

- General Anesthesia. This is also known as total body anesthesia. It causes the patient to become unconscious or put to sleep for a period.
- Regional or local Anesthesia. This causes loss of feelings or numbness in a specific area without causing loss of consciousness. It is usually injected with a local anesthetic drug such as lidocaine. Anesthesia must be given by a Provider or certified registered nurse anesthetist (CRNA).

Appeal – a process for reconsideration of our decision regarding a Member's claim or Prior Authorization.

Applied Behavioral Analysis – a treatment model to improve socially significant behaviors in individuals with Autism Spectrum Disorder.

Authorized Service – A Covered Service rendered by any Provider other than a network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the network level. For more information, see the "Member Payment Responsibility" section

Autism Spectrum Disorder – Autism Spectrum Disorder includes disorders characterized by delays in the development of multiple basic functions, including socialization and communication.

Benefit Period/Year – The period of time that We pay benefits for Covered Services. Generally, the Benefit Period/Year is a Calendar Year for this Plan, as listed in the "Schedule of Benefits (Who Pays What)." If Your coverage ends earlier, the Benefit Period/Year ends at the same time

Billed Charges – the dollar amount a Provider bills for services or supplies. This is before applicable Contracted Provider discounts or adjustments.

Biomarker – a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention, including known gene-drug interactions for medications being considered for use or already being administered. "Biomarker" includes gene mutations, characteristics of genes, or protein expression.

Biosimilars – A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful difference from the reference product.

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

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

Care Management – this is a way that we help Members with serious illnesses or injuries. Care Management is used when illnesses or injuries are so complex that personal coordination of care is helpful. Sometimes Care Management is also called case management.

Chemotherapy – medication therapy given as treatment for malignant conditions and diseases of certain body systems.

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

Chronic Pain – ongoing pain that lasts more than six months that is due to non-life-threatening causes. And it has not responded to current available treatment methods. Chronic Pain can continue for the rest of a person's life.

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

Complaint (Grievance) – an oral or written expression of dissatisfaction with the Plans services or the practices of a Contracted Provider, whether medical or non-medical in nature.

Congenital Defect – a condition or anomaly that exists at or dates from birth, such as a cleft palate or a clubfoot. Disorders of growth and development over time are not considered

congenital.

Consultation – a visit between a Provider and a patient to determine what medical examinations or procedures, if any, are appropriate and needed.

Coinsurance – a percentage you pay to get a specific service, supply, or Prescription Drugs after Deductibles are satisfied.

Contracted Provider – a Provider that is contracted with us to provide services to our Members.

Controlled Substances – Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA) which are divided into five schedules.

Copay (Copayment) – a dollar amount you pay to get a specific service, supply, or Prescription Drug. A Copay is a predetermined, fixed amount paid at the time the service is rendered.

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

Cost-Sharing – the general term used for out-of-pocket expenses paid by a Member. Copay, Coinsurance and Deductible are types of Cost-Sharing.

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

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

Custodial Care – care offered primarily to meet the personal needs of the patient. This includes help to walk, bathe, or dress. It also includes, but is not limited to, preparing food or special diets, feeding, administration of medicine that is usually self-administered, or any other care that does not require continuing services of specialized medical personnel.

Deductible – the amount you must pay each year before benefits are available under this Plan to get a specific service, supply, or Prescription Drug.

Dental Services – services performed for treatment of conditions related to the teeth or structures supporting the teeth.

Dependents - your eligible Dependents as set forth in Section 5: Eligibility.

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

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

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

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

Effective Date – the date coverage with the Plan begins.

Effectuate – when an enrollee has paid their first month's payment in full.

Elective Surgery – a procedure that does not have to be performed on an Emergency basis and can be reasonably delayed. Such Surgery may still be considered Medically Necessary.

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

Exchange – a governmental agency or non-profit entity that makes Qualified Health Plans such as this plan available to Qualified Individuals.

Exclusive Provider Organization (EPO) – a health plan that covers services received from Contracted Providers and facilities, except as otherwise required for Emergency or other covered out-of-network services. Members may access Contracted specialists without a Referral.

Experimental or Investigational – any drug, biologic, medical device, diagnostic test, product, equipment, procedure, treatment, service, or supply that is used for, or in connection with, the diagnosis, evaluation, or treatment of a disease, illness, injury, or other health condition and that the Plan determines, in its judgment, does not meet established standards for coverage. A drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply will be considered Experimental or Investigational if, at the time benefits are requested for the specific use, one or more of the following apply:

1. **Regulatory status.**
    - It cannot be lawfully marketed in the United States without final approval by the U.S. Food and Drug Administration (FDA) or another applicable federal or state

regulatory authority, and such approval has not been granted; or

- It has been determined by the FDA or another regulatory authority to be contraindicated for the requested use.

