DENVER HEALTH MEDICAL PLAN INC.™

DENVER HEALTH AND HOSPITAL AUTHORITY
2019 MEMBER HANDBOOK (HMO PLAN)

LOCAL. NONPROFIT. HEALTH INSURANCE.

ACCREDITED NCQA HEALTH PLAN ACCREDITED

1. Schedule of Benefits (Who Pays What)

Prior authorization may be required for some services. Please refer to the prior authorization list, which can be found on our website at denverhealthmedicalplan.org/medical-prior-authorization-list. For questions about prior authorization, call Health Plan Services at 303-602-2100 or toll-free at 1-800-700-8140 (TTY users call 711).

If you have a life or limb-threatening emergency, call 9-1-1 or go to the closest hospital emergency department or nearest medical facility. You are not required to get a referral for emergency care and cost sharing is the same in and out of network. Prior Authorizations do not apply to emergency admissions.

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible		
Individual	No deductible applies.	Not applicable.
Family	No deductible applies.	Not applicable.
Annual Out-of-Pocket Maximum		
Individual	$4,350/year.	Not applicable.
Family	$8,700/year.	Not applicable.
Lifetime Maximum		
	No lifetime maximum.	Not applicable.
Covered Providers		
	Denver Health and Hospital Authority providers and Denver Health Medical Center. Columbine network for chiropractic. Cofinity providers are in-network for outpatient mental health services only. See online provider directory for a complete list of current providers: denverhealthmedicalplan.org/find-doctor	Not applicable.
Office Visits		
Primary Care Visit	Three PCP visits per calendar year at $0 cost sharing. Then $25 copay/visit.	Not covered.
Specialist Visit	$30 copay/visit.	Not covered.
Preventive Services		
Children Adults	No copay (100% covered). This applies to all preventive services with an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF). See USPSTF list on our website at uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/	Not covered.
Maternity		
Prenatal and Postnatal Care	$0 copay/visit. Cost sharing may apply for additional services.	Not covered.
Delivery/Inpatient	$200 copay/admission.	Not covered.

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, cost share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and cost share amounts. For a complete explanation, please refer to the "Benefits/Coverage (What is Covered)" and "Limitations and Exclusions (What is not covered and Pre-existing Conditions"sections.

1. Schedule of Benefits (Who Pays What)

	IN-NETWORK	OUT-OF-NETWORK
Prescription Drugs		
Denver Health Pharmacies *Prescriptions filled at Denver Health Pharmacies must be written by a Denver Health physician.*	**Denver Health Pharmacy (30-day supply)** Discount: $4 copay Preferred Generics: $15 copay Non-Preferred Generics: $25 copay Preferred Brands: $40 copay Non-Preferred Brands: $50 copay Specialty: $60 copay **Denver Health Pharmacy by Mail (90-day supply)** Discount: $8 copay Preferred Generics: $30 copay Non-Preferred Generics: $50 copay Preferred Brands: $80 copay Non-Preferred Brands: $100 copay Specialty: N/A	Not covered.
National Network Pharmacies	**National Network Pharmacy (30-day supply)** Discount: $8 copay Preferred Generics: $30 copay Non-Preferred Generics: $50 copay Preferred Brands: $80 copay Non-Preferred Brands: $100 copay Specialty: $120 copay **National Network Pharmacy (90-day supply)** Discount: $16 copay Preferred Generics: $60 copay Non-Preferred Generics: $100 copay Preferred Brands: $160 copay Non-Preferred Brands: $200 copay Specialty: N/A	Not covered.
Hospital & Facility Services		
Inpatient Hospital	$400 copay/hospital stay.	Not covered.
Outpatient/ Ambulatory Surgery	$200 copay.	Not covered.
Emergency Room Services	$150 copay/visit.	$150 copay/visit.
Emergency Transportation	$150 copay/transport.	$150 copay/transport.
Urgent Care Center	$50 copay/visit.	$50 copay/visit.
DispatchHealth	$50 copay/visit.	N/A
Diagnostic Laboratory and Radiology		
Laboratory, X-Ray and CT	$0 copay/test.	Not covered.
MRI PET Scans	$150 copay/test.	Not covered.

1. Schedule of Benefits (Who Pays What)

	IN-NETWORK	OUT-OF-NETWORK
Other Diagnostic and Therapeutic Services		
Sleep Study	$150 copay/test.	Not covered.
Radiation Therapy	$10 copay/visit.	Not covered.
Infusion Therapy (includes chemotherapy)	$10 copay/visit.	Not covered.
Injections	$10 copay/visit. (Immunizations, allergy shots and any other injections administered by a nurse are a $0 copay).	Not covered.
Renal Dialysis	No copay (100% covered).	Not covered.
Behavioral Health		
Outpatient	$10 copay/visit at Denver Health. If using a Cofinity provider, $25 copay/visit applies.	Not covered.
Inpatient	$400 copay/admission.	Not covered.
Therapies		
Rehabilitative: Physical, Occupational, and Speech Therapy	$10 copay/visit. 20 of each therapy per calendar year.	Not covered.
Habilitative: Physical, Occupational, and Speech Therapy	$10 copay/visit. 20 of each therapy per calendar year.	Not covered.
Pulmonary Rehabilitation	$10 copay/visit. 20 visit limit per calendar year.	Not covered.
Cardiac Rehabilitation	$10 copay/visit. 20 visit limit per calendar year.	Not covered.
Durable Medical Equipment		
	20% coinsurance applies.	Not covered.
Hearing Aids		
Adult	Medically necessary hearing aids prescribed by an in-network provider are covered every 5 years in-network. For adults age 18 and over, there is a $1,500 benefit maximum every 5 years. Charges exceeding the $1,500 hearing aid maximum benefit, are the responsibility of the member. Cochlear implants: the device is covered at 100%; applicable inpatient/outpatient surgery charges will apply.	Not covered.
Children	Children under age 18 are covered at 100%, no maximum benefit applies. Hearing screens and fittings for hearing aids are covered under office visits and the applicable copayment applies. Hearing aids no longer apply to the annual DME limit. Cochlear implants: the device is covered at 100%; applicable inpatient/outpatient surgery charges will apply.	Not covered.

1. Schedule of Benefits (Who Pays What)

	IN-NETWORK	OUT-OF-NETWORK
Prosthetics		
	20% coinsurance applies; no maximum benefit.	Not covered.
Shoe Orthotics		
	Medically necessary orthotics are reimbursed up to $100 per calendar year.	Not covered.
Oxygen/Oxygen Equipment		
Oxygen	100% covered.	Not covered.
Equipment	20% coinsurance applies; no maximum benefit.	Not covered.
Organ Transplants		
	$400 copay/admission. Only covered at authorized facilities. Coverage no less extensive than for other physical illness. Covered transplants include: cornea, kidney, kidney-pancreas, heart, lung, heart-lung, liver, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer and Wiskott-Aldrich Syndrome only. Peripheral stem cell support is a covered benefit for the same conditions listed above for bone marrow transplants.	Not covered.
Home Health Care		
	No copay (100% covered) for prescribed medically necessary skilled home health services.	Not covered.
Hospice Care		
	No copay (100% covered).	Not covered.
Skilled Nursing Facility		
	No copay (100% covered). Benefit maximum is 100 days per calendar year at an authorized facility.	Not covered.
Dental Care		
	Dental care not covered except for flouride varnish at PCP visit for children under the age of 18.	Not covered.
Vision Care		
Eye Exams	$30 copay/visit for routine eye exams exams at either Denver Health Eye Clinic or One Hour Optical. Limit of 1 routine eye exam every 24 months.	Not covered.
Eyewear	Plan pays up to $350 one time per 24-month period per member for prescription eyewear. Only one claim can be submitted in a 24-month period, i.e. if you are using the benefit for contacts, you may want to wait until you have accumulated $350 in charges before submitting a claim in order to use full benefit. $200 toward Lasik surgery once per lifetime. This benefit can be used at any time regardless of whether or not the $350/24-month benefit has been used.	
Chiropractic		
	$20 copay/visit. Maximum 20 visits per calendar year. Services must be provided by Columbine Chiropractic in order to be covered.	Not covered.

2. Title Page (Cover Page)

January 2019

The information contained in this Member Handbook explains the administration of the benefits of Denver Health Medical Plan (DHMP). DHMP is a health insurance plan offered by Denver Health Medical Plan, Inc., a state-licensed health maintenance organization (HMO). This Member Handbook is also considered your Evidence of Coverage (EOC) document. Information regarding the administration of DHMP benefits can also be obtained through marketing materials, by contacting Health Plan Services at 303-602-2100 or toll-free at 1-800-700-8140 and on our website at denverhealthmedicalplan.org. In the event of a conflict between the terms and conditions of this Member Handbook and any supplements to it and any other materials provided by DHMP, the terms and conditions of this Member Handbook and its supplements will control.

Coverage as described in this Member Handbook commences January 1, 2019 and ends December 31, 2019.

3. Contact Us

Health Plan Services 303-602-2100 • TTY 711 • Fax 303-602-2138
Monday through Friday • 8 a.m. - 5 p.m.

- Benefit questions
- Prior authorization
- Eligibility questions
- Grievances (complaints) and Appeals
- Learn how to navigate the health care system
- Answer questions about DHMP's programs and services

Online Member Portal
https://b27cwsprodext.cishoc.com/tzg/cws/registration/registrationLogin.jsp

- Obtain a replacement ID Card
- Access claim information
- View/print Explanation of Benefits (EOB)
- Send a message to the NurseLine

Pharmacy Department 303-602-2070 • Fax 303-602-2081

- Pharmacy prior authorizations (medications that are not covered)
- Pharmacy claim rejections
- Medication cost
- Medication safety

Denver Health Appointment Center • 303-436-4949
24 Hour NurseLine • 303-739-1261

4. Table of Contents

5. Eligibility

WHO IS ELIGIBLE

You are eligible to participate in the Denver Health Medical Plan HMO plan if you are:

» A regular, full-time or eligible part-time employee who is actively employed at Denver Health and Hospital Authority.

Eligible dependents who may participate include (proof may be required):

» Your spouse as defined by applicable Colorado State Law (including common-law spouse or same sex domestic partner).

» A child married or unmarried until their 26th birthday as long as they are not eligible for health care benefits through their employer.

» An unmarried child of any age who is medically certified as disabled and dependent upon you.

A child, meeting the age limitations above, may be a depenedent whether the child is your biological child, your stepchild, your foster child, your adopted child, a child placed with you for adoption (see enrollment requirements), a child for whom you or your spouse is required by a qualified medical child support order to provide health care coverage (even if the child does not reside in your home), a child for whom you or your spouse has court-ordered custody, or the child of your eligible same sex domestic partner.

For coverage under a qualified medical child support order or other court order, you must provide a copy of the order.

Eligible dependents living outside of the Network Area may qualify to use First Health network providers. To qualify, Health Plan Services must be notified by calling 303-602-2100. There is no prior authorization required for primary care providers, OB GYN or outpatient behavioral health. All other specialty care visits require prior authorization (except ER and Urgent Care).

For a common-law spouse or same sex domestic partner, you must complete the appropriate paperwork (affidavit) and return it to your employer. This form is available from your employer or the DHMP Health Plan Services Department.

You may not participate in this plan as both an employee and as a dependent.

You may enroll in DHMP without regard to physical or mental condition, race, creed, age, color, national origin or ancestry, handicap, marital status, sex, sexual preference, or political/religious affiliation. No one is ineligible due to any pre-existing health condition. DHMP does not discriminate with respect to the provision of medically necessary covered benefits against persons who are participants in a publicly financed program.

ENROLLMENT

Initial Enrollment - To obtain medical coverage, you and your eligible dependents must enroll through DHMP within 30 days of hire.

Open Enrollment - Open enrollment is an annual period of time during which employees may enroll in their employer's health insurance plan if they have not already done so, or may change from one health insurance option to another.

Special Enrollment - A Special Enrollment Period allows benefit changes during the year outside of Open Enrollment. If you are an existing member and need to make changes to your benefits, you must contact your Benefits Department. Changes are only allowed if you have a life qualifying event. Once the change has been approved and finalized by Benefits Department your benefit elections are effective the first of the month following the event date. In each case, you and/or your eligible dependents must enroll within 30 days after the event.

Events that Trigger a Special Enrollment Period:

(1) Loss of other creditable coverage: If you were covered under other creditable coverage at the time of the initial enrollment period and lose that coverage as a result of termination of employment or eligibility, reduction in the number of hours of employment, the involuntary termination of the creditable coverage, death of a spouse, legal separation or divorce, or termination of employer contributions toward such coverage, you may request enrollment in DHMP.

If an eligible dependent was covered under other creditable coverage at the time of the initial enrollment and loses the coverage as a result of termination of employment or eligibility, reduction in the number of hours of employment, the involuntary termination of the creditable coverage, death of a spouse, legal separation or divorce, or termination of employer contributions toward such coverage, your eligible dependent may request enrollment in DHMP if you are a member of DHMP. Contact your Benefits Team to complete enrollment within 30 days.

(2) Court Order: If you are a DHMP member and a court orders you to provide coverage for an eligible dependent under your health benefit plan, you may request enrollment in DHMP for your eligible dependent. Contact your Benefits Team to complete enrollment within 30 days.

(3) New Dependents: If you are a DHMP member and a person becomes a dependent of yours through marriage, birth, adoption, or placement for adoption, you may request enrollment of such a person in DHMP. In such a case, coverage will begin on the date the person becomes a dependent. Contact your Benefits Team to complete enrollment within 30 days.

(4) Newborn Children: Remember to enroll your newborn in your health insurance plan within 30 days.

5. Eligibility

As long as you enroll your newborn within 30 days of birth, coverage will be effective on their date of birth. A newborn cannot be subject to a preexisting condition exclusion. Regardless of enrollment, your newborn child(ren) is (are) covered for the first 31 days after birth. If the mother of the newborn child is a Dependent child of the Participant, the newborn is not provided benefits. Services provided during the first 31 days of coverage are subject to the cost sharing requirements and any applicable benefit maximums. The family maximum out of pocket will apply to the newborn child(ren) (and all other members) for the first 31-day period following birth regardless of whether the child(ren) is (are) enrolled or not enrolled beyond the first 31 days of coverage. The family maximum out of pocket will continue to apply to the newborn child(ren) (and all other members) after the first 31 days if the newborn child(ren) is (are) actively enrolled in the plan.

To enroll your newborn child(ren) to your plan, you must complete the enrollment process through your Benefits Department. Contact your Benefits Team for additional information.

Deletion of Dependents (changes in eligibility)
You must inform your employer within 31 days if a death, divorce, marriage or other event occurs which changes the status of your dependents. Those who are no longer eligible will lose coverage under the Plan, unless they qualify for continuation or conversion coverage (see section 12). Insurance will end the last day of the month of the change.

Dependents of Dependents (Grandchildren)
Children of a dependent are not covered for any period of time, including the first 31 days of life, unless court-ordered parental responsibility is awarded to the DHMP subscriber. You must provide a copy of the court order to your Benefits Team, along with the enrollment form.

WHEN COVERAGE BEGINS

New Employees - If you are a new employee and have completed the enrollment process, your coverage begins on the first day of the calendar month following the month in which you began work. Coverage for your enrolled dependents begins when your coverage begins.

Open Enrollment - If you select DHMP during an annual open enrollment period, your coverage will begin January 1 of the following year. Coverage for your enrolled dependents begins when your coverage begins.

Newborn Children - Your newborn children are covered for the first 31 days after birth. You must complete and submit an enrollment change form within 31 days of birth to add your newborn children for coverage to continue beyond the first 31 days.

Other New Dependents - If you enroll any other new dependent, such as a new spouse, an adopted child or child placed for adoption, within 31 days of marriage, adoption or placement for adoption, coverage will be retroactive to the date of the event causing the change to dependent status.

Confined Members - If a member is confined to a medical facility at the time coverage begins and the member had previous coverage under a group health plan, the previous carrier will be responsible for all covered costs and services related to that confinement. DHMP will not be responsible for any services or costs related to that confinement. However, should any services be required that are not related to the original confinement, DHMP will be responsible for any services that are covered as stated in Section 7 - Benefits/ Coverage. If the member is confined to a medical facility and was not covered by a group health plan when DHMP coverage began, DHMP will be responsible for the covered costs and services related to the confinement from the time coverage begins.

WHEN COVERAGE ENDS

Your coverage will end at 11:59 p.m. on the last day of the month in which you become ineligible.

A member may become ineligible when:

- A newborn dependent, new spouse, adopted child or child placed for adoption is not enrolled within the first 31 days of birth, marriage, adoption or placement;
- You are no longer a regular, full-time or eligible part-time employee who is actively employed for an enrolled employer group, unless you qualify for continuation coverage (see section 12);
- You retire and do not select DHMP under your employer's retirement plan;
- You are a dependent who no longer meets eligibility requirements, unless you qualify for continuation coverage (see section 12);
- You exhaust any continuation coverage for which you were eligible;
- You no longer pay the monthly premium required for continuation coverage;
- Your employer terminates coverage under the Plan;
- Your employer fails to make the required premium payments;
- You commit a violation of the terms of the Plan (see section 5).

Coverage for your dependents will end at the same time your coverage ends.

Dependents Who Are Disabled - Coverage for dependent children who are medically certified as disabled and who are financially dependent on you will also end at the same time your coverage ends.

End of Coverage When a Member is Confined to an Inpatient Facility - If a member is confined to a hospital or institution on the date coverage would normally end, and the confinement is a covered benefit under the Plan, coverage will continue until the date of discharge,

provided the member continues to obtain all medical care for covered benefits in compliance with the terms of the Plan.

MEDICARE ELIGIBILITY FOR AGE OR DISABILITY ELIGIBLE EMPLOYEES (ACTIVELY WORKING)

If you become eligible for Medicare by reason of age or disability while covered on this Plan, you must enroll in Medicare Part A. During any waiting period for Medicare coverage to begin (usually 24 months for disability), your coverage under this Plan will continue unchanged. Once the waiting period is over, you must make one of the following two choices:

1. Continue your coverage with DHMP while you are an eligible current employee. If you do so, DHMP will provide and pay for benefits as if you were not eligible for or enrolled in Medicare, i.e., DHMP will be your primary coverage. Medicare will pay for costs not paid by DHMP, i.e., Medicare will be your secondary coverage.
2. Select Medicare as your coverage while you are an eligible current employee. If you do so, your coverage with DHMP will terminate, as required by law. However, your covered dependents may be eligible for continuation coverage. See section 12 for more information about continuation coverage. You should consider enrollment in Medicare Part B when Medicare is your only coverage.

RETIRED EMPLOYEES

If you become eligible for Medicare by reason of age, your coverage under this Plan will terminate. However, you may be eligible for a Medicare product offered by DHMP. Call Health Plan Services at 303-602-2100 or toll free at 1-800-700-8140 (TTY/TTD users should call 711) for details. The coverage of your dependents will also terminate. However, your covered dependents may be eligible for continuation coverage. See section 12 for more information about continuation coverage.

If you become eligible for Medicare before age 65 by reason of disability and are covered on this Plan as a retiree, you must enroll in Medicare Part A. During any waiting period for Medicare coverage to begin (usually 24 months for disability), your coverage under this Plan will continue unchanged. Once the waiting period is over, Medicare will be your primary coverage. Your coverage under this Plan will terminate. However, you may be eligible for a Medicare product offered by DHMP. You will be responsible for paying the Medicare Part B premium. Call Health Plan Services for more details.

If you continue on this Plan, your dependents may also continue on this Plan, with benefits unchanged. If you choose Medicare coverage only, the coverage for your dependents on this Plan will terminate. However, your covered dependents may be eligible for continuation coverage. See section 12 for more information about continuation coverage.

The following information is applicable to individuals eligible for Medicare due to End Stage Renal Disease (ESRD).

MEDICARE ELIGIBILITY FOR END STAGE RENAL DISEASE (ESRD) ELIGIBLE EMPLOYEES AND RETIREES

If you become eligible for Medicare before age 65 by reason of End Stage Renal Disease (ESRD) and are covered on this Plan, you must enroll in Medicare Part A but DHMP will continue to provide and pay for benefits as if you were not eligible for or enrolled in Medicare, i.e., DHMP will be your primary coverage, for a period of 30 months after you are eligible for Medicare – this period is called the coordination period because Medicare will coordinate with DHMP coverage and may pay for costs not paid by DHMP. Once the coordination period is over (or sooner if you are no longer an eligible employee), Medicare will be your primary coverage. If you are an Eligible Employee (actively working), you may continue your coverage under this Plan. If you do so, this Plan will be your secondary coverage and will pay costs not paid by Medicare Parts A and B, such as the Medicare Parts A and B deductibles and coinsurance amounts. One condition of secondary coverage under this Plan is that you must enroll in Medicare Part B. If you become eligible for Medicare by reason of End Stage Renal Disease (ESRD) you must enroll in Medicare Part B or you will be terminated from the plan. You will be responsible for paying the Medicare Part B premium but you may be eligible for reimbursement of the Part B premium amount from your former employer or the Plan. There is no requirement to enroll in Medicare Part D. If you are a retiree, when Medicare is your primary coverage, your coverage under this Plan will terminate. However, you may be eligible for a Medicare product offered by DHMP. Call Health Plan Services for more details.

SPECIAL SITUATIONS: EXTENSION OF COVERAGE

Medical or Personal Leaves of Absence - If you are on an approved medical or personal leave of absence, including leave under the Family and Medical Leave Act, coverage will continue in accordance with your employer's policies and procedures.

Military Leave of Absence - If you are on an approved military leave of absence, coverage may continue for the duration of the leave. Payment must be made in accordance with your employer's policies and procedures.

Standard Leave of Absence - A member who elects to take authorized Standard Leave of Absence may be eligible for coverage as permitted by DHHA rules. The Family Medical Leave Act of 1993 (FMLA) allows a worker up to 12 weeks of leave under certain circumstances.

