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 www.denverhealthmedicalplan.org/medical-prior-authorization-list. For questions about prior authorization, please call Health Plan Services at 303-602-2090 or toll-free at 1-855-823-8872 (TTY/TDD users should 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.

Benefit	In Network	Out of Network
Deductible		
Individual Family	$2,750 individual deductible. $5,500 family deductible. All individual deductible amounts will count toward the family deductible; an individual will not have to pay more than the individual deductible amount.	Not applicable.
Out-of-Pocket Maximum		
Individual Family	$7,000 individual deductible. $14,000 family deductible. The out-of-pocket maximum includes the annual deductible, coinsurance and all cost sharing. All individual out-of-pocket amounts will count toward the family out-of-pocket maximum; an individual will not have to pay more than the individual out-of-pocket maximum.	Not applicable.
Lifetime Maximum		
	No lifetime maximum.	Not applicable.
Covered Providers		
	Denver Health and Hospital Authority providers and Denver Health Medical Center. Cofinity providers are in network for outpatient mental health services only. See provider directory for a complete list of current DHMP providers (https://www.denverhealthmedicalplan.org/find-doctor) and Cofinity providers (www.cofinity.net).	Not applicable.
Medical Office Visits		
Primary Care Providers (Family Medicine, Internal Medicine and Pediatrics)	10% coinsurance, deductible does not apply.	Not covered.
Specialist	10% coinsurance, deductible does apply.	Not covered.

The information above is only a summary of the benefits described. The rest of this booklet includes important additional information about limitations, exclusions and covered benefits. The "Schedule of Benefits (Who Pays What)" section includes additional information about Copayments, Deductibles and Coinsurance. If you have questions, please call Health Plan Services at 303-602-2090.

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1. Schedule of Benefits (Who Pays What)

Benefit	In Network	Out of Network
Preventive Services		
Children and Adults	0% coinsurance, deductible does not apply (covered 100%). All immunizations recommended by the Centers for Disease Control and Prevention are covered at no cost. All preventive services with an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF) as well as those supported by the Health Resources and Services Administration are covered at no cost. Included but not limited to annual well visit, well woman exam, prenatal and postpartum visits, colonoscopy and mammogram. For an entire list see the USPSTF list on our website at www.denverhealthmedicalplan.org/elevate-current-members.	Not covered.
Maternity		
Prenatal Visit	10% coinsurance, deductible does apply. Cost sharing may apply to additional services.	Not covered.
Delivery, Inpatient and Well Baby Care	10% coinsurance, deductible does apply.	Not covered.
Infertility		
	10% coinsurance, deductible does apply.	Not covered.
Prescription Drugs		
For drugs on our approved list, call Health Plan Services at 303-602-2090 or visit our website at www.denverhealthmedicalplan.org/elevate-current-members.	**Denver Health Pharmacy (30-day supply).** • Generic: $15 copay, deductible does not apply. • Preferred Brand: $25 copay, deductible does not apply. • Non-Preferred Brand: $55 copay, deductible does not apply. • Specialty: $580 copay, deductible does not apply. **Denver Health Pharmacy (90-day supply).** • Generic: $30 copay, deductible does not apply. • Preferred Brand: $50 copay, deductible does not apply. • Non-Preferred Brand: $110 copay, deductible does not apply. • Specialty: N/A **National Network Pharmacy (30-day supply).** • Generic: $30 copay, deductible does not apply. • Preferred Brand: $50 copay, deductible does not apply. • Non-Preferred Brand: $110 copay, deductible does not apply. • Specialty: $580 copay, deductible does not apply. **National Network Pharmacy (90-day supply).** • Generic: $60 copay, deductible does not apply. • Preferred Brand: $100 copay, deductible does not apply. • Non-Preferred Brand: $220 copay, deductible does not apply. • Specialty: N/A	Not covered.
Inpatient Hospital		
	10% coinsurance, deductible does apply. Medically necessary bariatric surgery is covered.	Not covered.
Outpatient/Ambulatory Surgery		
	10% coinsurance, deductible does apply.	Not covered.
Diagnostics Laboratory and Radiology		
Laboratory, X-Ray	10% coinsurance, deductible does not apply.	Not covered.