2. Research or evaluation context

- It is provided as part of a clinical trial, clinical study, or research protocol, including Phase I or II trials or the investigational arm of a Phase III trial, except where coverage of certain routine costs is required by law; or
- It is furnished in any manner intended primarily to assess safety, toxicity, effectiveness, or efficacy; or
- Its use is subject to review or approval by an Institutional Review Board (IRB) or another entity performing a comparable research oversight function.

3. Informed consent and study documentation

It is delivered pursuant to informed consent materials, protocols, or similar documentation that identify the service, drug, or device as experimental, investigational, or under evaluation, or otherwise indicate that its clinical outcomes have not been established.

A service, treatment, or supply that does not clearly fall within the categories above may nonetheless be classified as Experimental or Investigational if, after review, the Plan determines that the available evidence does not sufficiently demonstrate that the service meets accepted standards of medical practice. In making this determination, the Plan evaluates whether:

- The scientific evidence regarding the effect of the service on health outcomes is inconclusive or insufficient;
- The evidence shows that the service provides a meaningful improvement in net health outcomes compared to established alternatives for the population for whom it is proposed; and
- The service has been shown to improve net health outcomes when used under typical clinical conditions outside of investigational or research settings.

To assess whether a service is Experimental or Investigational, the Plan may consider information from one or more of the following sources, among others:

- Published results of well-designed, randomized, controlled clinical trials appearing in authoritative, peer-reviewed medical or scientific journals;

- Assessments, guidelines, or position statements from recognized medical associations, technology assessment bodies, or consensus panels;
- Filings, determinations, approvals, warnings, or other records issued by or submitted to the FDA or other governmental agencies with oversight authority;
- Records, protocols, or determinations of an Institutional Review Board or similar research oversight body;
- Informed consent documents, protocols, or study materials used by treating providers or by other providers investigating the same or a substantially similar service;
- Relevant medical records; and
- Opinions from consulting providers or other experts with appropriate clinical or scientific expertise.

The Plan retains sole discretion to identify, evaluate, and weigh the information it deems relevant and to make all determinations regarding whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational. The Plan evaluates new and emerging medical technology using clinical evidence, regulatory status, and professional standards to determine whether a service should be included as a Covered Benefit under the Plan.

Explanation Of Benefits (EOB) – a printed form sent by Colorado Access Choice to a Member after a claim has been filed and a decision has been made about the claim. The EOB includes things like the date of service, name of Provider, amount covered, and what the patient owes.

Facility - A service location including but not limited to, a Hospital, freestanding ambulatory surgical Facility, Residential Treatment Center, or Skilled Nursing Facility, as defined in this Member Handbook. The Facility must be licensed as required by law, satisfy Our accreditation requirements, and approved by Us.

Formulary List – a list of Prescription Drugs approved for use by Members of the Plan. This list is subject to periodic review and modification.

Formulas – authorized Formulas for metabolic disorders, total parenteral nutrition, enteral nutrition and nutrition products, and Formulas for gastrostomy tubes are covered for documented medical needs, including attainment of normal growth and development.

Habilitation Services - health care services that help a person keep, learn, or improve skills and functioning for daily living. Habilitation Services may include Physical Therapy, Occupational

Therapy, Speech Therapy, and other services.

Healthy Living Initiatives – these are projects to promote healthy lifestyles. They also can help Members avoid preventable diseases.

High-Tech Imaging - advanced diagnostic imaging services that produce detailed internal images of the body, such as magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), and nuclear medicine imaging.

Holistic Medicine – various preventive and healing techniques that are based on the influence of the external environment and the many ways different body tissues affect each other along with the body's natural healing powers.

Homemaker Services - services constituting general household activities such as meal preparation, routine household care, and instruction to the Member's family on practices that promote healthy living.

Home Health Agency – an agency certified by the Colorado Department of Public Health and Environment as meeting the provisions of Title XVIII of the federal Social Security Act, as amended, for Home Health Agencies. A Home Health Agency primarily arranges and provides nursing services, home health aide services, and other therapeutic and related services.