6. How to Access Your Services and Obtain Approval of Benefits

WELCOME TO DENVER HEALTH MEDICAL PLAN!

At Denver Health Medical Plan, Inc. (DHMP), our main concern is that you receive quality health care services.

As a member of DHMP's HMO plan, you must receive your health care services within the contracted network. Please see section 1 - Schedule of Benefits for a breakdown of cost sharing.

If you have an eligible dependent residing outside the network area, they may qualify to access the First Health network. You must call Health Plan Services at 303-602-2100 to set this up.

RECEIVING CARE THROUGH DHMP

Members in the DHHA HMO plan have access only to Denver Health providers and facilities, except for urgent and emergency care as well as dependents residing out of network. You are not required to choose a primary care provider (PCP) nor does the Plan require you to obtain a referral from a PCP for specialty care within the network. However, if you receive care through Denver Health, you will need a referral to most Denver Health specialists. Please refer to your summary of benefits for information regarding cost sharing. The DHMP provider directory is located online at denverhealthmedicalplan.org/find-doctor.

If you have a relationship with a primary care provider at Denver Health and require a service that is not offered by Denver Health Medical Center or you cannot get an appointment in a timely manner, you can be referred to a provider outside the network. However, you must have prior authorization in order for DHMP to pay for these services. If you have questions regarding this, call Health Plan Services at 303-602-2100.

YOUR PRIMARY CARE PROVIDER

Primary care providers include family doctors, internal medicine doctors, pediatric doctors, physician assistants, and nurse practitioners. You'll find a list of in-network primary care providers in our online provider directory. Health Plan Services can also help you find physicians and provide details about their services and professional qualifications.

While you are not required to select a primary care provider, these practitioners can assist you in maintaining and monitoring your health as well as access the wide range of medical services from our network specialists and facilities.

SELECTING A PRIMARY CARE PROVIDER

To find primary care providers that participate in the DHMP network, visit denverhealthmedicalplan.org/find-doctor. You may also contact Health Plan Services at 303-602-2100 or toll-free at 1-800-700-8140 (TTY users should call 711).

You have the right to see any primary care provider who participates in our network and who is accepting new patients. For children, you may choose a pediatrician as the primary care provider.

CHANGING YOUR PRIMARY CARE PROVIDER

If you decide to select a new primary care provider, there is no need to tell us. You can change your selection at any time. In addition, when a PCP leaves the DHMP network, a notification will be sent to all members who recently received care from this provider. Our website provides the most up-to-date information on providers that participate in the DHMP network. Or call Health Plan Services at 303-602-2100 if you need more information.

SPECIALTY CARE

If you think you need to see a specialist or other provider, you should contact your primary care provider. He/she will work with you to determine if you need to see a specialist, provide you with a referral (if necessary), and help to coordinate your care. Members may self refer for the following services in-network: Behavioral Health, and Chiropractic .Applicable cost sharing will apply.

AFTER HOURS CARE

Medical care after hours is covered. If you have an urgent medical need, you may visit any urgent care center that is convenient for you. You may also call the NurseLine 24 hours/day, 7 days/week at 303-739-1261. If you have a life or limb-threatening emergency, go to the closest emergency room or dial 9-1-1. No authorization is necessary for urgent or emergency care.

EMERGENCY CARE

An emergency medical condition means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonable expect, in the absence of immediate medical attention, to result in:

- Placing the health of the individual or, with respect to a pregnant women, the health of the woman or her unborn child, in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

If you or a family member needs emergency care, go to the closest emergency room or dial 9-1-1. There is no need for prior authorization. Cost sharing is the same both in and out of network.

OUT OF NETWORK CARE

Care outside of the DHMP network may be covered if:

1. The type of care is not provided within the DHMP network, and
2. You receive a referral from your primary care provider or specialist, and
3. You receive authorization, in advance, from DHMP.

6. How to Access Your Services and Obtain Approval of Benefits

If you choose to see a provider who is not a participating network provider without prior authorization from DHMP, you will be responsible for all of the charges for all services. DHMP has no obligation to pay these charges.

COMPLEX CASE MANAGEMENT

We know that it can be hard to understand everything that needs to be done to manage your health, but we are here to assist you. We take your health personally and offer specialized services that are focused on you and your needs in our Complex Case Management (CCM) program.

Our Case Managers are available to:

- Help coordinate care among your different doctors.
- Help find community resources to meet your needs.
- Advocate to ensure you get the care and services you need.
- Help improve your health or function.
- Help you use and understand your health benefits.
- Provide one-on-one health care information, guidance and support.

Members or their caregivers may self-refer to gain access to these voluntary programs and services. Complex Case Management is provided at no cost to you and will not affect your plan benefits. To participate in any of these programs or to learn more, please call Health Plan Services at 303-602-2100. You can also obtain more information about our program eligibility and services at denverhealthmedicalplan.org.

UTILIZATION MANAGEMENT/AUTHORIZATION PROCESS

Some medical services must be reviewed and approved (prior authorization) by DHMP to ensure payment. It is the sole responsibility of your doctor or other provider to send a request to DHMP for authorization. The Plan will notify you and your provider when the request has been approved or denied. Sometimes, requests are denied because the care is either not a covered benefit or is not medically necessary. If you disagree with the decision to deny, you can appeal the decision - see "Appeals and Complaints" section.

If you have questions about prior authorization or about an authorization that is already in place, please call Health Plan Services at 303-602-2100 or toll-free at 1-800-700-8140 (TTY users should call 711). You can also refer to the prior authorization list, which is available on our website at denverhealthmedicalplan.org/medical-prior-authorization-list.

NURSELINE

DHMP members can call the Denver Health NurseLine 24 hours a day, 7 days a week at 303-739-1261. This service is staffed by nurses trained to answer your questions. In some cases the NurseLine representative can call in a prescription and save you a trip to urgent care.

LANGUAGE LINE SERVICES

DHMP is committed to meeting our plan members' needs. DHMP contracts with Language Line Services, Inc. to provide translation services at no cost to our plan members. For further assistance, please contact Health Plan Services at 303-602-2100 or toll-free at 1-800-700-8140. Our TTY number is 711.

ACCESS PLAN

DHMP has an Access Plan that evaluates all physicians, hospitals and other providers in the network to assure members have adequate access to services. This plan also explains DHMP's referral, coordination of care, and emergency coverage procedures. The access plan can be found on our website at denverhealthmedicalplan.org/employer-group-plans-access-care.

HEALTH MANAGEMENT

Health Coaching is a no-cost benefit offered through the Health Management department. Our health coaches help members take a more active role in their health care and control of illness. They help boost motivation by encouraging and supporting members in making lifestyle changes to improve their health.

Health Coaches can help you with:

- Starting an exercise program
- Eating better/losing weight
- Stopping smoking
- Lowering stress
- Taking your medications
- Community resources

Health Coaches can help you control chronic diseases such as asthma, diabetes, COPD, congestive heart failure and depression. To speak with a Health Coach, call Health Plan Services at 303-602-2100.

WHEN YOU ARE OUT OF TOWN

When you are traveling, you may go to any hospital or urgent care center that is convenient for you in an emergency. If you need emergency care, go to the nearest hospital or call 9-1-1. Following an emergency or urgent care visit out of network, one follow up visit is covered if you cannot reasonably travel back to your service area. Travel expenses back to the DHMP network are not a covered benefit. If you plan to be outside the DHMP service area and need your prescription filled, we have many network pharmacies across the country that you may use. Please check with Health Plan Services at 303-602-2100 or toll-free at 1-800-700-8140 (TTY users should call 711). DHMP members are NOT covered anywhere outside of the U.S.

6. How to Access Your Services and Obtain Approval of Benefits

DEPENDENTS RESIDING OUTSIDE SERVICE AREA

If you are a dependent residing or attending school outside of the DHMP service area, you can call Health Plan Services at 303-602-2100 for assistance in finding a network provider in our First Health network. Prescriptions are covered when filled at a network pharmacy, DHMP has a national prescription network. When urgent care or emergency services are needed, visit the closest facility or call 9-1-1.

CHANGE OF ADDRESS

If you change your name, mailing address, or telephone number, contact your benefits manager.

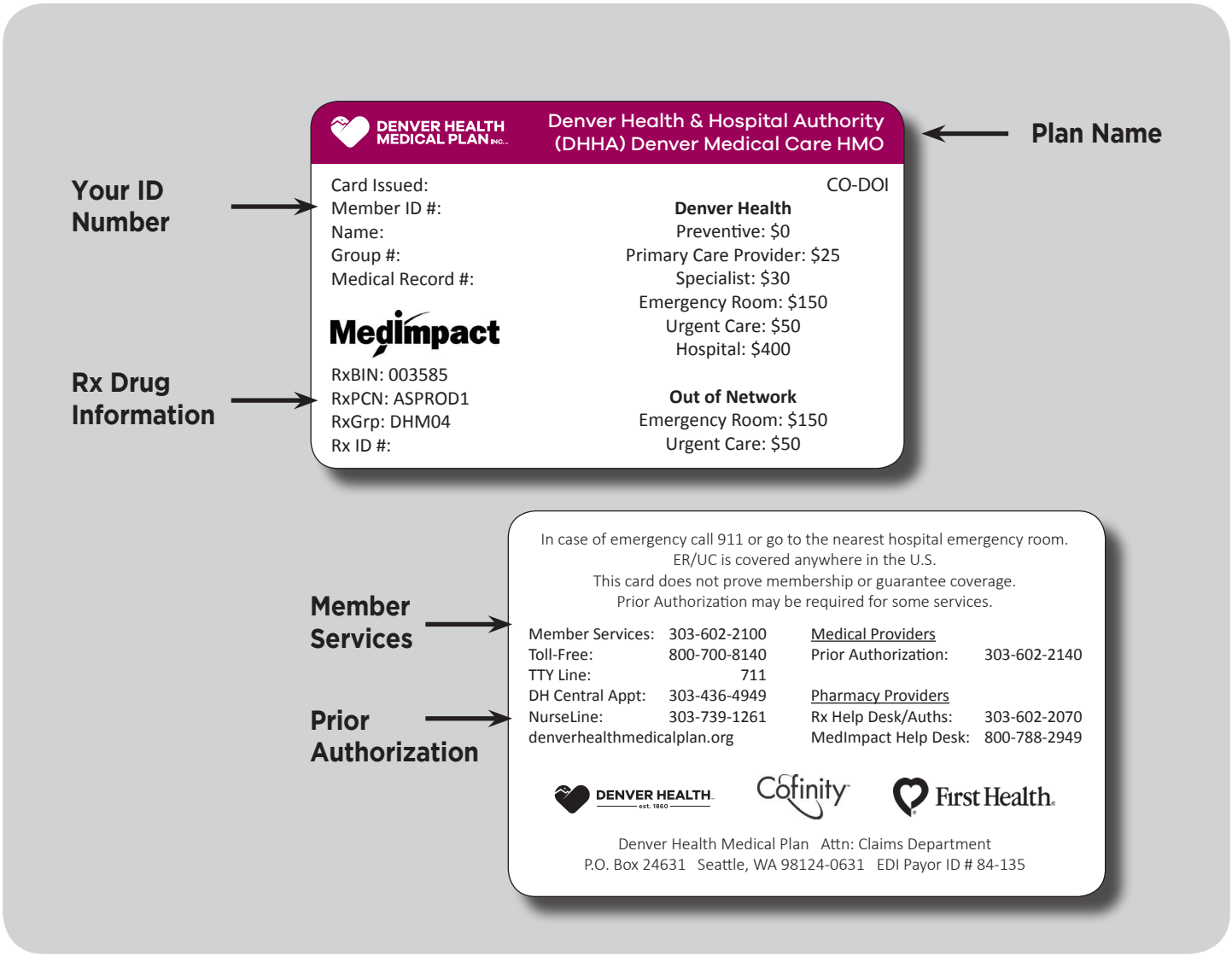
ADVANCE DIRECTIVES

Advance directives are written instructions concerning your wishes about your medical treatment. These are important health care decisions and they deserve careful thought. Advance Directive decisions include the right to consent to (accept) or refuse any medical care or treatment, and the right to give advance directives. It may be a good idea to discuss them with your doctor, family, friends, or staff members at your health care facility, and even a lawyer. You can obtain more information about advance directives, such as living wills, medical durable powers of attorney, and CPR directives (do not resuscitate orders) from your primary care provider, hospital, or lawyer. You are not required to have any advance directives to receive medical care or treatment. Advance Directive forms are available on the DHMP web site at denverhealthmedicalplan.org.

6. How to Access Your Services and Obtain Approval of Benefits

YOUR DENVER HEALTH MEDICAL PLAN IDENTIFICATION CARD

Keep your DHMP identification card with you at all times. Before receiving medical or prescription services, you must show your DHMP identification card. If you fail to do so, or misrepresent your membership status, claims payment may be denied. If you lose your identification card and need a new one, call Health Plan Services at 303-602-2100 or toll-free at 1-800-700-8140 Monday — Friday, 8 a.m. — 5 p.m. (TTY users should call 711). You can also access a copy of your ID card on the Member Portal at https://dhhcws481prod.tzghosting.net/tzg/cws/registration/registrationLogin.jsp. The ID card lists the most common cost sharing. You can find definitions for cost sharing below.



ID Card Abbreviations	
PRE	Preventive Care
PCP	Primary Care Provider
SCP	Specialist
ER	Emergency Room
UC	Urgent Care
Hospital	Inpatient stay

7. Benefits/Coverage (What is Covered)

MEMBER NEWSLETTER

As a DHMP member, you will receive newsletters throughout the year. Each newsletter contains important information such as benefit updates, upcoming health events, health tips and other information.

YOUR BENEFITS

It is important that you understand the benefits and cost sharing that apply to you. When in doubt, call the DHMP Health Plan Services department at 303-602-2100 or toll-free at 1-800-700-8140. This is the best source for information about your health care plan benefits.

OFFICE VISITS

Primary Care and Specialty Services are covered. Referrals to specialists, unless otherwise specified in this handbook, must be made by a primary care provider. Phone consultations are not subject to cost sharing. For information about preventive care services, please refer to the Preventive Care section of this book.

Primary Care Visit:

In-Network:	$25 copay per visit.
Out-of-network:	Not covered.

Specialty Visit:

In-Network:	$30 copay per visit.
Out-of-network:	Not covered.

ALLERGY TESTING AND TREATMENT

No cost sharing applies to injections given by a nurse when no other services are provided. Applicable pharmacy cost sharing will apply to injectable medication itself when billed through the outpatient pharmacy benefit.

Medically necessary allergy testing is covered.

Allergy Testing

In-Network:	100% covered.
Out-of-network:	Not covered.

Allergy Treatment

In-Network:	$30 copay per visit.
Out-of-network:	Not covered.

AUTISM SERVICES

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

» Evaluation and assessment services;

» Habilitative or rehabilitative care, including, but not limited to, occupational therapy, physical therapy, or speech therapy, or any combination of those therapies. See Therapies for Habilitative and Rehabilitative benefit limits for cost sharing.

» Behavior training and behavior management and applied behavior analysis, including but not limited to consultations, direct care, supervision, or treatment, or any combination thereof, for autism spectrum disorders provided by autism service providers.

In-Network:	Applicable cost sharing for type of service.
Out-of-network:	Not covered.

CHIROPRACTIC

Services must be provided by Columbine Chiropractic in order to be covered. $20 copay per visit will apply.

Benefit Maximum: 20 visits per plan year.

CLINICAL TRIALS AND STUDIES

Routine care during a clinical trial or study is covered if:

» The member's in network primary care provider recommends participation, determining that participation has potential therapeutic benefit to the member;

» The clinical trial or study is approved under the September 19, 2000, Medicare national coverage decision regarding clinical trials, as amended;

» The patient care is provided by a certified, registered, or licensed health care provider practicing within the scope of his or her practice and the facility and personnel providing the treatment have the experience and training to provide the treatment in a competent manner;

» Member has signed a statement of consent for participation in the clinical trial or study and understands all applicable cost sharing will apply;

» Health care services excluded from coverage under the member's health plan will not be covered. DHMP will not cover any service, drug or device that is paid for by another entity involved in the clinical trial/study;

» The member suffers from a condition that is disabling, progressive, or life-threatening;

» Extraneous expenses related to participation in the clinical trial or study or an item or service that is provided solely to satisfy a need for data collection or analysis are not covered.

See Definitions section for more information.

In-Network:	Applicable cost sharing for type of service.
Out-of-network:	Not covered.

7. Benefits/Coverage (What is Covered)

DIABETIC EDUCATION AND SUPPLIES

If you have been diagnosed with diabetes by an appropriately licensed health care professional, you are eligible for outpatient self-management training and education, as well as coverage of your diabetic equipment and supplies, including formulary glucometers, test strips, insulin and syringes. These supplies are provided by your pharmacist with a prescription from your provider. Some insulin supplies are covered through the DME benefit and may require prior authorization.

In-Network:	Applicable cost sharing for type of service.
Out-of-network:	Not covered.

DIETARY AND NUTRITIONAL COUNSELING

Coverage for health coach counseling is limited to the following covered situations:

» New onset diabetic.

» Weight reduction counseling by a dietitian.

In-Network:	Applicable cost sharing for type of service.
Out-of-network:	Not covered.

DURABLE MEDICAL EQUIPMENT

General

Durable Medical Equipment (DME) is covered if medically necessary and may require prior authorization. This includes consumables and diabetic footwear. Some DME can be rented, while other DME is purchased. Rentals are authorized for a specific period of time. If you still need the rented equipment when the authorization expires, you should call your primary care provider and request that the authorization be extended. All DME must be obtained from a DHMP network provider.

Necessary fittings, repairs and adjustments, other than those necessitated by misuse, are covered. The Plan may repair or replace a device at its option. Repair or replacement of defective equipment is covered at no additional charge.

See section 8 for Exclusions.

» Covered if medically necessary and prior authorized by DHMP: Air cleaners/purifiers, airjet injector (needle free injection device), bath tub/toilet lift, bidet toilet seats, commode chair (footrest, seat lift mechanism placed on or over a toilet), compression garments (not used with a pump), electrical stimulation/electromagnetic wound or cancer treatment devices, electronic salivary reflux stimulator, enuresis alarm, non-sterile gloves, grab bars/rails for bath/shower/stool/toilet, gravity assisted traction, heat/cold equipment/therapy game ready device, hospital bed accessories: bed board, over-bed table, board, table or support device, fully electric hospital bed, hydraulic van lift, hyperbaric oxygen therapy, incontinence supplies, interferential device, infrared heating pad system and replacement pad, intrapulmonary percussive vent system and accessories, inversion table, massage devices, portable ultrasonic nebulizer, non-thermal pulsed high frequency radiowaves/high peak power electromagnetic energy device, paraffin bath units (standard) non-portable, passenger vehicle restraint system, patient lifts-bathroom or toilet standing frame system-combination sit to stand system-moveable fixed system, positioning seat for persons with special orthopedic needs, raised toilet seat, reacher, scooter lift attachment for vehicle ramps (for home modifications), shower chair w/wo wheels, sock-aid, stroller (snug seat), telephone alert systems life line, therapeutic lightbox, transcutaneous electrical joint stimulation device system (bionicare), transfer bench for tub or toilet, vasopneumatic compression device, weighted blanket/weighted vest, wigs/artificial hair pieces, wound warming device and accessories. You are responsible for the entire cost of lost, stolen or damaged equipment (other than normal wear and tear).

In-Network:	20% coinsurance will apply.
Out-of-network:	Not covered.

DRESSINGS/SPLINTS/CASTING/STRAPPING

Dressings, splints, casts and strappings that are given to you by a provider are covered and no cost sharing is required. No benefit maximum.

Limitations: Coverage is limited to the standard item of DME, prosthetic device or orthotic device that adequately meets a Member's medical needs.

In-Network:	Applicable cost sharing for type of service.
Out-of-network:	Not covered.

No benefit maximum.

PROSTHETIC DEVICES

Prosthetic devices are those rigid or semi-rigid external devices that are required to replace all or part of a body organ or extremity. Prosthetic devices may require prior authorization.

Prosthetic devices require prior authorization.

Coverage includes the following prosthetic devices:

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

» Prosthetic devices for members who have had a mastectomy. Both internal and external prosthesis are covered in network. DHMP will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made

prostheses will be provided when necessary.

» Prosthetic devices, such as obturators and speech and feeding appliances, required for treatment of cleft lip and cleft palate in newborn members when prescribed by a network provider and obtained from sources designated by the Plan.

» Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Physician, as Medically Necessary and provided in accord with this EOC (including repairs and replacements).

» Artificial Eyes.

In-Network: 20% coinsurance will apply.

Out-of-network: Not covered.

No benefit maximum. See section 8 for Exclusions.

ORTHOTIC DEVICES

Orthotic devices are those rigid or semi-rigid external devices that are required to support or correct a defective form or function of an inoperative or malfunctioning body part, or to restrict motion in a diseased or injured part of the body.

Orthotic devices may require prior authorization.

In-Network: 20% coinsurance will apply.

Out-of-network: Not covered.

No benefit maximum. See section 8 for Exclusions.

Orthotics, Shoe Inserts:

There is a $100 annual reimbursement benefit is available for shoe inserts (orthotics) after deductible has been met. These are generally provided by a podiatrist and are not to be confused with orthoses for other parts of the body, including ankle-foot orthoses, that are commonly provided by an orthotist. These shoe inserts do not require prior authorization. Member must pay for the inserts and send in for reimbursement from the Plan.

EARLY INTERVENTION SERVICES

Early intervention services are covered for an eligible dependent from birth to age 3 who has, or has a high probability of having, developmental delays, as defined by state and federal law, and who is participating in Part C of the federal Individuals with Disabilities Education Act, 20 U.S.C. § 1400 et seq.

Early intervention services are those services that are authorized through the eligible dependent's individualized family service plan, including physical, occupational and speech therapies and case management. A copy of the individualized family service plan must be furnished to the Utilization Management department. All services must be provided by a qualified early intervention service provider who is in the DHMP network, unless otherwise approved by Utilization Management department.