1. Schedule of Benefits (Who Pays What)

Benefit	In Network	Out of Network
PET Scan, MRI, CT	10% coinsurance, deductible does apply.	Not covered.
Pulmonary Testing, Outpatient	10% coinsurance, deductible does apply.	Not covered.
Emergency Care		
	10% coinsurance per visit, deductible does apply.	10% coinsurance per visit, deductible does apply.
Urgent Care and Dispatch Health		
	10% coinsurance per visit, deductible does apply.	10% coinsurance per visit, deductible does apply.
Ambulance		
	10% coinsurance, deductible does apply.	10% coinsurance, deductible does apply.
Behavioral Health and Other Mental Health Care		
Outpatient	10% coinsurance per visit, deductible does apply.	Not covered.
Inpatient	10% coinsurance, deductible does apply.	Not covered.
Therapies		
Rehabilitative: Physical, Occupational and Speech Therapy	10% coinsurance, deductible does apply. Limitation: 20 visits of each therapy per calendar year.	Not covered.
Habilitative: Physical, Occupational and Speech Therapy	10% coinsurance, deductible does apply. Limitation: 20 visits of each therapy per calendar year.	Not covered.
Pulmonary Rehabilitation	10% coinsurance, deductible does apply.	Not covered.
Cardiac Rehabilitation	10% coinsurance, deductible does apply.	Not covered.
Durable Medical Equipment		
	10% coinsurance, deductible does apply.	Not covered.
Hearing Aids		
Adults 19 and over	Not covered.	Not covered.
Children 18 and under	Covered at 100% once every 5 years.	Not covered.
Prosthetics		
	10% coinsurance, deductible does apply.	Not covered.
Orthotics		
	10% coinsurance, deductible does apply.	Not covered.
Oxygen/Oxygen Equipment		
	10% coinsurance, deductible does apply.	Not covered.
	10% coinsurance, deductible does apply.	Not covered.
Organ Transplants		
	10% coinsurance, deductible does apply.	Not covered.
Home Health Care		
	10% coinsurance, deductible does apply. Limitation: 28 hours per week.	Not covered.
Hospice Care		
	10% coinsurance, deductible does apply.	Not covered.
Skilled Nursing Facility		
	10% coinsurance, deductible does apply. Limitation: 100 days per calendar year.	Not covered.
Chiropractic Care		

1. Schedule of Benefits (Who Pays What)

Benefit	In Network	Out of Network
	10% coinsurance, deductible does apply. Limitation: 20 visits per calendar year. Services must be provided by Columbine Chiropractic in order to be covered.	Not covered.
Dental Care		
	Not Covered.	Not covered.
Vision Care		
Adults 19 and over	10% coinsurance, deductible does apply. Glasses, including frames and lenses, and contacts are not covered.	Not covered.
Children 18 and under	Covered at 100%. One pair of eye glasses every 24 months from an in-network provider (includes the frame and lenses) or contact lenses at $0 cost sharing. Limit of 1 routine eye exam per 12 months.	Not covered.

January 2020

The information contained in this Member Handbook explains the administration of the Elevate plan benefits. Elevate 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 Elevate benefits can also be obtained through marketing materials, by contacting the Health Plan Services Department at 303-602-2090, or toll-free at 1-855-823-8872, and on our website at www.denverhealthmedicalplan.org/elevate-current-members. 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 Elevate, the terms and conditions of this Member Handbook and its supplements will control.

DENVER HEALTH MEDICAL PLAN INC.™

Elevate

GOLD STANDARD

Coverage as described in this Member Handbook commences January 1, 2020 and ends December 31, 2020.

Health Plan Services 303-602-2090 • Fax 303-602-2138

- Benefit questions
- Eligibility questions
- Prior authorization
- Billing questions
- Grievances (complaints)

Pharmacy Department 303-602-2081

- Pharmacy prior authorizations (medications that are non-formulary)
- Pharmacy claim rejections
- Medication cost
- Medication safety

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

Elevate Health Plans
938 Bannock Street, Mail Code 6000
Denver, CO 80204

www.denverhealthmedicalplan.org/elevate-current-members

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5. Eligibility

Elevate is a health insurance plan offered by Denver Health Medical Plan, Inc. (DHMP), a health maintenance organization (HMO) licensed to offer coverage in Denver, Arapahoe, Adams and Jefferson counties in Colorado.