Home Health Services – this is also called home health care. These are professional nursing services, certified nurse aide services, Medical Supplies, equipment, and appliances suitable for use in the home, and Physical Therapy, Occupational Therapy and Speech Therapy given by a certified Home Health Agency to eligible Members who are under a plan of care, in their place of residence.

Hospice Care – an alternative way to care for terminally ill individuals that stresses palliative care. Hospice care focuses on the patient/family as the unit of care. Supportive services are offered to the family before and after the death of the patient. Hospice care supports the physical, social, psychological, and spiritual needs of the patient and the patient's family.

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

ID Card – the card we give Members of the Plan. This has information such as the Member's name, ID number, and Copay amount (if applicable).

Infertility – a condition resulting from a disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the male or female reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery.

In-Network or Contracted – A Provider that has a contract, either directly or indirectly, with Us, or another organization, to give Covered Services to Members through negotiated payment arrangements.

In-Network or Contracted Pharmacy – An In-Network Pharmacy is a Pharmacy that has an In-Network Pharmacy agreement in effect with or for our benefit at the time services are rendered. In-Network Pharmacies may be based on a restricted network and may be different than the network of In-Network Pharmacies for Our other products. To find an In-Network Pharmacy near You, call Pharmacy Customer Services at 720-798-5704, or toll-free at 1-833-575-8033 (TTY users call 711).

Inpatient – A Member who receives care as a registered bed patient in a Hospital or other Facility where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Intensive Outpatient Program – Structured, multidisciplinary treatment for Mental Health and Substance Abuse Disorders that provides a combination of individual, group and family therapy to Members who require a type or frequency of treatment that is not available in a standard Outpatient setting.

Interchangeable Biologic Product – A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product. In addition to meeting the biosimilarity standard, is expected to produce the same clinical result as the reference product in any given patient.

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

Laboratory Services – testing procedures required for the diagnosis or treatment of a condition. These services involve the analysis of a specimen of tissue or other material that has been removed from the body.

Long-Term Acute Care Facility – an institution that provides an array of long-term crucial care services to patients with serious illnesses or injuries. Long-term acute care is given for patients with complex medical needs. These include patients with high-risk pulmonary conditions who have ventilator or tracheotomy needs or who are medically unstable, patients with extensive wound care needs or post-operative Surgery wound care needs, and patients with low-level,

closed-head injuries. Long-term acute care facilities do not provide care for low-intensity patient needs.

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

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

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

Maintenance Medication – A drug You take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes.

Maximum Allowed Amount – The maximum amount that We will allow for Covered Services You receive. For more information, see the "Member Payment Responsibility" section.

Medicaid – Title XIX of the United States Social Security Act, Grants to States for Medical Assistance Programs.

Maximum Medical Improvement – a determination at our sole discretion that no further medical care can reasonably be expected to measurably improve a patient's condition. Maximum Medical Improvement shall be determined without regard to whether continued care is necessary to prevent deterioration of the condition or is otherwise life sustaining.

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

Medically Necessary – Those covered physical health, mental health, and/or Substance Use Disorder services which are determined under the applicable Utilization Management program to be:

- Consistent with the symptoms, diagnosis, and treatment of a Member's medical condition.
- Widely accepted by the Provider's peer group as effective and reasonably safe based on scientific evidence.
- Not experimental, investigational, unproven, unusual, or not customary.
- Not just for cosmetic purposes.
- Not just for the convenience of the Member, Provider, or other Provider.
- The most appropriate level of care that can be safely given to the Member and

failure to provide the service would adversely affect the Member's health.
- When applied to inpatient care – Medically Necessary services cannot be safely given in an ambulatory setting.
- Not otherwise subject to an exclusion under this booklet.
- The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services, or supplies does not itself make such care, treatment, services, or supplies Medically Necessary.

Medical Supplies – items (except Prescription Drugs) needed for the treatment of an illness or injury.

Medicare – a federal health insurance program for people 65 and over, certain disabled people, and those with end-stage renal disease (ESRD).

Member – any person who is enrolled for coverage under the Plan

Member Handbook/Explanation of Coverage (EOC) – document provided to Enrollees that summarizes plan benefits, limitations, exclusions, and member rights and responsibilities, and explains how to access Covered Services and use the Plan.

Mental Health and Substance Abuse (Behavioral, Mental Health, and Substance Use Disorder) – A condition or disorder, regardless of etiology, that may be the result of a combination of genetic and environmental factors and that falls under any of the diagnostic categories listed in the mental disorders section of the most recent version of (a) the international statistical classification of diseases and related health problems; (b) the Diagnostic and Statistical Manual of Mental Disorders (DSM); or (c) the diagnostic classification of mental health and developmental disorders of infancy and early childhood. The phrase also includes Autism Spectrum Disorders, as defined in this document.