No cost sharing applies to early intervention services.

Benefit Maximum: 45 therapeutic visits for all early intervention services per plan year.

Limitations: Non-emergency medical transportation, respite care and service coordination services as defined under federal law are not covered. Assistive technology is covered only if a covered durable medical equipment benefit. See "Durable Medical Equipment."

EMERGENCY SERVICES

An emergency medical condition means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonable expect, in the absence of immediate medical attention, to result in:

» Placing the health of the individual or, with respect to a pregnant women, the health of the woman or her unborn child, in serious jeopardy;

» Serious impairment to bodily functions; or

» Serious dysfunction of any bodily organ or part.

If you or a family member needs emergency care, go to the closest emergency room or dial 9-1-1. There is no need for prior authorization. Cost sharing is the same both in and out of network.

Services for the treatment of an emergency are covered. See definition of "Emergency" in the Definitions section. If you are admitted to the hospital directly from the Emergency Department, you will not have to pay Emergency Department cost sharing, but will be responsible for the Inpatient cost sharing. See Inpatient Hospital section for more details.

Non-emergency care delivered by an Emergency Department is not covered unless you are referred to the Emergency Department for care by DHMP, the NurseLine, or your primary care provider.

Follow-up care following an Emergency Department visit must be received from a DHMP network provider, unless you are traveling outside the network area cannot reasonably travel to the service area. In this case, one follow up visit outside the network is covered.

In-Network: $150 copay per visit.

Out-of-network: $150 copay per visit.

AMBULANCE SERVICE

Medically necessary ambulance services, ground or air, related to the treatment of an emergency are covered. Non-emergent transport is covered with provider referral and plan authorization. Copay is not waived if you are admitted.

In-Network: $150 copay per transport

Out-of-network: $150 copay per transport

7. Benefits/Coverage (What is Covered)

URGENT CARE SERVICES

Urgent care is immediate outpatient medical treatment for acute illness and injury. Urgent care services are covered at any urgent care center with the same cost sharing in and out of network. Members may also call the NurseLine at 303-739-1261 for assistance.

In-Network:	$50 copay per visit.
Out-of-network:	$50 copay per visit.

EYE EXAMINATIONS AND OPHTHALMOLOGY

Routine visual screening examinations, including refraction to detect vision impairment, are covered once every 24 months in-network. Annual eye exam for diabetics is considered preventive and covered at 100%. Other ophthalmology services for eye disease, etc. are covered as noted below.

Routine vision care:

In-Network:	$30 copay per visit.
Out-of-network:	Not covered.

Ophthalmology Specialist Services:

In-Network:	$30 copay per visit.
Out-of-network:	Not covered.

FAMILY PLANNING SERVICES

You do not need prior authorization from DHMP or from any other person (including a primary care provider) to obtain access to an in-network obstetrical or gynecological specialist.

The following are covered if obtained from a network provider. These services are preventive and no cost sharing will apply.

- Family planning counseling.
- Information on birth control.
- Diaphragms (and fitting).
- Insertion and removal of intrauterine devices.
- Formulary Contraceptives (oral) (see Medicine/ Pharmacy. Currently the Foods and Drug Administration (FDA) has approved 18 different methods of contraception. All FDA approved methods of contraception are covered under this policy without cost sharing as required by federal and state law.

In-Network:	100% covered
Out-of-network:	Not covered.

Tubal ligations, vasectomies, and abortions up to the 17th week of pregnancy are covered (16 weeks and 6 days). See the Limitations and Exclusions (What is Not Covered and Pre-Existing Conditions) section. Prior authorization is required and applicable cost sharing applies.

Infertility Services

Covered infertility services including testing, appropriate medical advice and instruction, in accordance with accepted medical practice.

In-Network:	Applicable cost sharing for type of service.
Out-of-network:	Not covered.

See section 8 for Exclusions.

GENDER REASSIGNMENT SURGERY

Medically necessary treatments and procedures are covered. Prior authorization and a finding of medical necessity is required. For more detailed information on process, procedures covered, etc. please contact Health Plan Services at 303-602-2100. See Chapter 8 for Limitations and Exclusions.

HEARING TESTS AND HEARING AIDS

Medically necessary hearing aids are covered. Hearing tests and fittings for hearing aids are covered under clinic visits and the applicable cost sharing applies.

Adults (age 18 and over):

In-Network:	Plan covers $1,500 every 5 years.
Out-of-network:	Not covered.

Children (age 17 and under):

In-Network:	100% covered.
Out-of-network:	Not covered.

Benefit Maximum: Not covered more frequently than every 5 years, however a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. This requirement shall apply to each hearing aid if the minor child has two hearing aids. Adult: $1,500; Children: No limitation.

Cochlear implants are covered with prior authorization. The device is covered at 100%. Appropriate cost sharing will apply to surgical services associated with the device.

HOME HEALTH CARE

Home health care provided by an DHMP network home health care provider is covered. Coverage requires periodic assessment by your provider. Home health care must be ordered by a physician and may require prior authorization.

Newborn and Postpartum

Mothers and newborn children who, at their request and with physician approval, are discharged from the hospital prior to 48 hours after a vaginal delivery or prior to 96 hours after a cesarean-section are entitled to one home visit

by a registered nurse. Additional visits for medical necessity may be authorized by DHMP.

Physical, Occupational and Speech Therapy

Physical, occupational and speech therapy, as well as audiology services, in the home are covered when prescribed by your primary care provider or specialist and may require prior authorization. Periodic assessment and continued authorization may be required to extend therapy beyond the time specified by the initial authorization.

Generally, home physical therapy, occupational therapy and speech therapy and audiology services will be authorized only until maximum medical improvement is reached or the patient is able to participate in outpatient rehabilitation. However, early intervention services for children up to age three are covered, even if the purpose of the therapy is to maintain functional capacity. See "Early Intervention Services" for more detail about the therapies authorized.

Skilled Nursing Services

Intermittent, part-time skilled nursing care is covered in the home when treatment can only be provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Certified nurse aide services, under the supervision of a RN or LPN are also covered. These services are for immediate and temporary continuation of treatment for an illness or injury. This includes home infusion therapy. Home nursing services are provided only when prescribed by your primary care provider or specialist and may require prior authorization by DHMP, and then only for the length of time specified. Periodic review and continued authorization may be required to extend the benefit. Benefits will not be paid for custodial care or when maximum improvement is achieved and no further significant measurable improvement can be anticipated.

Other Services

Respiratory and inhalation therapy, nutrition counseling by a nutritionist or dietician and medical social work services are also covered home health services.

In-Network:	100% covered.
Out-of-network:	Not covered.

HOSPICE CARE

Inpatient and home hospice services for a terminally ill member are covered when provided by an approved network hospice program. Each hospice benefit period has a duration of three months. Hospice Services may require authorization by DHMP before you receive your care.

Hospice benefits are allowed only for individuals who are terminally ill and have a life expectancy of six months or less. Any member qualifying for hospice care is allowed two 3-month hospice benefit periods. Should the member continue to live beyond the prognosis for life expectancy and exhaust his/her two 3-month hospice benefit periods, hospice benefits will continue at the same rate for one additional benefit period. After the exhaustion of three benefit periods, Utilization Management department will work with the primary care physician and the hospice's medical director to determine the appropriateness of continuing hospice care. Services and charges incurred in connection with an unrelated illness or injury are processed in accordance with the provisions of this Handbook that are applicable to that illness or injury and not under this section. Palliative care is offered to our members. Network is limited so please call Health Plan Services at 303-602-2100 or toll-free at 1-800-700-8140 (TTY users should call 711) for further information.

Home Hospice Care

The following hospice services are available in a home hospice program. Please contact your hospice provider for details:

- Physician visits by hospice physicians;
- Intermittent skilled nursing services of an RN or LPN and 24 hour on-call nursing services;
- Medical supplies;
- Rental or purchase of durable medical equipment;
- Drugs and biologicals for the terminally ill member;
- Prosthesis and orthopedic appliances;
- Diagnostic testing;
- Oxygen and respiratory supplies;
- Transportation;
- Respite care for a period not to exceed five continuous days for every 60 days of hospice care - no more than two respite care stays are available during a hospice benefit period (respite care provides a brief break from total care giving by the family);
- Pastoral counseling;
- Services of a licensed therapist for physical, occupational, respiratory and speech therapy;
- Bereavement support services for the family of the deceased member during the 12 month period following death, up to a maximum benefit of $1,150;
- Intermittent medical social services provided by a qualified individual with a degree in social work, psychology, or counseling and 24 hour on-call services. Such services may be provided for purposes of assisting family members in dealing with a specified medical condition;
- Services of a certified nurse aide or homemaker under the supervision of an RN and in conjunction with skilled nursing care and nurse services delegated to other assistants and trained volunteers;

» Nutritional counseling by a nutritionist or dietician and nutritional guidance and support, such as intravenous feeding and hyperalimentation.

Hospice Facility

Hospice may be provided as an inpatient in a licensed hospice facility for pain control or when acute symptom management cannot be achieved in the home and may require prior authorization by DHMP. This includes care by the hospice staff, medical supplies and equipment, prescribed drugs and biologicals and family counseling ordinarily furnished by the hospice.

In-Network:	100% covered.
Out-of-network:	Not covered.

INPATIENT HOSPITAL

Any admission to a hospital, other than an emergency admission, must be to an in-network hospital and must be prior authorized by DHMP. Emergency hospitalization should be reported to DHMP at 303-602-2140 within 3 business days.

» Hospital services, including surgery, anesthesia, laboratory, pathology, radiology, radiation therapy, respiratory therapy, physical therapy, occupational therapy and speech therapy are covered. Oxygen, other gases, drugs, medications and biologicals (including blood and plasma) as prescribed are also covered. See "Limitations and Exclusions" section for non-covered services.

» General inpatient nursing care is covered. Private duty nursing services and sitters are covered when medically necessary and may require prior authorization.

» Accommodations necessary for the delivery of medically necessary covered services are covered, including bed (semi-private room, private when available, private room when medically necessary), meals and services of a dietitian; use of operating and specialized treatment rooms; and use of intensive care facilities.

In-Network:	$400 copay per admission.
Out-of-network:	Not covered except for emergency admissions.

Note: If you are admitted to a non-network hospital as the result of an emergency and then subsequently transferred in-network, you will be responsible for the cost sharing for the inpatient hospital admission.

Limitations: If you request a private room, the Plan will pay only what it would pay toward a semi-private room. You will be responsible for the difference in charges. If your medical condition requires that you be isolated to protect you or other patients from exposure to dangerous bacteria or you have a disease or condition that requires isolation according to public health laws, DHMP will pay for the private room.

IMMUNIZATIONS

There is no cost sharing for preventive immunizations. DHMP covers all immunizations recommended by the CDC. A schedule of these immunizations can be found on our website at denverhealthmedicalplan.org as well as the CDC website at http://cdc.gov/vaccines/schedules/index.html. DHMP will cover these vaccines based on the age and risk indicators listed by the CDC.

Travel immunizations are not a covered benefit. However, some travel vaccinations may be included on the CDC recommendation list. All immunizations on the CDC list are covered at 100%. Formulary prophylactic drugs for travel will be covered if prescribed by your primary care provider. Travel vaccines administered in a Travel Clinic are not covered unless the vaccines are on the CDC recommended immunization list. Vaccines with "travel" as the only indicator will not be covered.

Clinic visits for administration of covered immunizations do not require cost sharing. However, if the visit is a combination of the injection and a primary care provider or specialist visit the required cost sharing will apply.

INFUSION SERVICES

All medically necessary infusion services including chemotherapy are covered in-network.

In-Network:	$10 copay per visit.
Out-of-network:	Not covered.

INJECTION ADMINISTRATION

The injection cost sharing applies to complex injections that must be given by a physician. An allergy shot, immunization or any injection given by a nurse will not require cost sharing. However, if the visit is a combination of the injection and a primary care provider or specialist visit the required cost sharing will apply.

In-Network:	$10 copay per visit.
Out-of-network:	Not covered.

LABORATORY AND PATHOLOGY SERVICES

All medically necessary laboratory testing and pathology services ordered by your primary care provider or specialist, or resulting from emergency or urgent care, are covered.

Certain genetic tests are covered and may require prior authorization.

Prenatal diagnosis and screening during pregnancy using chorionic villus sampling (CVS), amniocentesis or ultrasound are covered to identify conditions or specific diseases/disorders for which a child and/or the pregnancy may be at risk.

In-Network:	100% covered.
Out-of-network:	Not covered.

7. Benefits/Coverage (What is Covered)

MATERNITY CARE

Prenatal Care

Office visits, physician services, laboratory and radiology services necessary for pregnancy, when such care is provided by a network provider, are covered although cost sharing may apply. You may obtain obstetrical services from your primary care provider or any network obstetrician. You do not need a referral from your primary care provider to see a participating OB/GYN, physician, Certified Nurse Midwife or Nurse Practitioner. Prenatal visits are treated as preventive well-woman visits and are 100% covered. Cost sharing will apply to services such as ultrasounds or bloodwork, etc. that are not listed as preventive with either the U.S. Preventive Services Task Force A and B list or the HRSA Women's Preventive Services Guidelines.

Expectant mothers are encouraged to limit travel out of the Denver Metro area during the last month of pregnancy. If a "high-risk" designation applies, mothers should limit non-emergency travel within two months of expected due date.

All prenatal visits and the first postpartum visit are considered preventive care and are 100% covered. Cost sharing may apply to additional services performed at these visits.

HighPoint Network:	Applicable cost sharing for type of service.
Cofinity Network:	Applicable cost sharing for type of service.
Out-of-network:	Not covered except for emergencies.

Delivery (Vaginal or Cesarean)

All hospital, physician, laboratory and other expenses related to a vaginal or medically necessary cesarean delivery are covered when done at an accredited facility within the DHMP network. Only emergency deliveries are covered outside of DHMP network facilities. Any sickness or disease that is a complication of pregnancy or childbirth will be covered in the same manner and with the same limitations as any other sickness or disease.

Mother and child may have a minimum hospital stay of 48 hours following a vaginal delivery or 96 hours following a cesarean delivery, unless mother and attending physician mutually agree to a shorter stay. If 48 hours or 96 hours following delivery falls after 8 p.m., the hospital stay will continue and be covered until at least 8 a.m. the following morning.

In-Network:	$200 copay per admission.
Out-of-network:	Not covered except for emergency admissions.

Note: If mother and baby are discharged together, one copay is applied. If discharged seperately, two copays will apply.

Limitations: Home deliveries are not covered.

Postpartum: Breastfeeding support and equipment* is available at no cost to members. Call 303-602-2100 for more information.

** Coverage is limited to the standard equipment provided by DHMP.*

MEDICAL FOOD

Medical food is covered for metabolic formulas to treat enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids shall include, but not be limited to, the following diagnosed conditions: Phenylketonuria: maternal phenylketonuria; maple syrup urine disease; tyrosinemia; homocystinuria; histidinemia; urea cycle disorders; hyperlysinemia; glutaric acidemias; methylmalonic acidemia; and propionic acidemia. Covered care and treatment of such conditions shall include, to the extent medically necessary, medical foods for home use for which a physician who is a participating provider has issued a written, oral, or electronic prescription. Enteral (by tube) or Parenteral (by intravenous infusion) nutrition—if member has non-function or disease of the structures that normally permit food to enter the small intestine or impairment of small bowel that impairs digestion and absorption of an oral diet is covered.

Exclusions:

Standardized or specialized infant formula for conditions other than inborn errors of metabolism or inherited metabolic diseases, including, but not limited to: food allergies; multiple protein intolerances; lactose intolerances; gluten-free formula for gluten-sensitive enteropathy/celiac disease; milk allergies; sensitivities to intact protein; protein or fat maldigestion; intolerances to soy formulas or protein hydrolysates; prematurity; or low birth-weight.

- Food thickeners
- Dietary and food supplements
- Lactose-free products; products to aid in lactose digestion
- Gluten-free food products
- Weight-loss foods and formula
- Normal grocery items
- Low carbohydrate diets
- Baby food
- Grocery items that can be blenderized and used with enteral feeding system
- Nutritional supplement puddings
- High protein powders and mixes
- Non formulary oral vitamins and minerals

7. Benefits/Coverage (What is Covered)

MENTAL HEALTH SERVICES

Inpatient Psychiatric/Mental Health Services

Inpatient psychiatric care is covered at an in-network facility.

Prior authorization is required for non-emergency admissions. Notification to the Plan should be made as soon as reasonably possible, preferably within one business day of an emergency admission.

In-Network:	$400 copay per admission.
Out-of-network:	Not covered except for emergencies.

Partial Hospitalization/Day Treatment

"Partial Hospitalization" is defined as continuous treatment at a network facility of at least 3 hours per day but not exceeding 12 hours per day.

Virtual Residency Therapy is a covered benefit when medically necessary and multiple other therapies and interventions have not been successful. See Definitions section for more information. Virtual Residency Therapy is considered outpatient care and the outpatient cost sharing applies for each day of service.

Prior authorization may be required.

In-Network:	$10 copay per visit at Denver Health ($25 copay per visit for Cofinity provider).
Out-of-network:	Not covered.

Outpatient Psychiatric/Mental Health Services

Individual and group psychotherapy sessions are covered. You may obtain mental health services from any mental health professional in the DHMP network, no referral is necesary. Cofinity providers are in-network for outpatient mental health services only.

In-Network:	$10 copay per visit whether an individual or group visit at Denver Health ($25 copay per visit for Cofinity provider).
Out-of-network:	Not covered.

There is no cost sharing for phone consultations with your mental health provider.

Marital Counseling, Stress Counseling and Family Therapy

Marital and couples counseling, family therapy and counseling for stress-related conditions are covered. You may obtain these services from any mental health professional in the DHMP network without a referral from your primary care provider. Cofinity providers are in-network for outpatient mental health services only.

In-Network:	$10 copay per visit whether an individual or group visit at Denver Health ($25 copay per visit for Cofinity provider).
Out-of-network:	Not covered.

Biologically-Based Mental Illnesses and Mental Disorders

DHMP will provide coverage for the treatment of biologically-based mental illnesses and mental disorders that is no less extensive than for any other physical illness. Biologically-based mental illnesses are: schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, obsessive-compulsive disorder and panic disorder. "Mental Disorders" are defined as post-traumatic stress disorder, drug and alcohol disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, general anxiety disorder, bulimia nervosa, and anorexia nervosa. Cofinity providers are in-network for outpatient mental health services only.

No benefit maximum.

Inpatient

In-Network:	$400 copay per admission.
Out-of-network:	Not covered except for emergencies.

Prior authorization required for Inpatient.

Outpatient

In-Network:	$10 copay per visit whether an individual or group visit at Denver Health ($25 copay per visit for Cofinity provider).
Out-of-network:	Not covered.

Note: Court ordered mental health services are covered. Applicable cost sharing will apply.

NEWBORN CARE

All in-network hospital, physician, laboratory and other expenses for your newborn are covered, including a well child examination in the hospital. During the first 31 days of your newborn's life, benefits consist of coverage for any injury or sickness treated by an in-network provider, including all medically necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, regardless of any limitations or exclusions that would normally apply under the Plan. Applicable cost sharing will apply. You must enroll your newborn during the first 31 days of life for coverage to continue.

The Plan covers all medically necessary care and treatment for cleft lip or cleft palate or both, including oral and facial surgery, surgical management and follow-up care by plastic surgeons and oral surgeons; prosthetic treatment such as obturators, habilitative speech therapy, speech appliances, feeding appliances,

medically necessary orthodontic and prosthodontic treatment; otolaryngology treatment and audiological assessments and treatment. Care under this provision for cleft lip or cleft palate or both will continue as long as the member is eligible. All care must be obtained through DHMP network providers and may require prior authorization.

OBSERVATIONAL HOSPITAL STAY

"Observational Stay" is defined as a hospital stay of typically 23 hours or less that is designed as outpatient care.

In-Network:	$150 copay per visit.
Out-of-network:	$150 copay per visit.

OSTOMY SUPPLIES

Colostomy, ileostomy and urostomy supplies are covered.

In- Network:	20% coinsurance
Out-of-network:	Not covered.

OXYGEN/OXYGEN EQUIPMENT

Equipment for the administration of oxygen is covered. Oxygen is covered and no cost sharing is required. There is no benefit maximum. Prior authorization may be required.

Oxygen:

In-Network:	100% covered.
Out-of-network:	Not covered.

Oxygen Equipment:

In-Network:	20% coinsurance.
Out-of-network:	Not covered.

PHARMACY BENEFITS

DHMP provides a pharmacy benefit that covers medically necessary drugs as discussed by the requirements and guidelines below. Depending upon where you have your prescription filled, cost sharing and restrictions may vary.

Where You Can Fill Your Prescription

» National Network Pharmacies: DHMP offers thousands of pharmacies nationwide for you to fill your prescriptions. A pharmacy locator tool is available at denverhealthmedicalplan.org to help you find a network pharmacy or you can call Health Plan Services.

» Denver Health Pharmacies: DHMP has conveniently located Denver Health Pharmacies in many of the Denver Health clinics. While you have the choice to fill your prescription at any national network pharmacy, filling your prescriptions at Denver Health Pharmacies will give you the lowest cost sharing and allows your provider to see your prescription fill information. This helps your provider to give you the most complete care at each visit.

» *To fill a prescription at a Denver Health Pharmacy your prescription must be written by a Denver Health provider.*

Refilling Your Prescription

It is best to call to refill your prescription 3-5 working days before you need your refill. Your prescription may be refilled once 75% has been used. This is calculated using the original prescription directions. If the directions have changed please contact your pharmacy or provider for an updated prescription. If your prescription directions have changed or you need an early refill, please let the pharmacy know ahead of time. The pharmacy will need extra time to talk to your provider to get a new prescription or get authorization to fill your prescription early.

» Eye drops can be filled after you have used 70% of your prescription. If your provider writes a prescription for you to get two bottles at a time for use at child or adult day care or school, this is covered by your plan.