Elevate is offered both through Connect for Health Colorado and directly through Denver Health Medical Plan. It is subject to all rules and regulations of Connect for Health Colorado. You can visit their website at http://www.connectforhealthco.com

No one is ineligible due to any pre-existing health condition.

Elevate does not discriminate with respect to the provision of medically necessary covered benefits against persons who are participants in a publicly financed program.

If you or your spouse is required, due to a Qualified Medical Child Support Order (QMCSO), to provide coverage for your child, you may ask Elevate to provide you, without charge, a written statement outlining the procedures for getting coverage for such children.

Who is Eligible to Join Elevate?

- All residents of Denver, Arapahoe, Adams or Jefferson counties are eligible to participate in an Elevate health plan.
- You are not eligible to enroll in Elevate if you have Child Health Plan Plus. Elevate members with APTC are ineligible to be dually enrolled in Medicaid or Medicare.
- You may enroll in an Elevate health plan 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.

Eligible Dependents

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 or partner in a civil union).
- A child married or unmarried until their 26th birthday.
- 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 dependent 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 QMSCO 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 parental responsibility or the child of your eligible same sex domestic partner.
- For coverage under a QSMCO or other court order, you must provide a copy of the order.
- Eligible dependents living outside of the network area must use the Denver Health Medical Plan Network providers for their medical care, except for urgent/ emergency care.

Initial Enrollment

To obtain medical coverage, you and your eligible dependents must enroll during an Open Enrollment or a Special Enrollment period.

Open Enrollment

Open Enrollment is an annual period of time during which members may enroll in an Elevate health plan. Elevate health plans follow the Connect for Health Colorado Open Enrollment period:

Enrollment for plans effective January 1st, 2020 begins November 1st, 2019 and ends December 15th, 2019.

Special Enrollment

The occurrence of certain events triggers a special enrollment period during which you and/or eligible dependents (depending on the event) can enroll in a health plan.

Of the cases below, you and/or your eligible dependent must enroll within 60 days after the event.

- Involuntarily losing existing creditable coverage for any reason other than fraud, misrepresentation or failure to pay a premium;
- Gaining a dependent or becoming a dependent through marriage, civil union, birth, adoption or placement for adoption, placement in Foster care or by entering into a designated beneficiary agreement if the carrier offers coverage to designated beneficiaries;
- An individual's enrollment or non-enrollment in a health benefit plan that is unintentional, inadvertent or erroneous and is the result of an error, misrepresentation or inaction of the carrier, producer or the Exchange;
- Demonstrating to the Commissioner that the health benefit plan in which the individual is enrolled has substantially violated a material provision of its

contract in relation to the individual;

- An Exchange enrollee becoming newly eligible or ineligible for the federal Advance Payment Tax Credit (APTC) or Cost Sharing Reductions (CSR) available through the Exchange;
- Gaining access to other creditable coverage as a result of a permanent change in residence;
- A parent or legal guardian dis-enrolling a dependent or a dependent becoming ineligible for the Children's Basic Health Plan;
- An individual becoming ineligible under the Colorado Medical Assistance Act;
- An individual, who was not previously a citizen, a national or a lawfully present individual, gains such status; or
- An American Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month.

When an individual is notified or becomes aware of a QLCE that will occur in the future, they may apply for enrollment in a new health benefit plan during the 30 calendar days prior to the effective date of the QLCE, with coverage beginning no earlier than the day the triggering event occurs to avoid a gap in coverage. The individual must be able to provide written documentation to support the effective date of the QLCE at the time of application.

For more information regarding QLCEs and the impact on APTC and CSR, contact Connect for Health Colorado at 1-855-PLANS-4-YOU (1-855-752-6749) or www.connectforhealthco.com.

When Coverage Begins

Open Enrollment - If you select Elevate during the annual Open Enrollment period, before December 15th, your coverage begins on January 1st of the following year. If you enroll on or after January 16th your coverage begins the February 1st. Coverage for your enrolled dependents begins when your coverage begins.