Minimum Essential Coverage – The term Minimum Essential Coverage means any of the following: Government sponsored programs (Medicare, Medicaid, CHIP, TRICARE for Life, veteran's healthcare program); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; coverage under a grandfathered health plan, and such other health benefits coverage, such as State high risk pool coverage, or as the Secretary of HHS recognizes.

Occupational Therapy – the use of educational and rehabilitation techniques to improve a patient's functional ability to live independently. Occupational Therapy requires that a properly accredited occupational therapist or certified Occupational Therapy assistant do such therapy.

Open Enrollment – the period each year during which you are given the opportunity to enroll your Dependents on the Plan or request Plan changes.

Out-of-Network or Non-Contracted – a term for Providers that do not enter into a network contract with Us. However, Out-of-Network Providers are subject to the Blue Cross Blue Shield Association rules governing claims filed by certain ancillary Providers. Services received from an Out-of-Network Provider are only covered under limited circumstances.

Out-of-Network or Non-Contracted Pharmacy – a Pharmacy that does not have an In-Network Pharmacy agreement in effect with or for the benefit of the Plan at the time services are rendered. In most instances, you will be responsible for a larger portion of Your pharmaceutical bill when You go to an Out-of-Network Pharmacy.

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

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

Non-Contracted Provider – an appropriately licensed health care Provider that has not contracted with us to provide services to our Members. We may not cover services given by a Provider who is not Contracted; this is unless you get Prior Authorization. A Member may be financially responsible for services done by a Provider who is not Contracted; this is unless stated otherwise in this booklet.

Out-of-Pocket Maximum – the total amount (Cost-Sharing) a Member of the Plan may be responsible for during a specified period as described in this booklet. The Out-of-Pocket Maximum is designed to protect Members from catastrophic health care expenses. For each Member's Calendar Year benefit period, after the Out-of-Pocket Maximum is reached, for most services, payment will be made at 100% of the allowable charge for the remainder of that Calendar Year.

Outpatient – non-surgical services offered in a Provider's office, the Outpatient department of a Hospital or other facility or the patient's home.

Overweight/Obesity – weight for height at greater than the 95th percentile or body mass index (BMI) greater than the 95th percentile. Obesity in children has long-term consequences that become major health issues later in life. Treatment plans are standard pediatric weight management programs medically supervised by medical professionals seldom using surgical or pharmacological interventions due to the long-term side effects of these treatments.

Partial Hospitalization Program – Structured, multidisciplinary treatment for Mental Health and Substance Abuse Disorders, including nursing care and active individual, group and family treatment for Members who require more care than is available in an Intensive Outpatient

Program.

Physical Therapy – the use of physical agents to treat a disability that results from disease or injury. Physical agents used include heat, cold, electrical currents, ultrasound, ultraviolet radiation, massage, and therapeutic exercise. A Provider or registered physical therapist must perform Physical Therapy.

Pharmacy – an establishment licensed to give Prescription Drugs and other medications through a licensed pharmacist. This is from an authorized health care professional's order. A Pharmacy may be a Contracted Provider or a Non-Contracted Provider. A Contracted Pharmacy is contracted with us to provide covered Prescription Drugs to Members under the terms and conditions of this booklet. A Pharmacy who is Non-Contracted is not contracted through us.

Plan – the set of benefits, conditions, exclusions, limitations, and Premiums described in this document.

Premium(s) - the amount periodically paid by or on behalf of each Member. Premiums are in addition to any Copayment, Coinsurance, or Deductible, if applicable.

Prescription Drugs - Drugs and medications that, by law, require a prescription.

- **Brand-Name:** The initial version of a medication developed by a pharmaceutical manufacturer or a version marketed under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted an exclusive patent to manufacture and market a new medication for a set number of years. After the patent expires and FDA requirements are met, any manufacturer may produce the medication and sell the medication under its own Brand-Name or under the medication's chemical (Generic) name.
- **Generic:** Medications determined by the FDA to be bioequivalent to Brand-Name medications and that are not manufactured or marketed under a registered trade name or trademark. A Generic medication's active ingredients are the same as those of a Brand-Name medication. Generic medications must meet the same FDA specifications as Brand-Name medications for safety, purity, and potency. They must be dispensed in the same dosage form (tablet, capsule, cream) as the counterpart Brand-Name medication. On average, Generic medications cost about half as much as the counterpart Brand-Name medication.
- **Legend Drug:** A medical substance dispensed for Outpatient use, which, under the federal Food, Drug, and Cosmetic Act, is required to bear on its original packing label, "Caution: Federal law prohibits dispensing without a prescription." Compound medications that contain at least one such medicinal substance are prescription Legend Drugs. Insulin is considered a prescription Legend Drug under this booklet.