You can refill prescriptions filled at the Denver Health Pharmacies by calling the Denver Health Refill Request Line (which is also the number on your Denver Health Pharmacy prescription bottle), or by visiting denverhealthmedicalplan.org. You can also use the MyChart smart phone app.

Mail Order Pharmacy

Save time by signing up to have your prescriptions delivered to your home by mail. DHMP members have two choices for Mail Order Pharmacy. If you are seeing a Denver Health provider, Denver Health Pharmacy by Mail is available to you. If you see a provider outside of Denver Health, MedImpact Direct (MID) Mail Order offers a 90-day mail order option. Registration forms and frequently asked question (FAQ) documents are available for both mail order options at denverhealthmedicalplan.org.

Denver Health Pharmacy by Mail

Phone: 303-389-1390
Monday – Friday, 9am – 5pm

» Denver Health Pharmacy by Mail will give you the lowest copay.

» To have your prescription filled at a Denver Health Pharmacy, your prescription must be written by a Denver Health provider.

» Registration/order forms are available from any of the Denver Health Pharmacies or call the Denver Health Pharmacy by Mail to have one sent to you.

MedImpact Direct (MID) Mail Order

» P.O. Box 51580
Phoenix, AZ 85076-1580
Phone: 866-873-8739
medimpactdirect.com

7. Benefits/Coverage (What is Covered)

90-Day Supply at Retail

Your pharmacy benefit allows you to get a 90 day supply of medication at any Choice 90 participating retail pharmacy. To find out if your drug and/or pharmacy are eligible for this benefit visit denverhealthmedicalplan.org and click the "Drug Price Check" link for your plan or call Health Plan Services.

Your Formulary

The formulary is a list of covered drugs that shows your drug costs for each tier and prior authorization requirements for each medication. DHMP has selected the tiers and determined the criteria for prior authorization based on efficacy and cost-effectiveness. There is a different cost for each tier. The formulary helps providers choose the most appropriate and cost-effective drug for you.

» Your formulary covers many drugs including oral anti-cancer drugs.

» Off-label use of cancer drugs is covered when appropriate.

Coverage of some drugs is based on medical necessity. For these drugs, you will need a prior authorization from the plan. These drugs are noted on the formulary as "PA". Clinical information on why the PA drug is needed is required on the prior authorization request. DHMP will review the prior authorization request according to our criteria for medical necessity and determine if the drug will be covered.

Your Right to Request an Exception (also known as a Prior Authorization)

The prior authorization process is available to you and your provider to ask the plan to cover your drug if it is not on the formulary or if you would like the plan to cover a quantity greater than what the plan's formulary allows. To start a prior authorization please contact Health Plan Services.

If your request requires immediate action and a delay could significantly increase the risk to your health or the ability to regain maximum function, call us as soon as possible. We will provide an urgent determination within 24 hours.

If you are not satisfied with the decision made by the plan you have the right to request an appeal or an external review. You or your representative may request an external review by sending a written request to us to the address set out in the determination letter that explains the plan's decision, or by calling Health Plan Services.

If you are not satisfied with our determination of your exception request and it involves an urgent situation, you or your representative may request an expedited appeal or expedited external review by sending a written request to us to the address set out in the determination letter that explains the plan's decision, or by calling Health Plan Services. For expedited requests you will be notified of our determination within 24 hours.

If your drug is not on the formulary, there may be a covered drug that works just as well for you. If your provider does not want to change the drug to a formulary alternative, you will need a prior authorization from the plan.

You can view the current formulary, restrictions, and Pharmaceutical Management Procedures at denverhealthmedicalplan.org or call Health Plan Services to ask for a printed copy.

Specialty Drugs

If you fill prescriptions written by a specialist provider such as an infectious disease specialist, rheumatologist, neurologist, or oncologist, you may have specialty drugs.

Specialty drugs are usually for a more complex disease state and require extra care and handling.

All drugs on the formulary listed in the Specialty Tier are specialty drugs. Some drugs in other tiers may also be specialty drugs.

» *To find out if your drug is a specialty drug, please call Health Plan Services.*

Most specialty drugs can only be filled at a Denver Health Pharmacy or the preferred specialty pharmacies chosen by DHMP.

Most specialty drugs can only be filled for a 30-day supply, even if they are sent to your home in the mail.

Generic and Brand Name Drugs

You can save money by using generic drugs which have lower costs. Generic drugs are approved by the U.S. Food and Drug Administration for safety and effectiveness and are made using the same strict standards that apply to the brand name alternative. By law, generic drugs must contain identical amounts of the same active drug ingredient as the brand name drug.

A generic preferred program is in place. This means if you fill a prescription with a brand name drug when a generic is available, you will have to pay the cost plus the difference in cost between the generic and the brand name drug. If your provider feels you need the brand name drug, they can fill out a prior authorization request form to tell DHMP why the brand is needed. If approved you will only need to pay the exception tier (Tier 4) copay.

Drug Exclusions (See General exclusions and limitations for additional limitations)

Some drugs are not covered at all. These include drugs for the following:

» Cosmetic use (anti-wrinkle, hair removal, and hair growth products)

» Dietary supplements

7. Benefits/Coverage (What is Covered)

- Blood or blood plasma (except anti-hemophilic factor VIII and IX when approved with a prior authorization)
- Infertility
- Over-the-counter drugs (unless listed in the formulary)
- Pigmenting/de-pigmenting
- Therapeutic devices or appliances (unless listed in the formulary)
- Investigational or experimental treatments

Drug Plan Information

Please visit denverhealthmedicalplan.org where you will find:

- A list of pharmaceuticals, including restrictions and preferences
- Information on how to use the pharmaceutical management procedures
- An explanation on limits or quotas
- Information on how practitioners must provide information to support an exception request
- The process for generic substitution, therapeutic interchange and step-therapy protocols
- You may also call and request a printed copy of this information by calling Health Plan Services

Deductible does not apply. Preventive drugs are $0 at all pharmacies.

	Discount	Preferred Generic	Non Preferred Generic	Preferred Brand	Non Preferred Brand	Specialty
DH Pharmacy (30 day supply)	$4	$15	$25	$40	$50	$60
DH Pharmacy or DH Pharmacy by Mail (90 day supply)	$8	$30	$50	$80	$100	N/A
National Network Pharmacy (30 day supply)	$8	$30	$50	$80	$100	$120
National Network Pharmacy or MedImpact Direct (MID) Mail Order (90 day supply)	$16	$60	$100	$160	$200	N/A

7. Benefits/Coverage (What is Covered)

PREVENTIVE CARE

DHMP has developed clinical and preventive care guidelines and health management programs to assist members with common health conditions including diabetes management, asthma, and pregnancy care. For information, please call 303-602-2100 or visit our website at: denverhealthmedicalplan.org. Preventive care services are designed to keep you healthy or to prevent illness, and are not intended to treat an existing illness, injury or condition. Please refer to the following chart for cost sharing that may apply to preventive care services received by a network provider.

You should consult with your physician to determine which screenings are appropriate for you.

Preventive Care Service	In-Network (Denver Health, HighPoint and Cofinity Network Providers)	Out-of-Network
Adult annual preventive care exams, as well as all screenings rated A or B by the U.S. Preventive Services Task Force (USPSTF).* Age-appropriate adult preventive care screenings including but not limited to: ▯ Cholesterol (lipid profile) screening. ▯ Mammograms. ▯ Screening colonoscopy/sigmoidoscopy.	100% covered. There is no additional charge for these tests.	Not covered.
Well-woman exams including: ▯ Prenatal visits. ▯ Medical history. ▯ Physical exam of pelvic organs including PAP test. ▯ Vaginal smear. ▯ Physical exam of the breasts. ▯ Rectal exam including FOBT. ▯ Consultation for birth control, if requested. ▯ Urinalysis.	100% covered.	Not covered.
Well-child care including routine exams, blood lead level screenings, and immunizations.	100% covered.	Not covered.
Additional Newborn Examination. One newborn home visit during the first week of life if discharged less than 48 hours after a vaginal delivery or less than 96 hours after a cesarean-section delivery.	100% covered.	Not covered.
Routine immunizations – ordered by the provider and in accordance with national guidelines.	100% covered. (Clinic visits for immunizations alone do not require cost sharing. If the visit is a combination of the injection and a primary care or specialist visit, the required cost sharing will apply).	Not covered.

** A woman may need more than one well-woman exam, i.e. prenatal visits are covered as a well-woman exam.*

7. Benefits/Coverage (What is Covered)

RADIOLOGY/X-RAY DIAGNOSTIC AND THERAPEUTIC SERVICES

All medically necessary radiology and X-ray tests, diagnostic services and materials prescribed by a licensed provider are covered, including diagnostic and therapeutic X-rays, CT and isotopes.

In-Network:	100% covered.
Out-of-network:	Not covered.

Radiation Therapy:

In-Network:	$10 copay per visit.
Out-of-network:	Not covered.

MRI and PET Scans:

In-Network:	$150 copay per visit.
Out-of-network:	Not covered.

Prior authorization required for MRI and PET Scans.

RENAL DIALYSIS

Renal dialysis is covered if provided at an authorized facility.

In-Network:	100% covered.
Out-of-network:	Not covered.

SKILLED NURSING FACILITY/ EXTENDED CARE SERVICES

Extended care services at authorized skilled nursing facilities are covered. Covered services include skilled nursing care, bed and board, physical therapy, occupational therapy, speech therapy, respiratory therapy, medical social services, prescribed drugs, medications, medical supplies and equipment and other services ordinarily furnished by the skilled nursing facility. Prior authorization is required.

In-Network:	100% covered.
Out-of-network:	Not covered.

Benefit Maximum: 100 days per plan year.

SLEEP STUDIES

Covered if provided at a network facility or in home.

In-Network:	$150 copay per visit.
Out-of-network:	Not covered.

SMOKING CESSATION

Talk to your primary care provider about smoking cessation. The Colorado Quitline has tools and resources to help including counseling and nicotine replacement such as patches or gum. You can contact the Colorado Quitline at 1-800-QUIT-NOW. Formulary smoking cessation drugs including Chantix, the generic form of Zyban, nicotine patches, gum and lozenges are all available and are 100% covered. You also have access to a Health Coach who can assist and support you through the process. For more information, contact Health Plan Services at 303-602-2100.

SUBSTANCE ABUSE SERVICES

Drug and Alcohol Abuse - Detoxification

Emergency medical detoxification is limited to the removal of the toxic substance or substances from your system, including diagnosis, evaluation and emergency or acute medical care. In the event of an emergency, you should notify DHMP as soon as reasonably possible, preferably within one business day.

In-Network:	$400 copay per admission.
Out-of-network:	Not covered except for emergencies.

Inpatient Substance Abuse Rehabilitation

Your admission and treatment must be at an in-network facility and prior authorization is required.

In-Network:	$400 copay per admission.
Out-of-network:	Not covered except for emergencies.

Exclusions: Maintenance, residential care or aftercare following a rehabilitation program.

Outpatient Substance Abuse Services

Substance abuse services that are provided to members who are living at home and receiving services at a network facility on an outpatient basis are covered. Members may self refer in network.

In-Network:	$10 copay per visit whether an individual or group visit at Denver Health ($25 copay per visit for Cofinity provider).
Out-of-network:	Not covered.

Note: Court ordered mental health services are covered. Applicable cost sharing will apply.

SURGERY SERVICES

Inpatient Surgery

Surgery and anesthesia in conjunction with a covered inpatient stay are covered.

In-Network:	$400 copay per admission, except for transplants.
Out-of-network:	Not covered.

Outpatient Surgery

Surgical services at a DHMP network hospital, outpatient surgical facility, or a physician's office are covered, including the services of a surgical assistant and anesthesiologist. Services may require prior authorization by DHMP.

In-Network:	$200 copay per visit.
Out-of-network:	Not covered.

7. Benefits/Coverage (What is Covered)

Oral/Dental Surgery

Oral/dental surgical services are covered when such services are associated with the following: emergency treatment following the occurrence of injury to the jaw or mouth (no follow-up dental restoration procedures are covered); treatment for tumors of the mouth; treatment of congenital conditions of the jaw that may be significantly detrimental to the member's physical condition because of inadequate nutrition or respiration; cleft lip, cleft palate or a resulting condition or illness.

General anesthesia for dental care, as well as related hospital and facility charges, are covered for a dependent child if:

» The child has a physical, mental, or medically compromising condition: or

» The child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or

» The child is an extremely uncooperative, unmanageable, anxious, or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred; or

» The child has sustained extensive orofacial and dental trauma.

General anesthesia for dependent dental care must be prior authorized by DHMP and must be performed by a network anesthesiologist in a network hospital, outpatient surgical facility or other licensed health care facility for surgery performed by a dentist qualified in pediatric dentistry.

With regard to children born with cleft lip or cleft palate or both, see Newborn Care.

Exclusions: Dental services not described above; dental ancillary services; occlusal splints; overbite or underbite; osteotomies; TemporoMandibular Joint (TMJ) services (except as a result of trauma or fracture); hard or soft tissue surgery; maxillary, mandibular or other orthogenic conditions, unless certified by a participating provider as medically necessary as a result of trauma.

The following services for TMJ may be covered if a network physician determines ther are medically necessary: diagnostic x-rays, lab testing, physical therapy and surgery.

Breast Surgery

The Plan provides coverage for medically necessary mastectomies, lumpectomies and the physical complications of mastectomies, including lymphedemas. Breast reconstruction of the affected and non-affected side, by a network provider, as well as internal prosthetic devices are covered if prior authorized by DHMP. Medically necessary breast reduction is covered when prior authorized by DHMP. External prosthetic devices following medically necessary mastectomy or lumpectomies are covered according to criteria for durable medical equipment (DME).

Reconstructive Surgery

Reconstructive surgery, to restore anatomical function of the body from a loss due to illness or injury, when determined to be medically necessary by a participating primary care provider and prior authorized by the Utilization Management, is covered.

Transplants

Corneal, kidney, kidney-pancreas, heart, lung, heart-lung, and liver transplants and bone marrow transplants for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, Wiskott-Aldrich syndrome, neuroblastoma, high-risk Stage II and III breast cancer and lymphoma are covered. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants. Transplants must be non-experimental, meet protocol criteria and be prior authorized by the DHMP Utilization Management Department.

Benefits include the directly related, reasonable medical and hospital expenses of a donor. Coverage is limited to transplant services provided to the donor and/or recipient only when the recipient is a DHMP member.

Transplant services must be provided at an approved facility. DHMP does not assume responsibility for the furnishing of donors, organs or facility capacity.

In-Network:	$400 copay per admission.
Out-of-network:	Not covered.

TELEHEALTH

Telehealth services are a covered benefit under this plan when services are appropriately provided. There is no requirement to access care through telehealth services. Cost sharing is the same as "in person" care for specific service. For instance, if you see a mental health provider for telehealth services, the cost sharing is the same as if you access care with a mental health provider in person. No prior authorization is required. Health care services via telephone, facsimile machine, or electronic mail systems do not qualify as "telehealth" services.

THERAPIES

Habilitative Services

Medically necessary physical therapy, occupational therapy and speech therapy for services that help a person retain, learn or improve skills and functioning for daily living.

In-Network:	$10 copay per visit.
Out-of-network:	Not covered.

Benefit Maximum: 20 visits per plan year for each of physical therapy, occupational therapy and speech therapy to learn skills for the first time or maintain current skills. Benefit limit per type of therapy is a combined total of visits in both HighPoint and Cofinity.

7. Benefits/Coverage (What is Covered)

Rehabilitative Services

Physical therapy, occupational therapy and speech therapy will be authorized only until maximum medical improvement is reached or the annual benefit is exhausted, whichever comes first. However, early intervention services for children up to age 3 with developmental delays are covered without regard to maximum medical improvement. See "Early Intervention Services."

In-Network:	$10 copay per visit.
Out-of-network:	Not covered.

Benefit Maximum: 20 visits per plan year for each of physical therapy, occupational therapy and speech therapy to learn skills for the first time or maintain current skills. Benefit limit per type of therapy is a combined total of visits in both HighPoint and Cofinity.

Cardiac Rehabilitation

Treatment in a cardiac rehabilitation program is provided if prescribed or recommended by a Plan Physician and provided by therapists at designated facilities.

In-Network:	$10 copay per visit.
Out-of-network:	Not covered.

Benefit Maximum: 20 visits per plan year. Benefit limit per type of therapy is a combined total of visits in both HighPoint and Cofinity.

Pulmonary Rehabilitation

Treatment in a pulmonary rehabilitation program is provided if prescribed or recommended by a Plan Physician and provided by therapists at designated facilities.

In-Network:	$10 copay per visit.
Out-of-network:	Not covered.

Benefit Maximum: 20 visits per plan year. Benefit limit per type of therapy is a combined total of visits in both HighPoint and Cofinity.

8. Limitations and Exclusions (What is Not Covered)

All accommodations, care, services, equipment, medication, or supplies furnished for the following are expressly excluded from coverage (regardless of medical necessity).

NON-NETWORK PROVIDERS

Services provided by a hospital, pharmacy or other facility or by a physician, or other provider not participating in the DHMP network are not covered unless they are:

» Provided under prior written referral by a participating primary care provider and prior authorized by the Utilization Management department or;

» Provided in an Emergency or urgent circumstance, and notification is made to the Utilization Management department as soon as reasonably possible, preferably within 1 business day.

GENERAL EXCLUSIONS

The following services and supplies are excluded from coverage under this Plan:

» **Abortions:** Elective abortions are not covered.

» **Acupuncture**

» **Adaptive Equipment/Corrective Appliances:** Adaptation to telephone for the deaf; replacement of artificial eyes if lost, stolen or damaged; reading aids, vision enhancement devices; wheelchair ramps; home remodeling or installation of bathroom equipment; prosthetic devices (except for artificial limbs and breast prostheses).

» **Ambulance Services:** Ambulance service for non-emergency care or transportation except as requested by DHMP.

» **Artificial Hair:** Wigs, artificial hairpieces, hair transplants or implants, even if there is a medical reason for hair loss.

» **Care Not Medically Necessary:** Medical care, procedures, equipment, supplies, and/or pharmaceuticals that are not consistent with generally accepted principles of professional medical practice, as determined by whether or not: (1) the service is the most appropriate available supply or level of service for the insured in question, considering potential benefits and harms to the individual; (2) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; (3) for services and interventions not in widespread use, is based on scientific evidence.

» **Comfort and Convenience Items:** Personal comfort or convenience items or services obtained or rendered in or out of a hospital or other facility, such as television, telephone, guest meals, articles for personal hygiene, and any other similar incidental services and supplies.

» **Cosmetic and Reconstructive Surgery:** Elective cosmetic and reconstructive surgeries or procedures that are only performed to improve or preserve physical appearance.

» **Criminal Exclusions:** A medical treatment for accidental bodily injury or sickness resulting from or occurring during the member's commission of a crime, except for a crime defined 18 and under 18-102(5) C.R.S.

» **Dental Services:** Dental services; dental ancillary services; occlusal splints; overbite or underbite; osteotomies; TMJ (except as a result of trauma or fracture); hard or soft tissue surgery; maxillary, mandibular or other orthogenic conditions unless certified by a participating primary care practitioner (primary care provider) as medically necessary as a result of trauma. The following services for TMJ may be covered if a network physician determines they are medically necessary: diagnostic x-rays, lab testing, physical therapy and surgery.

» **Disability/Insurance Physicals:** Coverage for physicals to determine or evaluate a member's health for enrollment in another insurance is excluded from coverage.

» **Drugs/Medications:** Non-formulary drugs and/or drugs that require prior authorization if prior authorization is not received.

» **Durable Medical Equipment:** Humidifiers, air conditioners, exercise equipment, whirlpools, health spa or club are excluded whether or not prescribed by a physician.

» **Enzyme Infusions:** Therapies for chronic metabolic disorders.

» **Employment Exams:** Physical examinations for purposes of employment or employment-required annual examinations (e.g., D.O.T. exams) are excluded from coverage.

» **Excluded drugs and drug classes for the prescription drug benefit:** Some drugs are not covered at all. These include drugs for the following: cosmetic use (anti-wrinkle, hair removal, and hair growth products), dietary supplements, blood or blood plasma (anti-hemophilic factor VIII and IX are covered), infertility, over-the-counter drugs (unless listed in the formulary), pigmenting/de-pigmenting, therapeutic devices or appliances (unless listed in the formulary), prescription vitamins (unless listed in the formulary), investigational or experimental treatments.

» **Experimental Procedures and Drugs:** Medical care, procedures, equipment, supplies, and/or pharmaceutics determined by DHMP to be experimental, investigational, or not generally accepted in the medical community are not covered. This means any medical procedure,

equipment, treatment or course of treatment, or drugs or medicines that are considered to be unsafe, experimental, or investigational. This is determined by formal or informal studies, opinions and references to or by the American Medical Association, the Food and Drug Administration, the Department of Health and Human Services, the National Institutes of Health, the Council of Medical Specialty Societies, experts in the field, and any other association or federal program or agency that has the authority to approve medical testing, treatment, or pharmaceutical drug efficacy and appropriateness.