During special enrollment periods or if you are newly eligible for coverage, the effective date of coverage will begin the first of the next month if enrolled before the 15th of the month. If enrollment is between the 16th and the end of the month, coverage will begin the first day of the second following month.

Effective Dates for Special Enrollment –

- In the case of marriage, civil union or in the case where an individual loses creditable coverage, coverage must be effective no later than the first day of the following month.
- In the case of birth, adoption, placement for adoption or placement in foster care, coverage must be effective on the date of the event.
- In the case of all other QLCEs, where individual coverage is purchased between the first and fifteenth day of the month, coverage shall become effective no later than the first day of the following month.
- In the case of all other QLCEs, where individual coverage is purchased between the sixteenth and last day of the month, coverage shall become effective no later than the first day of the second following month.

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. Elevate 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, Elevate will be responsible for any services that are covered as stated in "Benefits/Coverage" section. If the member is confined to a medical facility and was not covered by a group health plan when Elevate coverage began, Elevate will be responsible for the covered costs and services related to the confinement from the time coverage begins.

When Coverage Ends

- You or a dependent no longer meets eligibility requirements.
- You no longer pay the monthly premium required for continuation of coverage.
- You commit a violation of the terms of the plan.
- 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 dependent on you will also end at the same time your coverage ends.

- No member will be terminated due to health status or previous use of medical services.
- See "Termination/Non-Renewal/Continuation" section.

Welcome to Elevate

At Elevate our main concern is that you receive quality health care services.

As a member of Elevate, you must receive your health care services within the contracted network.

Your basic membership obligation is to consult with your personal provider before seeking most health care services.

Please see the Schedule of Benefits for a breakdown of cost sharing.

Your Primary Care Provider

Primary care providers include family doctors, internal medicine doctors, pediatric doctors, physician assistants and nurse practitioners. You will find a list of in network primary care providers in our online "Find a Doctor" directory. Services can also help you find a physician.

While you are not required to select a primary care provider, these practitioners can assist you to maintain and monitor your health, as well as access the services of specialty care physicians.

Your primary care provider can help you 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 Elevate network, visit: www.denverhealthmedicalplan.org/elevate-current-members and select "Find a Provider." You may also contact Health Plan Services at 303-602-2090.

You have the right to see any primary care provider who participates in our network and who is accepting new members. For children, you may designate 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 Denver Health 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 Elevate network. You may call Health Plan Services at 303-602-2090 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. They will work with you to determine if you need to see a specialist, provide you with a referral and help to coordinate your care.

Members may self-refer for the following services: OB/ GYN, Behavioral Health and routine eye care.

Your Health Network

The Elevate network is made up of all Denver Health clinics and facilities. This includes nine community health centers, 17 school-based health centers and the main Denver Health Medical Center campus. The main campus includes the Webb Primary Care Center for outpatient care, as well as the inpatient hospital facility. In addition, members have access to Clinica and Salud clinics in the four-county service area.

To find a full list of Elevate network providers, visit www.denverhealthmedicalplan.org/elevate-current-members and click on "Find a Provider" for our web based provider directory, or call Health Plan Services at 303-602-2090.

If you need 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 this network. However, you must have prior authorization for Elevate to pay for the services. If you have questions regarding this, call Health Plan Services at 303-602-2090.

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 a day, seven days a 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.

Emergency Care

An emergency medical condition is defined as 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 reasonably expect, in the absence of immediate medical attention, to result in:

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

Serious impairment to bodily functions;

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 for both in network and out of network providers.

Care outside the Health Plan Network:

Care outside of the Elevate network may be covered if:

- The type of care is not provided within the Elevate network; and
- You receive a referral from your primary care provider or specialist; and
- The referral is approved (authorized), in advance, by Utilization Management.
- Self-referral to Cofinity providers is allowed for outpatient mental health services only.

If you choose to see a provider who is not a participating provider without a referral from your primary care provider and without prior authorization from Elevate, you will be responsible for all of the charges for all services. Elevate has no obligation to pay these charges.