Preventive Care – comprehensive care that focuses on prevention, early detection, and early treatment of conditions through routine physical exams, immunizations, and health education.

Prior Authorization – a process during which requests for procedures, services, or certain Prescription Drugs are reviewed prior to being given, for approval of benefits, length of stay, appropriate location, and Medical Necessity. For Prescription Drugs, the designated Plan Pharmacy and therapeutics committee defines the criteria for coverage. This includes the need for Prior Authorization for certain Prescription Drugs.

Primary Care Provider (PCP) – the appropriately licensed and credentialed Provider who has contracted with us to supervise, coordinate, and provide initial and basic care to our Members. They also can initiate a Referral for Specialist care and maintain continuity of patient care.

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

Prosthetic Device – an artificial device that replaces all or part of a missing body part.

Provider – a Doctor of Medicine or osteopathy who is licensed to practice medicine under the laws of the state where the services are given. A person or facility that is recognized by this Plan as a health care Provider and fits one or more of the following descriptions:

- **Professional Provider:** a Provider who is licensed or otherwise authorized by the state where services are given to perform designated health care services. For benefits to be payable, services of a Provider must be within the scope of the authority granted by the license and covered by this Plan. Such services are subject to review by a medical authority appointed by us. Other Professional Providers include, among others, certified nurse midwives, dentists, optometrists, and certified registered nurse anesthetists. Services of such a Provider must be among those covered by this Member Handbook and are subject to review by a medical authority appointed by us.
- **Facility Provider:** an inpatient and Outpatient Facility Provider, as defined below:
    - **Inpatient Facility Provider –** a Hospital, Hospice facility, Skilled Nursing Facility, or other facility that we recognize as a health care Provider. These Facility Providers may collectively be called a Facility Provider or separately as a Substance Use Disorder Treatment Center.
    - **Outpatient Facility Provider –** a Dialysis center, Home Health Agency, or other Facility Provider such as an ambulatory surgery center (but not a Hospital, Hospice facility, or Skilled Nursing Facility) recognized by this Plan and licensed or certified to perform designated health care services by the state where services are given. Services of such a Provider must be covered by this Plan and are subject to review by a medical authority

appointed by us.

Qualified Health Plan (QHP) – A health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

Radiation Therapy – X-Ray, radon, cobalt, betatron, telocobalt, radioactive isotope, and similar treatments. These are for malignant diseases and other medical conditions.

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

Referral – We consider a Referral to be a clinical communication between the Primary Care Provider (PCP) and the specialty Provider. This is for the purposes of care continuity, treatment planning, and providing a medical home. Office visits for a Non-Contracted Specialist require Prior Authorization from this Plan. .

Rehabilitative Services – Healthcare services that help a person get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of Inpatient and/or Outpatient settings.

Residential Treatment Center - a licensed psychiatric facility which provides 24-hour continuous, individually planned programs of therapeutic treatment and supervision.

Routine Care – services for conditions that do not require immediate attention that can usually be received in the PCP's office, or services that are usually done periodically within a specific period (for example, immunizations and physical exams).

Second Opinion – a visit to another Professional Provider (following a first visit with a different Provider) for review of the first Provider's opinion of proposed Surgery or treatment.

Service Area – consists of certain geographic areas in Colorado which are designated by county. Our Service Area may change. Contact us for a complete list of our Service Area counties.

Skilled Nursing Facility – an institution that provides skilled nursing care (for example, therapies and protective supervision for patients with uncontrolled, unstable, or chronic conditions). Skilled nursing care is given under medical supervision to carry out non-surgical treatment of chronic diseases or convalescent stages of acute diseases or injuries. Skilled nursing care facilities do not provide care for patients with high-intensive medical needs, or for patients who are medically unstable.

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

Speech Therapy – services used for the diagnosis and treatment of speech and language disorders. A licensed and accredited speech/language pathologist must perform Speech Therapy.