- **Extended Care:** Sanitarium, custodial or respite care (except as provided under Hospice Services), maintenance care, chronic care and private duty nursing.
- **Eyewear:** Glasses, contacts, all eyewear except as noted in specific plan benefits.
- **Family Planning and Infertility:** This plan has no covered benefit for infertility, including but not limited to: reversal of voluntarily induced infertility (sterilization); procedures considered to be experimental; in vitro fertilization; the Gamete Intrafallopian Transfer (GIFT); surrogate parents; drug therapy for infertility and the cost of services related to each of these procedures; the cost related to donor sperm (collection, preparation, storage etc.).
- **Gender Reassignment:** The following procedures are considered cosmetic when used to improve the gender specific appearance of an individual who has undergone or is planning to undergo gender reassignment surgery, including, but not limited to: abdominoplasty, blepharoplasty, breast augmentation, brow lift, calf implants, electrolysis, face lift, facial bone reconstruction, facial implants, gluteal augmentation, hair removal/hairplasty (except to treat tissue donor sites for a planned phalloplasty or vaginoplasty procedure), jaw reduction/contouring, lip reduction/enhancement, lipofilling/collagen injections, liposuction, nose implants, pectoral implants, rhinoplasty, thyroid cartilage reduction (chondroplasty), voice modification surgery, voice therapy.
- **Governmental Facilities:** Services or items for which payment is made by or available from the federal or any state government or agency or subdivision of these entities; services or items for which a DHMP member has no legal obligation to pay.
- **Infertility Services:** Artificial insemination, reversal of voluntarily induced infertility (sterilization), procedures considered to be experimental, invitro fertilization, the Gamete Intrafallopian Transfer (GIFT) procedure, drug therapy for infertility, the costs for services related to each of these excluded procedures, the costs related to sperm collection, preparation, and/or storage for members not actually seeking active treatment for infertility utilizing this assisted reproductive technology, the costs related to sperm collection from non-DHMP members.
- **Learning and Behavior Problems:** Special education, counseling, therapy or care for learning disabilities or behavioral problems, whether or not associated with a manifest mental disorder, retardation or other disturbance.
- **Long-term, Non-structured Treatment Centers**
- **Massage Therapy**
- **Maternity Care:** Home deliveries; scheduled, non-medically necessary Cesarean sections.
- **Medical Food:** Food products for cystic fibrosis or lactose or soy intolerance or other food allergies.
- **Neurostimulators:** Replacements or repairs, including batteries.
- **Obesity:** Maximum on surgical treatment of morbid obesity of once per lifetime. Commercial weight loss programs or exercise programs are not covered benefits although discount programs may be available.
- **Optometric Vision Therapy/Treatment:** Individualized treatment regimen prescribed in order to provide medically necessary treatment for diagnosed visual dysfunctions, prevent the development of visual problems, or enhance visual performance to meet defined needs of the patient. Optometric vision therapy includes visual conditions such as strabismus, amblyopia, accommodative dysfunctions, ocular motor dysfunctions, visual motor disorders, and visual perceptual (visual information processing) disorders.
- **Orthotics:** Corrective shoes and orthotic devices for podiatric use and arch supports. Dental devices and appliances except that Medically Necessary treatment of cleft lip or cleft palate for newborn members is covered when prescribed by a network provider. Experimental and research braces. More than one orthotic device for the same part of the body, except for replacements; spare devices or alternate use devices. Replacement of lost orthotic devices. Repairs, adjustments or replacements necessitated by misuse.
- **Other Providers:** Services provided by acupuncturists, massage therapists, faith healers, palm readers, physiologists, naturopaths, reflexologists, rolfers, iridologists, or other alternative health practitioners.
- **Over-the-Counter Drugs:** Over-the-counter drugs (except as required by law), nutritional supplements or diets, and over-the-counter medical supplies (except insulin and diabetic testing supplies) are

not covered. This includes vitamins, minerals or special diets, even if prescribed by a physician (except medical food for children with inherited enzymatic disorders) with the exception of formulary prescription items such as electrolytes, certain vitamins and minerals listed in the Denver Health Medical Plan formulary.

- **Paternity Testing**
- **Pet Therapy**
- **Plastic Surgery:** Plastic surgery for cosmetic purposes; removal of tattoos and scars; chemical peels or skin abrasion for acne.
- **Prosthetic Devices:** Dental prostheses, except for Medically Necessary prosthodontic treatment for treatment of cleft lip and cleft palate in newborn members, as described above. Internally implanted devices, equipment and prosthetics related to treatment of sexual dysfunction. More than one prosthetic device for the same part of the body, except for replacements; spare devices or alternate use devices. Replacement of lost prosthetic devices. Repairs, adjustments or replacements necessitated by misuse.
- **Psychological Testing Required by a Third Party:** Psychological testing required by a third party; educational or occupational testing or counseling; vocational or religious counseling; developmental disorders such as reading, arithmetic, language or articulation disorders; IQ testing.
- **Refractive Surgery:** Vision correction surgery such as Lasik. Except as noted in specific plan benefits.
- **Transplants:** Organ transplants not listed in Overview of Covered Services; donor-related expenses for DHMP members who are donating to an individual who is not a DHMP member.
- **Vocational Rehabilitation:** Vocational rehabilitation, services related to screening exam or immunizations given primarily for insurance, licensing, employment, weight reduction programs, or for any other non-preventive purpose.
- **Work-Related Injury or Illness:** Charges for services and supplies (including Return to Work exams) resulting from a work-related illness or injury, including expenses resulting from occupational illnesses or accidents covered under workers' compensation, employers' liability, municipal, state or federal law or occupational disease laws except for members who are not required to maintain or be covered by workers' compensation insurance as defined by Colorado workers' compensation laws.

9. Member Payment Responsibility

ABOUT YOUR MEDICAL BENEFITS

All services covered by DHMP must satisfy certain basic requirements. The services you seek must be medically necessary, you must use DHMP network providers, the services cannot exceed benefit maximums, and the services must be appropriate for the illness or injury. These requirements are commonly included in health benefit plans but are often not well understood or are simply overlooked. By communicating with your primary care provider and allowing your primary care provider to manage your care, these requirements will be met and will help to ensure that you receive medically necessary covered services.

AN "ALLOWED" AMOUNT

DHMP negotiates a discount with each provider in our network.You have the advantage of this discount (allowed amount) and will never pay more than our negotiated price.

A "BILLED" AMOUNT

This is what the provider bills for a service you received. These are "full" charges and the discount DHMP negotiated has not been applied yet.

COPAYMENTS

A copayment (or copay) is a predetermined amount, sometimes stated as a percentage and sometimes stated as a fixed dollar amount that you are required to pay to receive a covered service. Copayments are paid directly by you to the provider. For applicable copayments, see the Summary of Benefits table at the beginning of this handbook. You are responsible for all expenses incurred for non-covered services.

BENEFIT MAXIMUMS

Benefit maximums are the limits set by DHMP on the number of visits per plan year or services per lifetime.

COINSURANCE

The charge, stated as a percentage of Eligible Expenses that you are required to pay for certain Covered Health Services after applicable deductibles are met. This amount will apply to your out-of-pocket maximum.

DEDUCTIBLES

The amount you owe for medical services BEFORE your health insurance plan pays.You will pay the full deductible amount toward medical expenses before your health plan pays anything. In a HDHP the deductible will also apply to pharmacy costs. Once you meet the applicable deductible, your plan will start to cover your expenses based on your list of benefits.

OUT-OF-POCKET COSTS

What you pay for medical expenses that aren't paid back by your health insurance plan.Your out-of-pocket costs include deductibles, copays, and coinsurance for health care services. In other words, any costs you personally pay for covered medical or pharmacy services.

OUT-OF-POCKET MAXIMUM

The MOST you pay out during a policy period (one plan year) before your health insurance plan PAYS 100% for your covered health insurance benefits.This limit includes the TOTAL of your deductible, coinsurance and copays. This DOES NOT include your monthly premiums. In a HDHP, the individual out-of-pocket maximum does not apply to a family plan.

10. Claims Procedure (How to File a Claim)

HOW TO FILE A CLAIM

For Medical Service

When you receive health care services, you must show your provider your identification card. Your identification card gives your provider important information about your benefits, cost sharing, and where to call for prior authorizations, and tells them how they can bill DHMP for the care you receive.

In most cases, your provider will bill DHMP directly for the services you receive. You are responsible for any coinsurance or deductible, if applicable, and should pay them directly to your provider.

There are situations in which you may need to file a claim for care you receive. If you receive emergency or urgent care from a provider outside of the DHMP network, you may be asked to pay the entire bill or a portion of the bill at the time of service. You may be required to pay the entire amount to the provider at the time of service. DHMP will reimburse you up to the limits noted in Summary of Benefits. If you are required to pay at the time of service, mail your receipt, including your name, home mailing address and member ID number to the following address:

Denver Health Medical Plan
Attn: Claims Department
P.O. Box 24992
Seattle, WA 98124-0992

DHMP will mail a reimbursement check to the subscriber's home address, in the amount eligible up to the benefit maximum. Claims submitted later than 120 days after the date of service may be denied due to late filing.

Authorized claims that were part of a utilization management review, will be paid within 30 days of receipt.

If you want your reimbursement to be paid directly to another party, please provide a signed authorization with the claim form or bill that you submit. If conditions exist under which a valid release or assignment of benefits cannot be obtained, DHMP may make payment to any individual or organization that has assumed care or principal support for the member. DHMP may honor benefit assignments made prior to the member's death with regard to remaining benefits payable by DHMP. Payments made in accordance with an assignment are made in good faith and release DHMP from further obligation for payments due.

For Pharmacy Service

Present your DHMP identification card at any network pharmacy when you have your prescriptions filled. You are responsible for paying the pharmacy cost sharing. If you are out of the network area and cannot locate a network pharmacy, please call the Health Plan Services Department at 303-602-2100 or toll-free at 1-800-700-8140 for information on how to get your prescription filled.

Claims Investigation

If you have questions or concerns about how a claim is settled, please call the Health Plan Services Department at 303-602-2100 or toll-free at 1-800-700-8140 , TTY users should call 711. If you disagree with the manner in which DHMP has settled a claim, or if you disagree with a denial of a claim payment, you may file a written or verbal grievance. See Attachment A at the back of the handbook for a copy of this form. You may also obtain a grievance form, or if you wish, give DHMP the details of your disagreement over the telephone by calling 303-602-2100 or toll-free at 1-800-700-8140 . You may also write to:

DHMP
Attention: Grievance Coordinator
777 Bannock St., Mail Code 6000
Denver, CO 80204

If you are appealing a claim that was denied due to lack of medical necessity or prior authorization, denial of prior authorization, or experimental status, please see Appeals and Complaints (Grievances) section.

Claims Timeframes

» Claims will be paid in a timely manner:

» Electronic claims within 30 days

» Paper claims within 45 days

» All claims within 90 days

Claims Fraud

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

COORDINATION OF BENEFITS

Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and chose to have family coverage through both employers.

When you are covered by more than one group health plan, state law permits each group health plan to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The aim is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

10. Claims Procedure (How to File a Claim)

Coordination of Benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones.

Primary or Secondary?

You will be asked to identify all the plans that cover family members. We need this information to determine whether we are "primary" or "secondary." The primary plan always pays first. Any plan that does not contain your state's coordination of benefits rules will always be primary.

When This Plan Is Primary

If you are a family member covered under another plan in addition to this one, we will be primary when:

Your Own Expense

» The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired.

Your Spouse's Expense

» The claim is for your spouse, who is covered by Medicare, and you are not both retired.

Your Child's Expense

» The claim is for the health care expenses of a child covered by this plan and

» Your birthday is earlier in the year than your spouse's. This is known as the "birthday rule"; or

» You have informed us of a court decree that makes you responsible for the child health care expenses; or

» There is no court decree but you have parental responsibility of the child.

Other Situations

We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary

When we are the primary plan, we will pay the benefits provided by your contract, just as if you had no other coverage.

How We Pay Claims When We are Secondary

We will be secondary whenever the rules do not require us to be primary.

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part of all of the allowable expenses left unpaid. An "allowable expense" is a health care service or expense covered by one of the plans, including deductible and coinsurance.

» If there is a difference between the amounts the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the contract calls for. Health maintenance organizations (HMO) and preferred provider organizations (PPO) usually have contracts with their providers.

» We will determine our payment by subtracting the amount the primary plan paid from the amount we should have paid if we had been primary. We will credit any savings to a "benefit reserve" that can be used to pay the balance of any unpaid allowable expenses covered by either plan.

» If the primary plan covers similar kinds of health care, but allows expenses we do not cover, we will pay for those items as long as you have a balance in your benefit reserve.

We will not pay an amount the primary plan didn't cover because you didn't follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain pre-certification, we will not pay the amount of the reduction, because it is not an allowable expense.

Coordination of benefits applies when you have automobile insurance with medical payment coverage. Medical payment coverage is always primary to this Plan when you are injured in an automobile accident. Medical payment coverage can also be used to pay any cost sharing amounts that you may be required to pay under this Plan. If you are covered by more than one plan, fill out the Coordination of Benefits form at denverhealthmedicalplan.org/coordination-benefits and fax or mail to us.

WHEN ANOTHER PARTY CAUSES YOUR INJURIES OR ILLNESS

Your injuries or illness may be caused by another party. The party who caused your injury or illness ("liable party") could be another driver, your employer, a store, a restaurant, or someone else. If another party causes your injury or illness, you agree that:

» DHMP may collect paid benefits directly from the liable party, the liable party's insurance company, and from any other person, business, or insurance company obligated to provide benefits or payments to you including your own insurance company if you have other coverage.

» You will tell DHMP, within 30 days of your becoming injured or ill:

  » *If another party caused your injury or illness.*

  » *The names of the liable party and that party's insurance company.*

  » *The name of your own insurance company if you have other coverage for your injury or illness.*

  » *The name of any lawyer that you hired to help you collect your claim from a liable party.*

  » *You or your lawyer will notify the liable party's*

insurance company, and your own insurance company, that DHMP is paying your medical bills.

- The insurance company must contact DHMP to discuss payment.
- The insurance company must pay DHMP before it pays you or your lawyer.
- Neither you nor your lawyer will collect any money from an insurance company until after DHMP is paid in full. This applies even if the insurance money to be paid is referred to as damages for pain and suffering, lost wages, or other damages.
- If an insurance company pays you or your lawyer and not DHMP, you or your lawyer will reimburse DHMP up to the amount of benefits paid out. DHMP will not pay your lawyer any attorney's fees or costs for collecting the insurance money.
- DHMP will have an automatic subrogation lien, and direct right of reimbursement, against any insurance money that is owed to you by an insurance company, or that has been paid to your lawyer. DHMP may notify other parties of its lien and direct right of reimbursement.
- DHMP may give an insurance company and your lawyer any DHMP records necessary for collection. If asked, you agree to sign a release allowing DHMP records to be provided to an insurance company and your lawyer. If asked, you agree to sign any other papers that will help DHMP collect money due.
- You and your lawyer will give DHMP any information requested about your claim against the liable party.
- You and your lawyer will notify DHMP of any dealings with, or lawsuits against, the liable party.
- You and your lawyer will not do anything to hurt the ability of DHMP to collect paid benefits from the liable party or an insurance company.
- You will owe DHMP any money that the Plan is unable to collect because of your, or your lawyer's, lack of help or interference. You agree to pay to DHMP any attorney's fees and costs that the Plan must pay in order to collect this money from you.
- DHMP will not pay any medical bills that should have been paid by another party or insurance company.

If you have questions, please call our Health Plan Services Department at 303-602-2100.

DISCLOSURE OF HEALTH AND BILLING INFORMATION TO THIRD-PARTIES

DHMP may disclose your health and billing information to third parties for the adjudication and subrogation of health benefit claims. This includes providing DHMP's claim processing records, provider billing records, and member's medical records to a third party and that third party's legal representatives and insurers for the purpose of determining the third party's liability and coverage of the member's medical expenses.

VENUE

Any action brought by the member or DHMP to interpret or enforce the terms of this Plan will be brought in the District Court for the City and County of Denver, State of Colorado. The prevailing party in any such action will be awarded its reasonable attorney's fees and court costs.

PRIVACY/HIPAA INFORMATION

Confidential Information

DHMP is committed to protecting your privacy. All patient information is kept confidential. In addition, we will not discuss any of your Protected Health Information (PHI) with anyone other than yourself without approval. If you'd like for us to discuss your information with another family member, you will need to fill out the Designation of Personal Representative (DPR) form (see Attachment B in your handbook). Your handbook can be accessed on our website at denverhealthmedicalplan.org, or you may call Health Plan Services at 303-602-2100 and request a hard copy be mailed to you.

Also, complete privacy information is available on our website at denverhealthmedicalplan.org, or you may call Health Plan Services and request it be mailed to you.

Original Effective Date: April 14, 2003.

Revised Effective Date: September 23, 2013.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Denver Health Medical Plan, Inc. (DHMP) and Denver Health Medicaid Choice (DHMC), hereinafter referred to collectively as the "Company," respects the privacy of your health information and will protect your information in a responsible and professional manner. We are required by law to maintain the privacy of your health information and to send you this notice.

This notice explains how we use information about you and when we can share that information with others. It also informs you of your rights with respect to your health information and how you can exercise those rights.

When we talk about "information" or "personal health information" in this notice, we mean personal information that may identify you or that relates to health care services provided to you; the payment of health care services provided to you; or your past, present, or future physical or mental health.

We are required to follow the terms of this notice until it is replaced. We reserve the right to change the terms of this notice and to make the new notice effective for all protected health information we maintain. Once revised, the new notice will be available upon request, on our website at denverhealthmedicalplan.org, or we can mail a copy to you.

Our Uses and Disclosures:

Federal law allows us to use or share protected health information for the purposes of treatment, payment, and health care operations without your authorization.

The following are ways we may use or share information about you:

- To pay for your health services and make sure your medical bills sent to us for payment are handled the right way.
- To help your doctors or hospitals provide medical care to you.
- To help manage the health care treatment you receive.
- To conduct health care operations such as: quality assessment and improvement activities; care coordination; and underwriting or premium rating.
- With others who conduct our business operations. For example, consultants who provide legal, actuarial, or auditing services, or collection activities. We will not share your information with these outside groups unless they agree to keep it protected.
- For certain types of public health or disaster relief efforts.
- To give you information about alternative health care treatments, services, and programs you may be interested in, such as a weight-loss program.
- With the plan sponsor employer as necessary for plan administration.

We will not share detailed health information with your health benefit Plan Sponsor for employment or other benefit related decisions. We will never share your genetic information for underwriting purposes.

State and Federal Laws Pertaining to Personal Health Information

There are also state and federal laws that may require us to use or share your health information without your authorization. For example, we may use or share protected health information as follows:

- If you are injured or unconscious, we may share PHI with your family or friends to ensure you get the care you need and talk about how the care will be paid for.
- To a personal representative designated by you or by law.
- To state and federal agencies that regulate us, such as the US Department of Health and Human Services, Colorado Division of Insurance, Colorado Department of Public Health and Environment, and the Colorado Department of Health Care Policy and Financing.

- For public health activities. This may include reporting disease outbreaks or helping with product recalls.
- To public health agencies if we believe there is a serious health or safety threat.
- With a health oversight agency for certain oversight activities, such as: audits, inspections, licensure, and disciplinary actions.
- To a court or administrative agency, for example, pursuant to a court order or search warrant.
- For law enforcement purposes or with a law enforcement official.
- To a government authority regarding child abuse, neglect, or domestic violence.
- To respond to organ and tissue donation requests and work with a funeral director or medical examiner.
- For special government functions, such as for national safety.
- For job-related injuries because of state workers' compensation laws.

The examples above are not provided as an all-inclusive list of how we may use or share information. They are provided to describe in general the ways in which we may use or share your information.

Other uses and Disclosures of Health Information:

If one of the above reasons does not apply, we must get your written permission (or authorization) to use or share your health information. Upon authorization, PHI will be used or disclosed only in the manner authorized by you. If you give us written permission and later change your mind, you may revoke the authorization at any time by providing us with written notice of your desire to revoke the authorization. We will honor a request to revoke as of the day it is received and to the extent that we have not already used or shared information in good faith with the authorization.

We will also not use or disclose your health information for the following purposes without your specific, written Authorization.

- For our marketing purposes. This does not including face-to-face communication about products or services that may be of benefit to you and about prescriptions you have already been prescribed.
- For the purpose of selling your health information. We may receive payment for sharing your information for, as an example, public health purposes, research and releases to you or others you authorize as long as payment is reasonable and related to the cost of providing your health information.
- For fundraising. We may contact you for fundraising campaigns. Please notify us if you do not wish to be contacted during fundraising campaigns. If you advise us in writing that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

Your Rights Regarding Personal Health Information

The following are your rights with respect to your health information. If you would like to exercise the following rights, please contact the Privacy Officer by telephone at 303-602-2004, fax at 303-602-2074, and via email at privacyofficerdhmp@dhha.org, Monday through Friday between the hours of 8 a.m. and 5 p.m., or by US mail at or walk-in at Denver Health Medical Plan, Inc. Attn: Privacy Officer at 938 Bannock Street, Mail Code 6000, Denver, CO 80204.

- You have the right to ask us to restrict how we use or disclose your information for treatment, payment, or health care operations. You also have the right to ask us to restrict information that we have been asked to give to family members or to others who are involved in your health care or payment for your health care. Any such request must be made in writing to our Privacy Officer, and must state the specific restriction requested and to whom that restriction would apply.

Please note that while we will try to honor your request, we are not required to agree to a restriction. If we do agree, we may not violate that restriction except as necessary to allow the provision of emergency medical care to you or as may be required by law.

We are required to agree to your request for a restriction if you pay for treatment, services, supplies and prescriptions "out of pocket" and you request the information not be communicated to your health plan for payment or health care operations.

- You have the right to ask to receive confidential communications of information. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not. Any such request must be made in writing to the Privacy Officer.
- You have the right to inspect and obtain a copy of information that we maintain about you. You have the right to obtain such information in an electronic format and you may direct us to send a copy directly to your designee, provided we receive a clear and specific written request to do so.

However, you do not have the right to access certain types of information and we may decide not to provide you with copies of information:

- Contained in psychotherapy notes (which may, but are not likely to, come into our possession);

» Compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding; and

» Subject to certain federal laws governing biological products and clinical laboratories.

In certain other situations, we may deny your request to inspect or obtain a copy of your information. If we deny your request, we will notify you in writing and may provide you with a right to have the denial reviewed.

» You have the right to ask us to make changes to information we maintain about you. These changes are known as amendments. Your request must be made in writing to the Privacy Officer, and you must provide a reason for your request. We will respond to your request no later than 60 days after we receive it. If we are unable to act within 60 days, we may extend that time by no more than an additional 30 days. If we need to extend this time, we will notify you of the delay and the date by which we will complete action on your request.