When living or traveling outside of the Denver metropolitan area but still within the United States, only emergencies, urgent care services, and prescriptions, when filled at a network pharmacy, will be covered.

Complex Case Management (CCM)

Complex Case Managers are available if you have complex medical issues, psychosocial and care coordination needs that require intensive support. 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.

Our team of Complex Case Managers includes Nurses, Social Workers and other qualified professionals. We take your health personally and offer specialized services that are focused on you and your needs.

- Complex 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 you need.
- Provide one-on-one health care information, guidance and support.
- Provide education to support self-care skills.

Our goal is to assist you to:

- Regain and/or improve health or function. Better understand your health conditions and concerns.
- Understand your health care benefits and get the care you need.
- Take a more active role in your care and treatment plan.

Members or their caregivers may self-refer to gain access to these voluntary services. Complex Case Management services are provided at no cost to you and will not affect your plan benefits.

To participate in a Complex Case Management Program or to learn more about Complex Case Management, please call Health Plan Services at 303-602-2090. You can also obtain more information about program eligibility and services at www.denverhealthmedicalplan.org/elevate-current-members.

Utilization Management / Authorization Process

Some medical services must be reviewed and approved (prior authorization) by Elevate to ensure payment.

Your doctor or other provider will send a request to Elevate for authorization. DHMP will notify you and your provider when the request has been approved or denied. Requests may be 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 the “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 303-602-2090. You can also refer to the prior authorization list which is available on our website at www.denverhealthmedicalplan.org/medical-prior-authorization-list.

Nurse Line

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

Language Line Services

Elevate is committed to meeting our plan members’ needs. Elevate contracts with Language Line Services, Inc. to provide translation services at no cost to our plan members. If you need an interpreter during your clinic visit, please tell the Appointment Center representative when you make your appointment. For further assistance, please contact Health Plan Services at 303-602-2090.

Access Plan

Elevate 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 Elevate’s referral, coordination of care and emergency coverage procedures. The Access Plan is available on the Elevate website at www.denverhealthmedicalplan.org/elevate-access-care.

Health and Wellness

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. This helps boost motivation by encouraging and supporting members in making lifestyle changes to improve their health.

Health coaching can help you with:

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

Health coaching 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 303-602-2090.

When You Are Out of Town

When you are traveling within the United States, only emergency and urgent care services are covered outside the Elevate service area and network. You may go to any hospital or urgent care center that is convenient for you. If you need emergency care, go to the nearest hospital or call 9-1-1. Routine care is not covered out of network. Out of country services urgent or not, are not a covered benefit. 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 Elevate network are not a covered benefit. If you plan to be outside the Elevate service area and need your prescriptions filled, we have many network pharmacies across the country that you may use. Please check with Health Plan Services at 303-602- 2090.