Stabilize – with respect to an Emergency medical condition, to provide medical treatment as necessary to assure that no material deterioration of the condition is likely if the individual is transferred from a facility, or, with respect to a pregnant woman who is having contractions, to deliver.

Step Therapy – a protocol that requires a Member to use a Prescription Drug or sequence of Prescription Drugs, other than the drug that the Member's health care Provider recommends for the Member's treatment before the carrier provides coverage for the recommended Prescription Drug.

Subscriber – a Member who is eligible for membership on their own behalf and not by virtue of Dependent status. For Member eligibility requirements, see Section 5: Eligibility.

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

Substance Use Disorder Treatment Center – a Withdrawal Management and/or treatment facility licensed by the state to treat Substance Use Disorders

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

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

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

Utilization Review – a set of formal techniques using standardized criteria designed to monitor the use, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency, of health care

services, procedures, or settings. Techniques include ambulatory review, prospective review, second opinion, certification, and concurrent review, Care Management, Discharge Planning, and/or retrospective review. Utilization Review also includes review to determine coverage. This is based on whether a procedure or treatment is considered experimental/investigational in each circumstance (except if it is specifically excluded in this booklet) and review of a Member's medical circumstances, when such a review is necessary to determine if an exclusion applies in each situation.

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

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

Section 16: Language Services

ATTENTION: If you speak English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call 1-833-575-8033 (TTY 711).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al 1-833-575-8033 (TTY 711).

አማርኛ (Amharic) ትኩረት፡ አማርኛ የሚናገሩ ከሆነ ተገቢ የሆኑ ረዳት መርጃዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ 1-833-575-8033 ይደውሉ (TTY 711)።

تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية بما في ذلك من وسائل المساعدة والخدمات المناسبة (Arabic) . العربية(TTY 711) 1-833-575-8033 بالمجان. اتصل بالرقم

中文 **(Chinese)** 注意事項：如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電 1-833-575-8033（TTY 711）。

از جمله کمکا ه و خدمات پشتیبانی مناسب، بهـ «تسهیلات زبانی » ، **توجه:** اگر بهـ زبان فارسی صحبت مین ک ید صورت رایگان در 1-833-575-8033 (TTY) (تماس بگیرید. (TTY 711) **(فارسی** تلفن متنی **(Farsi)** دسترستان است اب

Français (French) ATTENTION: si vous parlez français, des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le 1-833-575-8033 (TTY 711).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistenz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie 1-833-575-8033 an (TTY 711).

日本語 **(Japanese)** 注意：日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。1-833-575-8033 までお電話ください（TTY 711）。

한국어 **(Korean)** 주의: 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. 1-833-575-8033 로 전화해 주세요(TTY 711).

नेपाल (Nepali) ध्यान दिनुहोस्: यद तपाइँ नेपाल बोल्नुहुन्छ भने, उपयुक्त सहायक सहायता र सेवाहरू सहत भाषा सहायता सेवाहरू, निःशुल्क उपलब्ध छन्। फोन 1-833-575-8033 (TTY 711).

Русский (Russian) ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру 1-833-575-8033 (TTY 711).

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa 1-833-575-8033 (TTY 711).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi 1-833-575-8033 (TTY 711).

Hindi: ध्यान द: य द आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-833-575-8033 (TTY 711)पर कॉल कर ।

Af-Soomaali (Somali): Fiiro gaar ah: Haddii aad ku hadasho Af-Soomaali, adeegyada kaalmada luqadda, oo bilaash ah, ayaa kuu diyaar ah. Wixii macluumaad dheeraad ah, fadlan wac 1-833-575-8033 (TTY 711).

Section 17: Notice of Non-Discrimination

Discrimination is against the law. Colorado Access Choice complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Colorado Access Choice does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

17.1 Auxiliary Aids and Language Services:

We provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).

Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact our ADA Coordinator at 720-798-5704 or toll-free at 1-833-575-8033 (TTY users call 711).

17.2 Grievance Procedure

If you believe we have failed to provide these services or discriminated in another way, you can file a grievance with our ADA Coordinator:

Online: www.coaccesschoice.com
Phone: 720-798-5704 or toll-free at 1-833-575-8033 (TTY users call 711)
Mail: Colorado Access Choice, P.O. Box 5637, Denver, CO 80217

You can file a grievance online, over the phone, or by mail. If you need help filing a grievance, Customer Service is available to help you.

17.3 Filing a Civil Rights Complaint

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Mail:
Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W. Room 509F HHH Bldg.
Washington, D.C. 20201

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html