If we make the amendment, we will notify you that it was made. In addition, we will provide the amendment to any person that we know has received your health information from us. We will also provide the amendment to other persons identified by you.

If we deny your request to amend, we will notify you in writing of the reason for the denial. Reasons may include that the information was not created by us, is not part of the designated record set, is not information that is available for inspection, or that the information is accurate and complete. The denial will explain your right to file a written statement of disagreement. We have a right to respond to your statement. However, you have the right to request that your written request, our written denial, and your statement of disagreement be included with your information for any future disclosures.

» You have the right to receive an accounting of certain disclosures of your information made by us during the six years prior to your request. We are not required to provide you with an accounting of the following:

1. Any information collected prior to April 14, 2003;
2. Information disclosed or used for treatment, payment, and health care operations purposes;
3. Information disclosed to you or pursuant to your authorization;
4. Information that is incident to a use or disclosure otherwise permitted;
5. Information disclosed for a facility's directory or to persons involved in your care or other notification purposes;
6. Information disclosed for national security or intelligence purposes;
7. Information disclosed to correctional institutions, law enforcement officials, or health oversight agencies;
8. Information that was disclosed or used as part of a limited data set for research, public health, or health care operations purposes.

Your request must be made in writing to the Privacy Officer. We will act on your request for an accounting within 60 days. We may need additional time to act on your request. If so, we may take up to an additional 30 days. Your first accounting will be free. We will continue to provide you with one free accounting upon request every 12 months. If you request an additional accounting within 12 months of receiving your free accounting, we may charge you a fee. We will inform you in advance of the fee and provide you with an opportunity to withdraw or modify your request.

Please be advised that oral, written, and electronic PHI is protected internally. In the case of a breach, we have a duty to notify affected individuals of a breach of PHI.

Please be advised that oral, written, and electronic PHI is protected internally. In the case of a breach, we have a duty to notify affected individuals of a breach of PHI. We protect PHI by locking sensitive information away in a safe place, adhering to confidentiality rules and not discussing personal and sensitive information while in personal and common areas, and lastly, our internal computers systems will be automatically encrypting all emails that contain PHI. You have a right to receive a copy of this notice upon request at any time. Requests for a copy of this notice should be directed to the Privacy Officer.

Questions or Complaints

If you have any questions about this notice, how we use or share information, or if you believe your privacy rights have been violated, please contact the Privacy Officer at 303-602-2004, fax at 303-602-2074, or via email at privacyofficerdhmp@dhha.org, Monday through Friday between the hours of 8 a.m. and 5 p.m. You may also contact us by US mail at Denver Health Medical Plan, Inc. Attn: Privacy Officer at 938 Bannock Street, Mail Code 6000, Denver, CO 80204.
You can file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights, 200 Independence Avenue S.W., Washington, D.C. 20201 or by calling (877) 696-6775. We will not take any action against you for filing a complaint.

MEMBER RIGHTS AND RESPONSIBILITIES

As an DHMP member you are entitled to certain rights under federal law.

Member's Rights:

Members have the right to:

11. General Policy Provisions

- Have access to practitioners and staff who are committed to providing quality health care to all members without regard for race, religion, color, creed, national origin, age, sex, sexual preference, political party, disability, or participation in a publicly financed program.
- Receive medical/behavioral health care that is based on objective scientific evidence and human relationships. A partnership based on trust, respect, and cooperation among the provider, the staff and the member will result in better health care.
- Be treated with courtesy, respect, and recognition of your dignity and right to privacy.
- Receive equal and fair treatment, without regard to race, religion, color, creed, national origin, age, sex, sexual preference, political party, disability, or participation in a publicly financed program.
- Choose or change your primary care provider within the network of providers, to contact your primary care provider whenever a health problem is of concern to you and arrange for a second opinion if desired.
- Expect that your medical records and anything that you say to your provider will be treated confidentially and will not be released without your consent, except as required or allowed by law.
- Get copies of your medical records or limit access to these records, according to state and federal law;
- Ask for a second opinion, at no cost to you;
- Know the names and titles of the doctors, nurses, and other persons who provide care or services for the member.
- A candid discussion with your provider about appropriate or medically necessary treatment options for your condition regardless of cost or benefit coverage.
- A right to participate with providers in making decisions about your health care.
- Request or refuse treatment to the extent of the law and to know what the outcomes may be.
- Receive quality care and be informed of the DHMP Quality Improvement program.
- Receive information about DHMP, its services, its practitioners and providers and members' rights and responsibilities, as well as prompt notification of termination or other changes in benefits, services or the DHMP network. This includes how to get services during regular hours, emergency care, after-hours care, out-of-area care, exclusions, and limits on covered service.
- Learn more about your primary care provider and his/her qualifications, such as medical school attended or residency, go to denverhealthmedicalplan.org and click on Find a Doctor/Provider for our web based provider directory or call Health Plan Services at 303-602-2100.
- Express your opinion about DHMP or its providers to legislative bodies or the media without fear of losing health benefits.
- Receive an explanation of all consent forms or other papers DHMP or its providers ask you to sign; refuse to sign these forms until you understand them; refuse treatment and to understand the consequences of doing so; refuse to participate in research projects; cross out any part of a consent form that you do not want applied to your care; or to change your mind before undergoing a procedure for which you have already given consent.
- Instruct your providers about your wishes related to advance directives (such issues as durable power of attorney, living will or organ donation).
- Receive care at any time, 24 hours a day, 7 days a week, for emergency conditions and care within 48 hours for urgent conditions.
- Have interpreter services if you need them when getting your health care.
- Change enrollment during the times when rules and regulations allow you to make this choice.
- Have referral options that are not restricted to less than all providers in the network that are qualified to provide covered specialty services; applicable cost sharing will apply.
- Expect that referrals approved by the Plan cannot be changed after Prior authorization or retrospectively denied except for fraud, abuse or change in eligibility status at the time of service.
- Make recommendations regarding DHMP's Members' Rights and Responsibilities' policies.
- Voice a complaint about or appeal a decision concerning the DHMP organization or the care provided and receive a reply according to the grievance/appeal process.
- Receive a standing referral, from a personal provider to see a DHMP network specialty treatment center, for an illness or injury that requires ongoing care.

Member's Rights for Pregnancy and Special Needs:

- To receive family planning services from any licensed physician or clinic in the DHMP network.
- To go to any participating OB/GYN in the DHMP network without getting a referral from your primary care provider.
- To see your current non-network provider for prenatal care, until after delivery of the baby if you

become a member of DHMP during your second or third trimester. This is dependent upon the non-network provider agreeing to accept DHMP's arrangements.

» To continue to see your non-network doctor(s) or provider(s), when medically necessary, for up to 60 days after becoming a DHMP member. (Dependent upon the non-network provider accepting DHMP's arrangements for this transition.)

Member's Responsibilities:

» To treat providers and their staff with courtesy, dignity and respect.

» To pay all premiums and applicable cost sharing (i.e.. deductible, coinsurance, copays).

» To make and keep appointments, to be on time, call if you will be late or must cancel an appointment, and to have your DHMP identification card available at the time of service and pay for any charges for non-covered benefits.

» To report your symptoms and problems to your primary care provider and to ask questions, and take part in your health care.

» To learn about any procedure or treatment and to think about it before it is done.

» To think about the outcomes of refusing treatment that your primary care provider suggests.

» To follow plans and instructions for care that you have agreed upon with your provider.

» To provide, to the extent possible, correct and necessary information and records that DHMP and its providers need in order to provide care.

» To understand your health problems and participate in developing mutually agreed upon treatment goals to the degree possible.

» To state your complaints and concerns in a civil and appropriate way.

» To learn and know about plan benefits (which services are covered and non-covered) and to contact a DHMP Health Plan Services representative with any questions.

» To inform providers or a representative from DHMP when not pleased with care or service.

DHMP Records

You have the right to examine, without charge, DHMP's administrative office or other specified locations, and certain documents of the Plan, such as detailed annual reports and plan descriptions. You may obtain copies upon written request to the DHMP Director of Health Plan Services. DHMP may charge a reasonable fee for the copies. You are also entitled to receive a summary of DHMP's annual financial report.

Member Medical Records

DHMP maintains and preserves the confidentiality of any and all medical records of members in accordance with all applicable State and Federal laws, including HIPAA. In accordance with HIPAA, DHMP may use any and all of a member's medical, billing and related information for the purposes of utilization review, care management, quality review, processing of claims, processing of appeals, payment, collection and subrogation activities, financial audit and coordination of benefits, to the extent permitted by HIPAA. Members authorize DHMP's use of this type of information for health plan operations when they sign the enrollment form or approve it online. Outside of these activities, DHMP will not release any information that would directly or indirectly indicate a member is receiving or has received Covered Services, unless authorized to do so by the member or HIPAA. DHMP will advise its employees, agents, and subcontractors, if any, that they are subject to these confidentiality requirements.

Members have the right to inspect and obtain copies of their own medical records and other health information pertaining to them that is maintained by DHMP.

To make a request, call Health Plan Services at 303-602-2100 or toll-free at 1-800-700-8140 . Members also have the right to inspect and obtain copies of their medical records maintained by DHMP network providers. Please contact the individual provider for more details.

Notice of Privacy Practices

(HIPAA-Health Insurance Portability and Accountability Act of 1996)

The DHMP Notice of Privacy Practices is available on the DHMP website at denverhealthmedicalplan.org. A new notice will be provided if there is any material change in our practices. You may, at any time, obtain a copy of the notice by contacting Health Plan Services at 303-602-2100 or by calling toll-free at 1-800-700-8140 .

Administration of Covered Benefits

Under federal law, individuals responsible for the operation of DHMP must perform their duties in a careful and conscientious manner, and with the interest of all members taken into consideration. DHMP and/or its agents will professionally and consistently strive to administer the Plan in accordance with this handbook, to the specific definitions of terms used (see Definitions of Terms) and applicable state and federal laws. DHMP will assist you in obtaining the benefits for which you are eligible. No one, including your employer, a union or any other person, may fire you or discriminate against you to prevent you from obtaining any benefit under this plan or exercising your rights under law.

Agreement to the Terms in Handbook

By selecting DHMP, paying the premium, and accepting the benefits offered, all members and their legal representatives expressly agree to all terms, conditions

and provisions of the Plan outlined in this member handbook. As a member, you are required to receive covered services through the DHMP network unless otherwise directed by your primary care provider and authorized by DHMP.

Affirmative Statement about Incentives

DHMP wants to assure its membership that all covered benefits are open to its members without regard to any financial gains from reduction in utilization.

DHMP affirms the following regarding utilization management (UM) practices:

» UM decision-making is based only on appropriateness of care and services and the existence of coverage,

» Practitioners or other individuals are not rewarded for issuing denials of coverage or service of care;

» UM decision makers do not receive financial incentives to encourage decisions that result in underutilization.

Please feel free to contact DHMP at 303-602-2100 should you have questions regarding this practice.

Relationship between DHMP and network providers

All providers in the DHMP network are independent contractors. These providers are not agents or employees of DHMP. DHMP is not responsible for any claim or demand for damages arising out of, or connected with any injuries suffered by a member while that member was receiving care from a network provider or in a network provider's facility.

Statement of Appropriate Care

The staff and providers of DHMP make treatment decisions based only on the appropriateness of care and services. DHMP subscribes to the following policies:

» DHMP does not reward staff or providers for issuing denials.

» DHMP does not offer incentives to encourage under utilization.

» DHMP participates in a national pharmacy benefit management program that makes drug rebate programs available to participating health plans.

If you feel that a DHMP representative or network provider has violated any of the above principles, you can contact the Health Plan Services department at 303-602-2100 or toll-free at 1-800-700-8140 .

Conformity with State Law

If any provision of this handbook is not in conformity with state law, such provision will be construed and applied as if it was in full compliance with the applicable law.

Quality Improvement Program

DHMP continually strives to improve the quality of care and service to our members by ongoing monitoring of services. DHMP's Quality Improvement Program:

» Monitors and measures the level and quality of service and care.

» Monitors compliance with certain preventive health measures.

» Identifies opportunities to improve patient care and service.

» Addresses identified disparities through appropriate intervention and education.

Please visit denverhealthmedicalplan.org or call Health Plan Services to learn more about our Quality Improvement Program such as program goals, progress toward goals, processes, outcomes and specific measurements.

Statement of Rights under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

» All stages of reconstruction of the breast on which the mastectomy was performed;

» Surgery and reconstruction of the other breast to produce a symmetrical appearance;

» Prostheses; and

» Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under Elevate. (See the "Schedule of Benefits (Who Pays What)" for details.)

If you would like more information on WHCRA benefits, please call the Health Plan Services number on the back of your Identification Card.

New Technologies

As new technologies or new indications for current technologies are identified that may have broad applicability for Members, an ad hoc committee is convened that includes experts in the area under evaluation. The committee reviews technology assessments, published studies and deliberations of other expert panels including coverage decisions by other insurance companies to determine appropriate coverage guidelines.

11. General Policy Provisions

Contract

This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

Compliance Statement

It is DHMP's policy to conduct its business in compliance with the laws and regulations of the United States and the State of Colorado and to assure that DHMP operates in a manner consistent with the letter and the spirit of the law. DHMP is committed to compliance with such laws and regulations and intends to assure that DHMP's activities and operations, as carried out by the employees and other agents of DHMP, are conducted in compliance with such laws and regulations. In recognition of this commitment, DHMP has developed a Corporate Compliance Program and a Fraud and Abuse Prevention Plan that has been adopted and endorsed by the DHMP Board of Directors. We expect that every employee, subcontractor, agent, and provider of DHMP respect and adhere to our Corporate Compliance Program.

Fraud, Waste, and Abuse Prevention Program

DHMP is committed to ensuring that staff members, subcontractors and network providers perform administrative services and deliver healthcare services in a manner reflecting compliance with all laws, regulations,and contractual obligations. Further, DHMP is committed to fulfilling its duties with honesty, integrity, and high ethical standards. DHMP supports the federal and state government in their goal to decrease financial loss from false claims and has, as its own goal, the reduction of potential exposure to criminal penalties, civil damages, and administrative actions.

In the context of the DHMP Corporate Compliance Program, fraud is considered an act of purposeful deception or misrepresentation committed by any person to gain an unauthorized benefit. Abuse committed by a health care provider means activities that are inconsistent with standard fiscal, business, or medical practices that result in unnecessary cost to a government healthcare program or other healthcare plan, or that fail to meet professionally recognized standards for healthcare. Abuse can also include beneficiary practices that may result in unnecessary cost to the Commercial and Health Exchange program. Audits are performed on a routine, scheduled basis, to monitor for compliance with requirements associated with regulatory requirements.

DHMP uses a 3rd party vendor for data analytic software for post-payment reviews to evaluate claim payments and to verify the clinical accuracy of processing claims in accordance with clinical editing criteria. This coding program contains complete sets of rules that correspond to CPT-4, HCPCS, ICD-10, AMA, and CMS guidelines as well as industry standards, medical policy and literature, and CCI (Correct Coding Initiative) edits and rules. Providers are required to submit claims in accordance with these rules. Routine monitoring activity includes comparative data analysis on areas such as service utilization and outcomes. Routine reviews focus onidentified high-risk or problem areas and ensuring documentation supports submitted claims data. Audits are also performed following the identification of an area of concern which may suggest possible abusive or fraudulent activity. Such referrals may come from internal and external sources, unusual trends in claims or other data, provider self-disclosures, and other ongoing monitoring activity. DHMP seeks to ensure the integrity of the claims billing and payment process by investigating any suspected fraud and abuse. Provider fraud and abuse can include:

- Billing more than once for the same service
- Falsifying records
- Performing inappropriate or unnecessary services
- Misrepresenting the diagnosis of the member to justify the services or equipment furnished
- Altering claim forms or medical records to obtain a higher payment amount
- Deliberately applying for duplicate payment (for example, billing DHMP and the member for the same service or billing both DHMP and another insurer in an attempt to get paid twice)
- Unbundling or billing for separate portions, rather than for the whole procedure
- Characterizing the service differently than the service actually rendered or misrepresenting the services rendered, amounts charged for services rendered, identity of the person receiving the services, dates of services (for example, falsely indicating that a particular healthcare professional attended a procedure)
- Billing or charging members for covered services that is outside of the member's copayment, coinsurance, and deductible financial responsibility

Reporting Concerns

Please tell us if you have a concern that involves fraud, waste, and abuse or any type of compliance concern. You can call our toll-free anonymous Compliance Hotline (Values Line) or send us a letter via fax or mail. When making a report, please provide as much detail as possible. Names, dates, and a description of the issues in question are helpful. For example, you may wish to describe why you think an activity is a cause for concern. If possible, please include your name and

telephone number. That way, we can contact you if we have any questions during our investigation. When making an anonymous report to the Compliance Hotline (ValuesLine), you will be provided with a call identification number and a call back date. This will allow yout o provide additional information (if needed) and receive status updates on the investigation.

Compliance Hotline	1-800-273-8452 (available seven days a week, 24 hours a day). Reports can be made anonymously.
Fax Number	(303) 602-2074
Mailing Address or In-Person	Denver Health Medical Plan, Inc. Attn: Compliance Officer 938 Bannock Street, MC 6000 Denver, CO 80204

12. Termination/Non-Renewal/Continuation

SPECIAL SITUATIONS: TERMINATION OF COVERAGE

Under certain circumstances, your coverage or that of one or more of your dependents, may be terminated by DHMP. These circumstances are described below. You may use the complaint and appeal process available through DHMP if you feel there is a valid reason why coverage should not be terminated.

Non-Payment of Cost Sharing - If a member does not pay required cost sharing or does not make satisfactory arrangements to pay cost sharing, DHMP may terminate the member with not less than 31 days written notice.

False or Misleading Information - If a member attempts to obtain benefits under DHMP by means of false, misleading, or fraudulent information, acts or omissions for themselves or others, DHMP may terminate the member's coverage upon seven days written notification.

Misuse of Identification Card - The DHMP identification card is solely for identification purposes. Possession of the card does not ensure eligibility and/or rights to services or benefits. The holder of the card must be a member for whom all premiums under the Plan have been paid. If a member allows the use of his/her DHMP identification card by any other person, DHMP may terminate the member's coverage upon seven days written notice. Payment for services received as a result of the improper use of a DHMP identification card is the responsibility of the individual who received the services.

CONTINUATION OF COVERAGE

You may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility as required by the federal COBRA law. Please contact your Benefits department if you want to know how to elect COBRA coverage.

If you and/or your dependents move outside of the DHMP service area, your coverage under the Plan will be limited to emergency and urgent services only. Because the Plan does not provide out-of-network coverage, nonemergency and non-urgent services will not be covered under the Plan outside of the DHMP service area.

13. Appeals and Complaints

As a member of DHMP, you have the right to file a complaint (also known as a grievance) and an appeal of an adverse decision. Please carefully review this important information. If you decide to file a complaint or an appeal, your request must be sent within the prescribed time period. If you miss a deadline, we may decline to review it. Except when simultaneous external review can occur, you must exhaust the internal complaint and appeal procedure as described below.

DEFINITIONS

Grievance: a written or oral expression of dissatisfaction about the quality of care you receive, the failure of a provider or the Plan to accommodate your needs, an unpleasant experience, disagreement with a claim related issue, such as a cost sharing, or any other service issue. This is also called a complaint.

Adverse benefit determination: a decision to take any of the following actions:

a. deny your claim, in whole or in part, including:

(1) a denial of a preauthorization for a service;

(2) a denial of a request for services on the ground that the service is not medically necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; and/or

(3) a denial of a request for services on the ground that the service is experimental or investigational,

b. terminate your coverage by the Plan retroactively except as the result of non-payment of premiums (also known as rescission or cancellation),

c. deny your (or, if applicable, your dependent's) application for individual plan coverage.

d. uphold our previous adverse benefit determination when you appeal.

Appeal: a request for us to review our initial adverse benefit determination. In addition, when we deny a request for medical care because it is excluded under Plan coverage rules, and you present evidence from medical professional licensed pursuant to the Colorado Medical Practice Act acting within the scope of his or her license that there is a reasonable medical basis that the contractual exclusion does not apply to the denied benefit, then such evidence establishes that the denial is subject to the appeals process.

Appointing a Representative to Act on Your Behalf

If you would like someone to act on your behalf regarding your complaint or appeal request, you may appoint an authorized representative. You must make this appointment in writing. You may designate any individual you choose, such as a relative, friend, advocate, ombudsman, an attorney, or any physician, to act on your behalf as your appointed representative. To be appointed by a member, both the member making the appointment and the representative accepting the appointment (including attorneys) must sign, date, and complete a Designation of Personal Representative Form. You may obtain a copy of the Designation of Personal Representative Form at the end of this Member Handbook or call the Health Plan Services Department at 303-602-2090 to learn how to name your appointed representative. Upon receipt of the completed Designation of Personal Representative Form, we will process your complaint or appeal.

How To File A Complaint or Appeal

You can file a complaint by telephone, fax, in person, or in writing. Additionally, you may complete a Member Complaint and Appeal Form that is located at the end of this Member Handbook. You may call the Grievance and Appeal Department at the telephone number given below to have the Member Complaint and Appeal Form sent to you.

Please see below information for the method in which to contact the Plan. Please note all appeal requests must be in writing. The appeal request must contain the following elements: (1) date; (2) member name; (3) member address; (4) member ID number; (5) if the member is a minor or is legally incompetent, the name and relationship to the member; (6) the reason for the appeal; (7) the signature of the member or legal guardian if the member is a minor; and (8) any evidence, such as medical records, you wish us to consider in support of your position.

Denver Health Medical Plan
ATTN: Grievance and Appeal Department
938 Bannock Street, Mail Code 6000
Denver, Colorado 80204
Telephone: 303-602-2261
Toll-Free: 800-700-8140
Fax: 303-602-2078*

**Please note this is a secure and confidential fax*

Initial Coverage Determination Process

There are several types of initial coverage requests and each has a different procedure described below.