Change of Address

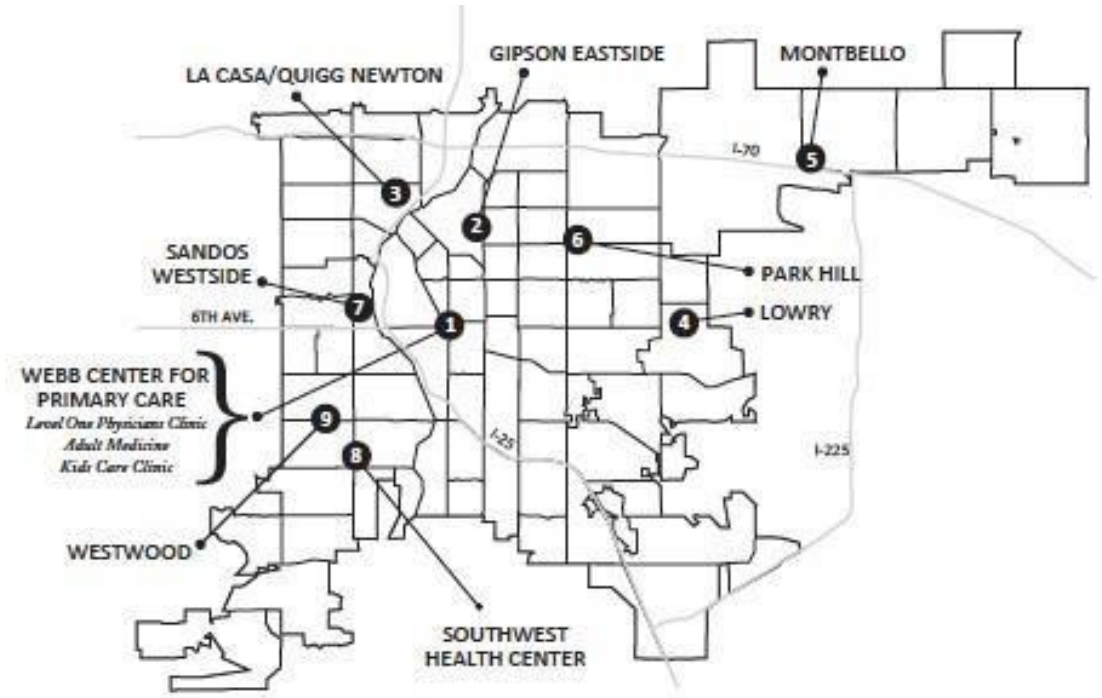
If you purchased your Elevate plan from Connect for Health Colorado, you must contact them directly for any changes in name, mailing address or phone number at 1-855-PLANS-4-YOU (1-855-752-6749) or www.connectforhealthco.com. If you purchased your Elevate plan directly from DHMP, call Health Plan Services at 303-602-2090.

Advance Directives

Advance Directive decisions include the right to consent to (accept) or refuse any medical care or treatment and the right to give 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. It may be a good idea to discuss them with your doctor, family, friends or staff members at your health care facility or even a lawyer. You can obtain more information about advance directives, such as living wills, medical durable powers of attorney and Do Not Resuscitate orders (DNR) from your personal 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 Elevate website at http://www.denverhealthmedicalplan.org/elevate-forms-documents-links.

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

Map of Denver Health Family Health Centers



FAMILY HEALTH CENTERS

1 ℞ **WELLINGTON WEBB CENTER FOR PRIMARY CARE**
301 W. 6th Ave.

LEVEL ONE PHYSICIANS CLINIC	303.602.8270
ADULT MEDICINE CLINIC	
Burgundy	303.602.8070
Green Team	303.602.8080
KIDS CARE CLINIC	303.602.8340
PHARMACY	303.602.8500

2 ℞ **GIPSON EASTSIDE**
501 28th St.

	303.436.4600
Pharmacy	303.436.4600

3 ℞ **LA CASA/QUIGG NEWTON**
4545 Navajo

	303.602.6700
Pharmacy	303.602.6700

4 ℞ **LOWRY**
1001 Yosemite St.
Suite 100

	303.602.4545
Pharmacy	303.602.4630

5 ℞ **MONTBELLO**
12600 Albrook Dr.