1. Pre-service coverage determination request (urgent and non-urgent)
2. Concurrent care coverage determination request (urgent and non-urgent)

1. Pre-Service Initial Coverage Determination Request (Urgent and Non-Urgent)

Pre-service requests are services that you have not yet received. Failure to receive authorization before receiving a service that must be authorized or pre-certified in order to be a covered benefit may be the basis for our denial of your pre-service request or a post-service claim for payment. If you receive any of the services you are requesting before we make our decision, your pre-service request will become a post-service appeal with respect to those services.

Tell us, in writing, that you want to make a request for us to provide or pay for a service you have not yet received. You must mail or fax your request to the Utilization Management (UM) Department at 938 Bannock Street, Mail Code 6000, Denver, CO 80204, fax (303) 602-2128.

If you want us to consider your pre-service initial coverage request on an urgent basis, your request should tell us that. We will decide whether your request is urgent or non-urgent unless your attending health care provider tells us your request is urgent. If we determine that your request is not urgent, we will treat your request as non-urgent. Generally, a request is urgent only if using the procedure for non-urgent requests (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you are already disabled, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the services you are requesting.

We will review your request and, if we have all the information we need, we will make a decision within a reasonable period of time but not later than 15 calendar days after we receive your request. We may extend the time for making a decision for an additional 15 calendar days if circumstances beyond our control delay our decision, if we notify you prior to the expiration of the initial 15 calendar day period and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information within the initial 15 day decision period, and we will give you 45 days to send the information. We will make a decision within 15 calendar days after we receive the requested information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45 day period.

We will send written notice of our decision to you and, if applicable to your provider.

If your pre-service appeal request was considered on an urgent basis, we will notify you of our decision (whether adverse or not) orally, or in writing, within a timeframe appropriate to your clinical condition but not later than 72 hours after we receive your claim. Within 24 hours after we receive your request, we may ask you for more information. We will notify you of our decision within 48 hours of receiving the first piece of requested information. If we do not receive any of the requested information, then we will notify you of our decision within 48 hours after making our request. If we notify you of our decision orally, we will send you written confirmation within 3 days after that. If we deny your claim (if we do not agree to provide or pay for all the services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

2. Concurrent Care Coverage Determination Request (Urgent and Non-Urgent)

Concurrent care coverage requests are requests that the Health Plan continue to provide, or pay for, an ongoing course of covered treatment to be provided over a period of time or number of treatments, when the course of treatment already being received is scheduled to end. We may either (a) deny your request to extend your current authorized ongoing care (your concurrent care request) or (b) inform you that authorized care that you are currently receiving is going to end early and you can appeal our adverse benefit determination at least 24 hours before your ongoing course of covered treatment will end, then during the time that we are considering your appeal, you may continue to receive the authorized services. If you continue to receive these services while we consider your appeal and your appeal does not result in our approval of your concurrent care coverage request, then we will only pay for the continuation of services until we notify you of our appeal decision.

Tell us, in writing, that you want to make a concurrent care request for an ongoing course of covered treatment. Inform us in detail of the reasons that your authorized ongoing care should be continued or extended. Your request and any related documents you give us constitute your request.

If you want us to consider your claim on an urgent basis and you contact us at least 24 hours before your care ends, you may request that we review your concurrent care request on an urgent basis. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health or ability to regain maximum function or if you are already disabled, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment; or (c) your attending provider requests that your claim be treated as urgent.

We will review your claim, and if we have all the information we need we will make a decision within a reasonable period of time. If you submitted your claim 24 hours or more before your care is ending, we will make our decision before your authorized care actually ends. If your authorized care ended before

you submitted your claim, we will make our decision but no later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 calendar days if circumstances beyond our control delay our decision, if we send you notice before the initial 15 calendar day decision period ends and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information before the initial decision period ends, and we will give you until your care is ending or, if your care has ended, 45 calendar days to send us the information. We will make our decision as soon as possible, if your care has not ended, or within 15 calendar days after we first receive any information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within the stated timeframe after we send our request, we will make a decision based on the information we have within the appropriate timeframe, not to exceed 15 calendar days following the end of the timeframe we gave you for sending the additional information.

We will send written notice of our decision to you and, if applicable to your provider, upon request. If we consider your concurrent claim on an urgent basis, we will notify you of our decision orally or in writing as soon as your clinical condition requires, but not later than 24 hours after we received your appeal. If we notify you of our decision orally, we will send you written confirmation within 3 calendar days after receiving your claim. If we deny your claim (if we do not agree to provide or pay for extending the ongoing course of treatment), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

APPEAL PROCESS

First Level Appeal Review

» **Non-Urgent Pre-Service Appeal**
Within 180 days after you receive our adverse benefit determination notice, you must tell us, in writing, that you want to appeal our denial of your pre-service initial coverage determination. Please include the following: (1) your name and Member I.D. Number, (2) your medical condition or relevant symptoms, (3) the specific service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit denial, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the Grievance and Appeal Department. We will make a decision within 30 calendar days. We may extend the time for making a decision for an additional 15 calendar days if circumstances beyond our control delay our decision, if we notify you prior to the expiration of the initial 15 calendar day period and explain the circumstances for which we need the extra time and when we expect to make a decision.

» **Urgent Pre-Service Appeal**
Within 180 days after you receive our adverse benefit determination notice, you must tell us, that you want to urgently appeal our adverse benefit determination regarding your pre-service request. Please include the following: (1) your name and Member I.D. Number, (2) your medical condition or symptoms, (3) the specific service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal by mail or by fax to the Grievance and Appeal Department.
When you send your appeal, you may also request simultaneous external review of our initial adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-service appeal qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review"), if our internal appeal decision is not in your favor.

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you are already disabled, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the services you are requesting; or (c) your attending provider requests that your appeal be treated as urgent. We will review your appeal and notify you of our decision orally or in writing as soon as your clinical condition requires, but no later than 72 hours after we receive your appeal. If we notify you of our decision orally, we will send you a written confirmation within 3 calendar days after that

» **Non-Urgent Concurrent Care Appeal**
Within 180 days after you receive our adverse benefit determination notice, you must tell us, in writing that you want to appeal our adverse benefit determination. Please include the following: (1) your name and Member I.D. Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5)

all supporting documents. Your request and all supporting documents constitute your appeal. You must either mail or fax appeal to the Grievance and Appeal Department. We will review your appeal and send you a written decision as soon as possible if you care has not ended but not later than 30 days after we receive your appeal. If we deny your appeal, our adverse benefit determination decision will tell you why we denied your appeal and will include information about any further process, including external review that may be available to you. We may extend the time for making a decision for an additional 15 calendar days if circumstances beyond our control delay our decision, if we notify you prior to the expiration of the initial 15 calendar day period and explain the circumstances for which we need the extra time and when we expect to make a decision.

» **Urgent Concurrent Care Appeal**
Tell us that you want to urgently appeal our adverse benefit determination regarding your urgent concurrent care appeal request. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the Grievance and Appeal Department. When you send your appeal, you may also request simultaneous external review of our adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your concurrent care claim qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" section).

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you are already disabled, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without continuing your course of covered treatment; or (c) your attending provider requests that your appeal be treated as urgent. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review. We will review your appeal and notify you of our decision orally or in writing as soon as your clinical condition requires, but no later than 72 hours after we receive your appeal. If we notify you of our decision orally, we will send you a written confirmation within 3 calendar days after that. If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information about any further process, including external review that may be available to you.

» **Post-Service Appeals**
Post-service claims are requests that we for pay for Services you already received, including claims for out-of-network Emergency Services. Within 180 days after you receive our adverse benefit determination, tell us, in writing, that you want to appeal our denial of your post-service claim. Please include the following: (1) your name and Member I.D. Number, (2) your medical condition or symptoms, (3) the specific Services that you want us to pay for, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) include all supporting documents. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the Grievance and Appeal Department. We will review your appeal and send you a written decision within 30 calendar days after we receive your appeal. We may extend the time for making a decision for an additional 15 calendar days if circumstances beyond our control delay our decision, if we notify you prior to the expiration of the initial 15 calendar day period and explain the circumstances for which we need the extra time and when we expect to make a decision. If we deny your appeal, our adverse benefit determination will tell you why we denied your appeal and will include information regarding any further process, including external review that may be available to you.

Voluntary Second Level Appeal Review

If you do not agree with the decision of the first level appeal review, you may request another review, in writing, called a "voluntary second level appeal" within 30 calendar days of the first level adverse determination. An Appeal Committee will conduct a second level appeal review. All Committee members will not have been involved in any prior decision of your issue nor be subordinates of previous decision-makers.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. Upon

request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will be notified, in writing, of the Appeal Committee's decision within 30 days. If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review that may be available to you.

External Review

Following receipt of an adverse benefit determination, you may have a right to request an external review. You have the right to request an independent external review of our decision if our decision involves an adverse benefit determination involving a denial of a claim, in whole or in part, that is (1) a denial of a preauthorization for a service; (2) a denial of a request for services on the ground that the service is not medically necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; and/or (3) a denial of a request for services on the ground that the service is experimental or investigational. If our final adverse decision does not involve an adverse benefit determination as described in the preceding sentence, then your claim is not eligible for external review. However, independent external review is available when we deny your appeal because you request medical care that is excluded under your benefit plan and you present evidence from a licensed Colorado professional that there is a reasonable medical basis that the exclusion does not apply.

You will not be responsible for the cost of the external review. There is no minimum dollar amount for a claim to be eligible for an external review.

To request external review, you must:

1. Submit a completed Independent External Review of Carrier's Final Adverse Determination form which will be included with the internal appeal decision letter and explanation of your appeal rights within 4 months of the date of receipt of the internal appeal decision.
2. Include in your written request a statement authorizing us to release your claim file with your health information including your medical records.

If we do not receive your external review request form and/or authorization form to release your health information, then we will not be able to act on your request. We must receive all of this information prior to the end of the applicable timeframe for your request of external review.

You may request an expedited review if (1) you have a medical condition for which the timeframe for completion of a standard review would seriously jeopardize your life, health, or ability to regain maximum function, or, if you have an existing disability, would create an imminent and substantial limitation to your existing ability to live independently, or (2) in the opinion of a physician with knowledge of your medical condition, the timeframe for completion of a standard review would subject you to severe pain that cannot be adequately managed without the medical services that you are seeking. You may request expedited external review simultaneously with your expedited internal appeal. A request for an expedited external review must be accompanied by a written statement from your physician that your condition meets the expedited criteria. You must include the physician's certification that you meet expedited external review criteria when you submit your request for external review along with the other required information (described, above).

You may request external review or expedited external review involving an adverse benefit determination based upon the Service being experimental or investigational. Your request for external review or expedited external review must include a written statement from your physician that either (a) standard health care services or treatments have not been effective in improving your condition or are not medically appropriate for you, or (b) there is no available standard health care service or treatment covered under this Membership Agreement that is more beneficial than the recommended or requested health care service (the physician must certify that scientifically valid studies using accepted protocols demonstrate that the requested health care service or treatment is more likely to be more beneficial to you than an available standard health care services or treatments), and the physician is a licensed, board-certified, or board-eligible physician to practice in the area of medicine to treat your condition. If you are requesting expedited external review, then your physician must also certify that the requested health care service or treatment would be significantly less effective if not promptly initiated. These certifications must be submitted with your request for external review.

No expedited external review is available when you have already received the medical care that is the subject of your request for external review. If you do not qualify for expedited external review, we will treat your request as a request for standard external review.

After we receive your request for external review, we shall notify you of the information regarding the independent external review entity that the Division of Insurance has selected to conduct the external review. If we deny your request for standard or expedited external review, including any assertion that we have not complied with the applicable requirements related to our internal claims and appeals procedure, then we may notify you in writing and include the specific reasons for the denial. Our notice will include information about appealing the denial to the Division of Insurance. At the same time that we send this notice to you, we will send a copy of it to the Division of Insurance.

You will not be able to present your appeal in person to the independent external review organization. You may, however, send any additional information that

is significantly different from information provided or considered during the internal claims and appeal procedure. If you send new information, we may consider it and reverse our decision regarding your appeal.

You may submit your additional information to the independent external review organization for consideration during its review within 5 working days of your receipt of our notice describing the independent review organization that has been selected to conduct the external review of your claim. Although it is not required to do so, the independent review organization may accept and consider additional information submitted after this 5 working day period ends.

The independent external review entity shall review information regarding your benefit claim and shall base its determination on an objective review of relevant medical and scientific evidence. Within 45 days of the independent external review entity's receipt of your request for standard external review, it shall provide written notice of its decision to you. If the independent external review entity is deciding your expedited external review request, then the independent external review entity shall make its decision as expeditiously as possible and no more than 72 hours after its receipt of your request for external review and within 48 hours of notifying you orally of its decision provide written confirmation of its decision. This notice shall explain the external review entity's decision and that the external review decision is the final appeal available under state insurance law. An external review decision is binding on the Health Plan and you except to the extent the Health Plan and you have other remedies available under federal or state law. You or your designated representative may not file a subsequent request for external review involving the same Health Plan adverse determination for which you have already received an external review decision.

If the independent external review organization overturns our denial of payment for care you have already received, we will issue payment within five (5) working days. If the independent review organization overturns our decision not to authorize pre-service or concurrent care claims, we will authorize care within one (1) working day. Such covered services shall be provided subject to the terms and conditions applicable to benefits under your plan.

Appeal For Retroactive Termination of Membership (Rescission)

We may terminate your membership retroactively. We will send you written notice at least 30 days prior to the termination. Within 180 days after you receive our adverse benefit determination that your membership will be terminated retroactively, you must tell us, in writing, that you want to appeal our termination of your membership retroactively. Please include the following: (1) your name and Medical Record Number, (2) all of the reasons why you disagree with our retroactive membership termination, and (3) all supporting documents.

Your request and the supporting documents constitute your appeal. You must either mail or fax your ap-peal to the Grievance and Appeal Department. We will make a decision within 30 calendar days. We may extend the time for making a decision for an additional 15 calendar days if circumstances beyond our con-trol delay our decision, if we notify you prior to the expiration of the initial 15 calendar day period and ex-plain the circumstances for which we need the extra time and when we expect to make a decision.

If you have general questions about retroactive membership terminations or appeals, please call the Health Plan Services Department at 303-602-2100, toll free at 1-800-700-8140, TTY users should call 711.

14. Information on Policy and Rate Changes

All commercial insurance policies offered by DHMP are written for a 12-month period of any given year. No benefit or rate changes will be made during this time.

Amendment or Termination of this Plan

This Plan cannot be modified by DHMP in the current benefit year unless the modification is required by a change in law.

15. Definitions

Acute Care: A pattern of health care in which a patient is treated for an immediate and severe episode of illness, delivery of a baby, for the subsequent treatment of injuries related to an accident or other trauma or during recovery from surgery. Acute care is usually provided in a hospital and is often necessary for only a short period of time. Acute care includes emergency and urgent care.

Adverse Determination: A denial of a pre authorization for a covered benefit; a denial of benefits based on the grounds that the treatment or covered benefit is not medically necessary, appropriate, effective, or efficient or is not provided in or at the appropriate health care setting or level of care; a rescission or cancellation of coverage that is not attributable to failure to pay premiums and that is applied retroactively; a denial of benefits on the grounds that the treatment or service is experimental or investigational; or a denial of coverage based on initial eligibility determination.

Ambulatory Surgical Facility: A facility, licensed and operated according to law, that does not provide services or accommodations for a patient to stay overnight. The facility must have an organized medical staff of physicians; maintain permanent facilities equipped and operated primarily for the purpose of performing surgical procedures; and supply registered professional nursing services whenever a patient is in the facility.

Appeal: A written request to change a previous decision made by DHMP.

Approved Clinical Trial: A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following subparagraphs:

A. FEDERALLY FUNDED TRIALS- The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
   i. The National Institutes of Health.
   ii. The Centers for Disease Control and Prevention.
   iii. The Agency for Health Care Research and Quality.
   iv. The Centers for Medicare & Medicaid Services.
   v. Cooperative group or center of any of the entities described in clauses (i)through (iv) or the Department of Defense or the Department of Veterans Affairs.
   vi. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   vii. Any of the following if the conditions described in paragraph (2) are met:
      a. The Department of Veterans Affairs.
      b. The Department of Defense.
      c. The Department of Energy.

B. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

C. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

CONDITIONS FOR DEPARTMENTS- The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines--

A. To be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

B. Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

Brand Name Drug: A drug that is identified by its trade name given by the manufacturer. Brand name drugs may have generic substitutes that are chemically the same.

Chronic Care: A pattern of care that focuses on individuals with long standing, persistent diseases or conditions. It includes care specific to the problems, as well as other measures to encourage self-care, promote health and prevent loss of function.

Coinsurance: The charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

Copayment: The predetermined amount, stated as a percentage or a fixed dollar, an enrollee must pay to receive a specific service or benefit. Copayments are due and payable at the time of receiving service.

Cosmetic Procedure/Surgery: An elective procedure performed only to preserve or improve physical appearance rather than to restore an anatomical function of the body lost or impaired due to an illness or injury.

Covered Benefit: A medically necessary service, item or supply that is specifically described as a benefit in this handbook. While a covered benefit must be medically necessary, not every medically necessary service is a covered benefit.

Custodial Care: Services and supplies furnished primarily to assist an individual in the activities of daily living. Activities of daily living include such things as

bathing, feeding, administration of oral medicines or other services that can be provided by persons without the training of a health care provider.

Deductible: The amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a plan year or benefit year) before the carrier will cover expenses. The specific expenses that are subject to deductible may vary by policy. This plan uses an embedded deductible. Embedded plans have individual deductibles and max out-of-pocket. Cost sharing will begin when the member reaches their individual deductible. This means the member will start paying copays or coinsurance for the remainder of the plan year or until the individual max out-of-pocket is met. Once the individual reaches their max out-of-pocket the plan will pay 100% of covered services. Please note that an individual who meets their embedded deductible will initiate cost sharing with the plan prior to other members on the plan.

Denver Health and Hospital Authority: A political subdivision of the State of Colorado organized for the primary purpose of providing comprehensive public health and medical health care services to the citizens of the City and County of Denver. DHMP is a separate legal entity from the Denver Health Hospital Authority.

Designated Personal Representative (DPR): A person including the treating health care professional authorized by member to provide substituted consent to act on member's behalf.

Drug and Alcohol Abuse - Detoxification: The medical treatment of an individual to ensure the removal of one or more toxic substances from the body. Detoxification may or may not be followed by a complete rehabilitation program for drug or alcohol abuse.

Drug and Alcohol Abuse - Rehabilitation: The restoration of an individual to normal or near-normal function following addiction. This may be accomplished on an inpatient or outpatient basis.

Durable Medical Equipment (DME): Medical equipment that can withstand repeated use; is not consumable or disposable except as needed for the effective use of covered DME and is used to serve a medical purpose in the treatment of an active illness or injury. Durable medical equipment is owned or rented to facilitate treatment and/or rehabilitation.

Emergency: Any event that a prudent layperson would believe threatens his or her life or limb in such a manner that a need for immediate medical care is needed to prevent death or serious impairment of health.

Emergency Care: Services delivered by an emergency care facility that are necessary to screen and stabilize a covered person. The Plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.

Experimental or Investigational Service(s): Not yet proven to be, or not yet approved by a regulatory agency, as a medically effective treatment or procedure.

Family Deductible: The maximum deductible amount that is required to be met for all family members covered under a policy and it may be an aggregated amount (e.g., "$3,000 per family") or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family").

Follow-Up Care: Care received following initial treatment of an illness or injury.

General Hospital: A health institution planned, organized, operated, and maintained to offer facilities, beds, and services over a continuous period exceeding 24 hours to individuals requiring diagnosis and treatment for illness, injury, deformity, abnormality, or pregnancy. Clinical laboratory, diagnostic X-ray, and definitive medical treatment under an organized medical staff are provided within the institution. Treatment facilities for emergency and surgical services are provided either within the institution or by contractual agreement for those services with another licensed hospital. Definitive medical treatment may include obstetrics, pediatrics, psychiatry, physical medicine and rehabilitation, radiation therapy, and similar specialized treatment.

Generic Drug: Generic drugs are chemical equivalents of brand name drugs and are substituted for the brand name drug. When an A-rated generic drug is substituted for a brand name drug you can expect the generic to produce the same clinical effect and safety profile as the brand name drug.

Genetic Testing: Examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Grievance: An oral or written statement (complaint) by a member or member's representative that expresses dissatisfaction with some aspect of DHMP service or administration.

Habilitative Services: Services That help a person retain, learn or improve skills and functioning for daily living.

Home Health Care/Agency: A program of care that is primarily engaged in providing skilled nursing

services and/or other therapeutic services in the home or other places of residence; an approved home health agency:

- Has policies established by a group of professional personnel associated with the agency or organization including policies to govern which services the agency will provide,
- Maintains medical records of all patients, and
- Is certified or accredited.

Hospice Care: An alternative way of caring for terminally ill individuals that stresses palliative care as opposed to curative or restorative care. Hospice care focuses upon 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 is not limited to medical intervention, but addresses physical, social, psychological and spiritual needs of the patient. Hospice services include but are not necessarily limited to the following: nursing, physician, certified nurse aide, nursing services delegated to other assistants, homemaker, physical therapy, pastoral, counseling, trained volunteer and social services. The emphasis of the hospice program is keeping the hospice patient at home among family and friends as much as possible.

Illness: Any bodily sickness, disease or mental/nervous disorder. For the purposes of this Plan, pregnancy and childbirth are considered the same as any other sickness, injury, disease or condition.

Individual Deductible: Means the deductible amount you and each individual covered by the policy will have to pay for allowable covered expenses before the carrier will cover those expenses.

Injury: A condition that results independently of an illness and all other causes, and is a result of an external force or accident.

Maintenance Care: Services and supplies that are provided solely to maintain a level of physical or mental function and from which no significant practical improvement can be expected.

Medically Necessary (Medical Necessity): A service or supply that is consistent with generally accepted principles of professional medical practice, as determined by whether or not: (1) the service is the most appropriate available supply or level of service for the insured in question, considering potential benefits and harms to the individual; (2) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; (3) for services and interventions not in widespread use, is based on scientific evidence.

Medicare: The Federal Health Insurance for the Aged and Disabled Act, Title XVIII of the United States Social Security Act.

Member: A subscriber or dependent enrolled in DHMP and for whom the monthly premium is paid to DHMP.

National Network Pharmacy: This is a nationwide network of pharmacies that include most retail pharmacies such as King Soopers, Safeway, Target, Walgreens and many more.

Network: refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your Plan may require you to use in order for you to get any coverage at all under the Plan, or that the Plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you do not (i.e., go out-of-network).

Network Provider: A health care provider who is contracted to be a provider in the DHMP network.

Nurse/Licensed Nurse/Registered Nurse: A person holding a license to practice as a Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.) in the State of Colorado and acting within the scope of his/her license.

Observation Stay: A hospitalization lasting 23 hours or less.

Office Visit: Visit with a health care provider that takes place in the office of that health care provider. Does not include care provided in an emergency room, ambulatory surgery suite or ancillary departments (laboratory and X-ray).

Out-Of-Pocket Maximum: The maximum amount you will have to pay for allowable covered expenses under a health plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy.

Partial Hospitalization/Day Treatment: is defined as continuous treatment at a network facility of at least 3 hours per day but not exceeding 12 hours per day.

Plan Year: The 12 month period beginning at 12:01 a.m. on the 1st day of January and ending at 11:59 p.m. on the last day of December.

Provider: A physician or person acting within the scope of applicable state licensure or certification requirements and possessing the credentials to practice as a Certified Nurse Midwife (C.N.M.), Certified Registered Nurse Anesthetist (C.R.N.A.), Child Health Associate (C.H.A.), Doctor of Osteopathy (D.O.), Doctor of Podiatry Medicine (D.P.M.), Licensed Clinical Social Worker (L.C.S.W.), Medical Doctor (M.D.), Nurse Practitioner (N.P.), Occupational Therapist (O.T.), Physician Assistant (P.A.), Psychologist (Ph.D., Ed.D., Psy.D.), Registered Physical Therapist (R.P.T.), Registered Respiratory Therapist (R.T.), Speech Therapist (S.T.).

15. Definitions

Premium: Monthly charge to a subscriber for medical benefit coverage for the subscriber and his/her eligible and enrolled dependents.

Preventive Visit: Preventive care services are designed to keep you healthy or to prevent illness, and are not intended to treat an existing illness, injury or condition.

Primary Care Practitioner (personal provider): The practitioner (physician, nurse practitioner or physician's assistant) that you choose from the DHMP network to supervise, coordinate and provide initial and basic care to you. The primary care provider maintains continuity of patient care (usually a physician practicing internal medicine, family practice or pediatrics).

Prior Authorization: If approved, provides an assurance by the plan to pay for a medically necessary covered benefit provided by a network provider for an eligible plan member and is received prior to receiving a specific service, treatment or care. This process can be initiated by a provider, patient, or designated patient representative.

Prudent Layperson: A non-expert using good judgment and reason.

Qualifying Event: For Continuation Coverage: An event (termination of employment, reduction in hours) affecting an individual's eligibility for coverage.

Referral: A written request, signed by a member's primary care provider, defining the type, extent and provider for a service.

Service Area: The geographical are in which a health plan is licensed to sell their products.

Short Term Residential Treatment: These facilities are typically designated residential, sub acute or intermediate care facilities and may occur in care systems that provide multiple levels of care. Residential treatment is 24 hours per day and requires a minimum of one physician visit per week in a facility based setting.

Skilled Nursing Care: The care provided when a registered nurse uses knowledge as a professional to execute skills, render judgments and evaluate process and outcomes. A non-professional may have limited skill function delegated by a registered nurse. Teaching, assessment and evaluation skills are some of the many areas of expertise that are classified as skilled services.

Skilled Nursing Facility: A public or private facility, licensed and operated according to the laws of the state in which it provides care, which has:

1. Permanent and full-time facilities for 10 or more resident patients;
2. A full-time registered nurse or physician in charge of patient care;
3. At least one registered nurse or licensed practical nurse on duty at all times;
4. A daily medical record for each patient;
5. Transfer arrangements with a hospital, and
6. A utilization review plan.

Specialized Treatment Facility: Specialized treatment facilities for the purposes of this plan include ambulatory surgical facilities, hospice facilities, skilled nursing facilities, mental health treatment facilities, substance abuse treatment facilities or renal dialysis facilities. The facility must have a physician on staff or on call. The facility must also prepare and maintain a written plan of treatment for each patient.

Standing Referral: Referral from primary care provider to a network specialist or specialty treatment center in the DHMP network for illness or injury that requires ongoing care.

Subrogation: The recovery by DHMP of costs for benefits paid by DHMP when a third party causes an injury and is found liable for payment of damages.

Subscriber: The head of household and is the basis for eligibility for enrollment in DHMP.

Telehealth: A mode of delivery of health care services through telecommunications systems, including information, electronic, and communication technologies, to facilitate the assessment, diagnosis, consultation, treatment, education, care management, or self-management of a covered person's health care while the covered person is located at an originating site and the provider is located at a distant site. The term includes synchronous interactions and store-and-forward transfers.

- **Distant site:** A site at which a provider is located while providing health care services by means of telehealth.
- **Originating site:** A site at which a patient is located at the time health care services are provided to him or her by means of telehealth.
- **Store-and-forward transfer:** The electronic transfer of a patient's medical information or an interaction between providers that occurs between an originating site and distant sites when the patient is not present.
- **Synchronous interaction:** A real-time interaction between a patient located at the origination site and a provider located at a distant site.

Temporarily Absent: Circumstances in which the member has left the DHMP's service area, but intends

to return within a reasonable period of time, such as a vacation trip.

Urgently Needed Services: Covered services that members require in order to treat and prevent a serious deterioration in their health but which does not rise to the level of an emergency.

USPSTF: The U.S. Preventive Services Task Force or any successor organization, sponsored by the Agency for Healthcare Research and Quality, the Health Services Research Arm of the federal Department of Health and Human Services.

https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/

US Preventive Task Force (USPSTF) A Recommendation: A recommendation adopted by the Task Force that strongly recommends that clinicians provide a preventive health care service because the Task Force found there is a high certainty that the net benefit of the preventive health care service is substantial.

US Preventive Task Force (USPSTF) B Recommendation: A recommendation adopted by the Task Force that recommends that clinicians provide a preventive health care service because the Task Force found there is a high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.

Utilization Review: 'Utilization review' means a set of formal techniques designed to monitor the use of, 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, concurrent review, case management, discharge planning, or retrospective review. Utilization review shall also include reviews for the purpose of determining coverage based on whether or not a procedure or treatment is considered experimental or investigational in a given circumstance, and reviews of a covered person's medical circumstances when necessary to determine if an exclusion applies in a given situation.

Virtual Residency Therapy: Home-based intensive services for clients and families which may include comprehensive case management, family therapy, individual therapy, parting skills training, communication skills counseling and case coordination with other services.

Well Baby Care: In-hospital newborn pediatric visit and newborn hearing screening.

DENVER HEALTH MEDICAL PLAN INC.™

MEMBER COMPLAINT AND APPEAL FORM

Completion of this form is voluntary. You or your designated representative must submit this request within 180 days of event occurrence for complaints or within 180 days of the date on the initial denial letter for appeals. Please attach copies of all documents which may support your request. If this is an urgent request please contact the Grievance & Appeals Department directly at 303-602-2261. This form and any accompanying documents may be mailed or faxed to:

Denver Health Medical Plan, Inc.
Attn: Grievance and Appeals Department
938 Bannock Street
Denver, CO 80204
Fax: 303-602-2078
denverhealthmedicalplan.org

DHMP PLAN TYPE (PLEASE CHECK ONE):

Denver Health and Hospital Authority (DHHA)
O Medical Care HMO
O HighPoint HMO
O HighPoint Point of Service (POS)

Denver Police
O Denver Health HDHP
O Denver Health DHMO

City & County of Denver/
Denver Employee Retirement Plan (DERP)
O Denver Health HDHP
O Denver Health DHMO

Elevate Health Plans
O Bronze Standard
O Bronze HDHP
O Silver Standard
O Silver Select
O Gold Standard
O Gold Select

Please provide the following information for the person the complaint or appeal is being submitted:

Name (Last, First, Middle Initial) _____ Member ID # _____

Home Address _____

City, State, Zip Code _____ Telephone # _____

Medical Record # _____ Date of Birth (MM/DD/YY) _____

If other than member listed above, please provide the following information for the person submitting the complaint or appeal. You must include a completed Designation of Personal Representative (DPR) Form with your request. Without this form, we will be unable to process your complaint or appeal. The DPR Form can be obtained by visiting our website or calling 303-602-2261.

Name (Last, First, Middle Initial) Telephone #

Mailing Address

City, State, Zip Code

Relationship to Member: O Spouse O Son/Daughter O Parent/Legal Guardian
O Member's Provider O Other (please specify) _____

SECTION A: COMPLAINT: If this is in regards to a complaint, please describe the issue in the box below. If you are filing an appeal, please go to Section B. Include dates of service and staff names if applicable. You may use additional pages if necessary and/or attach supporting documentation.

SECTION B: APPEAL: If you wish to file an appeal to a previously denied service or claim, please provide the information requested below.

Is this in regards to a denied claim? ○ **Yes** ○ **No**

If yes, please provide the Claim #: _____

Date(s) of Service: _____

Provider Name: _____

Is this in regards to a denied medical service or treatment? ○ **Yes** ○ **No**

If yes, please provide the date of the Denial Letter: _____

Please describe in the space provided below the reason and a brief description of your appeal. You may use additional pages if necessary and/or attach supporting documentation.

_____

Member Signature Date

_____

Designated Personal Representative Signature Date

If you have any questions or need help completing this form, please contact the DHMP Grievance & Appeals Department at 303-602-2261 from 8 a.m. to 5 p.m. Monday through Friday. If we are unable to take your call, please leave a message and we will return your call within 24 to 48 hours.

Internal Use Only - Please do not write below this line

Receipt Date: _____ ○ Complaint ○ Appeal Received By: _____
Type: ○ Clinical ○ Potential QOCC ○ Benefit ○ Pharmacy ○ Claim ○ Other

DENVER HEALTH MEDICAL PLAN INC.™

DENVER HEALTH MEDICAID CHOICE

APPOINTMENT OF PERSONAL REPRESENTATIVE FORM

Denver Health Medical Plan, Inc. (DHMP) must follow certain procedures before it may provide access to your Protected Health Information (PHI) to someone other than the Member. The purpose of appointing a Personal Representative is to enable another individual to act on your behalf with respect to: 1) making decisions about your health benefits; 2) requesting and/or disclosing your Protected Health Information; and 3) exercising some or all of the rights you have under your health insurance benefit plan. A Personal Representative may be legally appointed or designated by a Member to act on his/her behalf. Designating a Personal Representative is voluntary and can be a family member, friend, advocate, lawyer or an unrelated party. You may change or revoke the appointment of a Personal Representative at any time. If you choose to revoke an appointment, please complete Section H below and return to DHMP.

SECTION A: MEMBER/SUBSCRIBER INFORMATION		
Member Name: (Last, First, Middle Initial)	**Date of Birth:** | |	**Telephone #:** ( ) -
Address:	**Group #:** (as shown on the Member's ID Card)	
City, State, Zip:	**Member ID #:** (as shown on the Member's ID Card)	
Subscriber Name: (if different from Member)	**Date of Birth:** | |	**Telephone #:** ( ) -

SECTION B: PERSONAL REPRESENTATIVE INFORMATION		
Name: (Last, First, Middle Initial)	**Date of Birth:** | |	**Telephone #:** ( ) -
Address:	**Mother's Maiden Name:** (for identity verification)	
City, State, Zip:	**Last 4 digits of Social Security #:**	

SECTION C: PERSONAL REPRESENTATIVE'S RELATIONSHIP TO MEMBER (select one)

- ◯ Parent/guardian of a minor - Attach a copy of the minor's birth certificate or proof of guardianship
- ◯ Power of attorney with authority to make health care decisions on behalf of a member - Attach a copy of signed Power or Attorney form
- ◯ Executor or administrator of the deceased member's estate - Attach Letters Testamentary or other legal documents evidencing executor or administrator status
- ◯ Other: (Please describe your relationship to the member and attach proof of your authority to make health care decisions on behalf of the member)

_____

_____

_____

SECTION D: TYPE OF INFORMATION TO BE DISCLOSED/USED/RECEIVED BY THE PERSONAL REPRESENTATIVE (select all that apply)

- ◯ Prior Authorization/Referral Info
- ◯ Case Management
- ◯ Member ID Card
- ◯ Premium Invoices
- ◯ Plan Documents (e.g., Member ID Card, Member Handbook, Explanation of Benefits)
- ◯ Enrollment/Benefits
- ◯ Pharmacy Information
- ◯ Claims
- ◯ Grievance and Appeals
- ◯ All documents and information available, without limitation
- ◯ Other: _____

SECTION E: PLEASE RETURN THIS COMPLETED FORM AND ALL SUPPORTING DOCUMENTATION TO THE FOLLOWING MAILING ADDRESS OR FAX NUMBER

Mailing Address:
Denver Health Medical Plan, Inc.
Attn: Compliance Department
938 Bannock Street, MC 6000
Denver, CO 80204

Secured Fax #:
303-602-2025

SECTION F: MEMBER/SUBSCRIBER'S SIGNATURE:

I have completed the above information. I acknowledge that by signing this form I authorize DHMP to treat my Personal Representative as myself.

_____ _____

Signature of Member/Subscriber **Date**

SECTION G: PERSONAL REPRESENTATIVE'S ACCEPTANCE OF APPOINTMENT

I, _____ hereby accept the Member's appointment. I acknowledge that by signing this form I have authority to act on behalf of the Member. I have attached the required documentation, where applicable, to establish my status as the Personal Representative. I certify that the information on this Personal Representative form is true, correct and accurate to the best of my knowledge. I understand that the Company may request information, now or in the future, as it deems necessary to confirm my Personal Representative status.

_____ _____

Signature of Personal Representative **Date**

IMPORTANT NOTE: The appointment of a Personal Representative is valid for one year from the member signature date. You may revoke the appointment at any time by completing the revocation section (Section H) and returning it to DHMP at the address provided.

SECTION H: REVOCATION OF APPOINTMENT OF PERSONAL REPRESENTATIVE

I understand that by signing this section I am **revoking** my appointment of Personal Representation and no longer want the individual, (print individual's name legibly below),

_____

to act as my Personal Representative. I understand that this revocation applies to any future disclosures of Personal Health Information, whether verbal or written, and any future actions. I further understand that any disclosures or actions already taken by the Personal Representative and/or DHMP during the appointment of representation time period cannot be revoked. The revocation date that will be used is the date DHMP receives this revocation form.

_____ _____

Signature of Member/Subscriber **Date**

Please mail or fax form to:
Denver Health Medical Plan, Inc.
Attn: Compliance Department
938 Bannock Street, MC 6000
Denver, CO 80204
Fax: 303-602-2025

DENVER HEALTH MEDICAL PLAN INC.

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

SECTION A: MEMBER INFORMATION Complete all information requested in this section for the member whose information will be released.		
Name: Last, First, Middle Initial, Title (Sr., Jr., III.)	**Date of Birth:** | |	**Telephone #:** ( ) -
Address:	**Group #:** (as shown on the Member's ID Card)	
City, State, Zip:	**Member ID #:** (as shown on the Member's ID Card)	

SECTION B: AUTHORIZED INDIVIDUALS Please list the individuals and/or organizations that you are authorizing to view or receive your PHI. Include each individual's address and telephone number in case they need to be contacted in an emergency.		
1.	**Name/Organization:**	**Relationship:**
	Address:	**Telephone #:** ( ) -
2.	**Name/Organization:**	**Relationship:**
	Address:	**Telephone #:** ( ) -

SECTION C: DESCRIPTION OF INFORMATION THAT CAN BE RELEASED (CHECK ALL THAT APPLY).
If more space is needed to describe the PHI, please attach an additional page.

◯ Pre-Cert/Referral/ Authorization Information	◯ Enrollment/Benefits	◯ Disease Management
◯ Case Management Information	◯ Payment Information	◯ Pharmacy Information
◯ Demographic Information	◯ Health Management	◯ Claims Information
◯ **ALL OF THE ABOVE**	◯ Other: (Please Specify)	

I understand that my specific authorization is needed to release my information pertaining to the items listed below. By initialing, I authorize release of the following information pertinent to my case:

Pregnancy/Reproductive (initials)	**Psychotherapy/Mental Health** (initials)	**HIV/AIDS** (initials)	**Alcohol/Substance Abuse** (initials)

The information will be used/disclosed for the purpose of:

SECTION D: TIME PERIOD

Unless noted below, the authorized individuals in Section B can obtain your PHI from the coverage date of your plan with Denver Health Medical Plan, Inc.

◯ Only respond to inquiries from (insert date) to (insert date)

SECTION E: SCOPE OF AUTHORIZATION (CHECK ALL THAT APPLY; THIS SECTION MUST BE COMPLETE)

◯ The individual(s) in Section B may **discuss orally** my PHI with Denver Health Medical Plan, Inc.

◯ The individual(s) in Section B may **inspect and/or obtain copies** of my PHI from Denver Health Medical Plan, Inc.

◯ The individual(s) in Section B may **change my Primacy Care Physician (PCP and address)** maintained by Denver Health Medical Plan, Inc.

SECTION F: PERSONAL REPRESENTATIVE INFORMATION

Complete this section if you are a personal representative that is acting on behalf of a member. You must include a copy of one of the following documents as proof of your legal representation and authority:

- Valid Health Care Proxy
- Certificate of Guardianship Documentation
- Power of Attorney
- Valid Designation of Client Representative (DCR) Form

If the member is deceased, please include one of the following:

- Administrator's or Executor's Certificate
- Surviving Spouse's Certificate

Name: Last, First, Middle Initial, Title (Sr., Jr., III.)	**Relationship:**
Address:	**Telephone #:** ( ) -

By signing this form, I understand the following: (1) if the entity authorized to receive my PHI is not a health plan, health care provider or other covered entity as described by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, the released information may no longer be protected by federal and state law governing the use/disclosure of protected health information; (2) I may revoke this authorization at any time by notifying Denver Health Medical Plan, Inc. in writing; (3) if I do revoke this authorization, my revocation will have no effect on any action Denver Health Medical Plan, Inc. took according to this authorization before Denver Health Medical Plan, Inc. received my revocation; (4) it is my choice to sign this form and I do so voluntarily. Signing or not signing this authorization form will not affect any payment, enrollment, eligibility, or benefit coverage decisions made by Denver Health Medical Plan, Inc.

I sign this authorization under penalty of perjury and attest that the information contained in this authorization is true and correct and may be relied upon by Denver Health Medical Plan, Inc.

Signature of Member or Personal Representative:	**Date:** | |
Print Name:	**Relationship to Member:**

IMPORTANT NOTE

◯ **Yes, I would like a copy of this form for my records.**

◉ **No, I do not need a copy of this form for my records.**

SECTION H: RETURN THIS COMPLETED FORM AND SUPPORTING DOCUMENTATION TO:

Mail: Denver Health Medical Plan, Inc. ATTN: Privacy Officer 777 Bannock Street, Mail Code 6000 Denver, CO 80204	**Secure Fax:** (303) 602-2025 **Email:** PrivacyOfficerDHMP@dhha.org

Denver Health Medical Plan, Inc.
Member Reimbursement Form
DHHA HMO PLAN

Member's Name: _____
Mailing Address:_____
Member's I.D. Number: _____

OPTICAL BENEFITS (for plans that offer this benefit):

_____ Eyewear
$350.00 (Note: Only one claim can be submitted with in a 24 month calendar period)

_____ 65760
$200.00 Lasik Eye Surgery (Note: Once per life time benefit)

SHOE ORTHOTICS:

_____ L3000
$100.00 (Note: Maximum benefit per calendar year)

HEARING AID:

_____ V5100
$1500.00 every 5 years, if 18 years of age or older (Note: Under age 18, covered at 100%)

All necessary receipts must be submitted with reimbursement request.

Mail Claims to:
Denver Health Medical Plan, Inc.
Attn: Claims Department
P.O. Box 24992
Seattle, WA 98124-0992

16. Index

Visit denverhealthmedicalplan.org for information regarding the DHMP authorization process, including but not limited to, Utilization Management pre-service, urgent-concurrent, and post-service standards.

YOU HAVE THE RIGHT TO DESIGNATE ANY PRIMARY CARE PROVIDER WHO PARTICIPATES IN OUR NETWORK AND WHO IS AVAILABLE TO ACCEPT YOU OR YOUR FAMILY MEMBERS. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Health Plan Services at 303-602-2100 or visit our website at denverhealthmedicalplan.org. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Denver Health Medical Plan, Inc. or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Health Plan Services at 303-602-2100 or visit our website at denverhealthmedicalplan.org. The lifetime limit on the dollar value of benefits under Denver Health Medical Plan, Inc. no longer applies. Dependents may be covered up to the age of 26.

For forms and additional information visit:
https://www.denverhealthmedicalplan.org/dhha-forms-documents-links

For claims data, EOBs, replacement card etc. create an account in our Member Portal:
https://dhhcws481prod.tzghosting.net/tzg/cws/registration/registrationLogin.jsp

All DHMP enrollees have the option of calling 9-1-1 whenever an enrollee is confronted with a life- or limb-threatening emergency.

DENVER HEALTH MEDICAL PLAN INC.™

777 Bannock St., MC 6000
Denver, CO 80204
Health Plan Services: 303-602-2100
denverhealthmedicalplan.org