	303.602.4000
Pharmacy	303.602.4025

6 **PARK HILL**
4995 E. 33rd Ave. 303.602.3720

7 ℞ **SANDOS WESTSIDE**

1100 Federal Blvd.	303.436.4200
Pharmacy	303.436.4200

8 ℞ **SOUTHWEST HEALTH CENTER**

1339 S Federal Blvd.	303.602.0000
Pharmacy	303.602.0000

9 **WESTWOOD**
4320 W Alaska Ave. 303.602.4660

1 **HOSPITAL**

DENVER HEALTH MEDICAL CENTER
777 Bannock St. 303.436.6000

ADULT URGENT CARE WALK-IN CLINIC
777 Bannock St. 303.602.2822

PEDIATRIC URGENT CARE CLINIC
777 Bannock St. 303.602.3300

Clinica Family Health

Federal Heights Clinic
8300 Alcott Street, Suite 205
Westminster, CO 80031

Lafayette Clinic
2000 West South Boulder Road
Lafayette, CO 80026

Pecos Clinic
1701 West 72nd Avenue, 3rd Floor
Denver, CO 80229

People's Clinic 2525 13th Avenue
Boulder, CO 80304

Thornton Clinic
8990 North Washington Street
Thornton, CO 80229

Salud Family Health Centers

Audrey C. Farley Women's Center
30 South 20th Avenue
Brighton, CO 80601

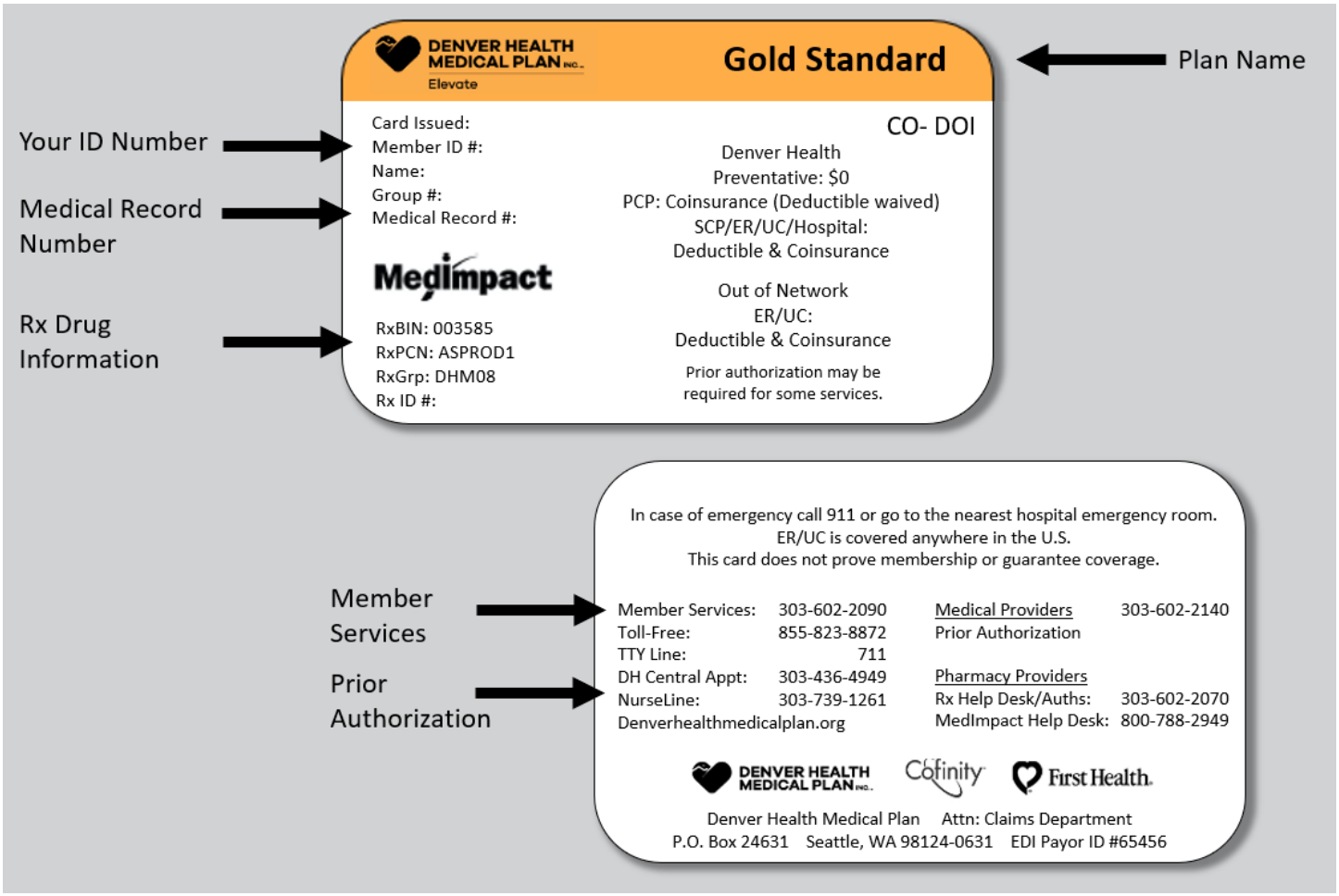
Brighton Salud Family Health Center
1860 Egbert Street
Brighton, CO 80601-3701

Commerce City Salud and Family Health Center
6255 Quebec Pkwy
Commerce City, CO 80022-5413

Community Reach Center Salud
4371 E. 72nd Avenue Commerce City, CO 80022

Your Elevate Identification Card

Keep your Elevate identification card with you at all times. Before receiving medical or prescription services, you must show your Elevate identification card. If you fail to do so, or misrepresent your membership status, claim payment may be denied. If you lose your identification card and need a new one, please call Health Plan Services at 303-602-2090, Monday - Friday 8 a.m. - 5 p.m. (TTY/TDD users should call 711).



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

Member Newsletter

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

Your Benefits

It is important that you understand the benefits and cost sharing that applies to you. When in doubt, call the Elevate Health Plan Services Department at 303-602-2090. This is the best source of information about your plan benefits.

Office Visits

Primary care 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 chapter.

Primary Care Visit:

In network: 10% coinsurance per visit, deductible does apply.

Out of network: Not covered.

Specialty Visit:

In network: 10% coinsurance per visit, deductible does apply.

Out of network: Not covered.

Allergy Testing and Treatment

Allergy specialist visit is covered with a referral from your provider.

Allergy Testing:

In network: 100% covered.

Out of network: Not covered.

Allergy Treatment:

In network: 10% coinsurance per visit, deductible does apply.

Out of network: Not covered.

Allergy injections given by a nurse, when no other services are provided, are not subject to cost sharing.

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

In network: Applicable cost sharing for type of service will apply.

Out of network: Not covered.

Bariatric Surgery

Bariatric surgery is a covered benefit. Must meet plan criteria to be eligible for coverage.

In network: 10% coinsurance, deductible does apply.

Out of network: Not covered.

Chiropractic Care

Coverage includes evaluation, lab services and x-rays required for chiropractic services and treatment of musculoskeletal disorders. Maximum 20 visits per plan year. Services must be provided by Columbine Chiropractic in order to be covered. See Chapter 8 for exclusions.

In network: 10% coinsurance per visit, deductible does apply.

Out of network: Not covered.

Clinical Trials and Studies

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

- The member is in network and their primary care physician 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/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, deductible and coinsurance will apply;
- Health care services excluded from coverage under the member's health plan will not be covered. Elevate

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 is not covered.

See "Definitions" section for more information.

In network: Applicable cost sharing for type of service will apply.

Out of network: Applicable cost sharing for type of service will apply.

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 physician. Some insulin pumps and supplies are covered through the DME benefit and may require prior authorization.

In network: Applicable cost sharing for type of service will apply.

Out of network: Not covered.

Dietary and Nutritional Counseling

Coverage for dietary 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 will apply.

Out of network: Not covered.

Durable Medical Equipment, Prosthetics and Orthotics

General

Durable Medical Equipment (DME) is covered if medically necessary and may require prior authorization by Elevate. This includes diabetic footwear and consumables. 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 personal provider and request that the authorization be extended. All DME must be obtained from an Elevate 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.

- Covered if medically necessary and may require prior authorization by Elevate: air cleaners/purifiers, air jet 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 radio waves/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).

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 or orthotic device that adequately meets a member's medical needs.

In network: 10% coinsurance, deductible does apply.

Out of network: Not covered.

Prosthetic Devices

Prosthetic devices are 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.

Coverage

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. Internal prosthesis must be obtained in network. Elevate will designate the source from which external prosthesis 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 Elevate.
- 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.

No benefit maximum. See "Limitations and Exclusions" section for what is not covered.

In network: 10% coinsurance, deductible does apply.
Out of network: Not covered.

Orthotic Devices Coverage

- 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.
- Not subject to deductible. See Chapter 8 for exclusions.
- Orthotic devices may require prior authorization.

In network: 10% coinsurance, deductible does apply.
Out of network: Not covered.

Early Intervention Services

Early intervention services are covered for an eligible dependent from birth to age three 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 Elevate network, unless otherwise approved by the Utilization Management Department.

No cost sharing applies to early intervention services.

Benefit Maximum: 45 therapeutic visits for all early intervention services per calendar 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 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, which a prudent layperson with an average knowledge of health and medicine could reasonably expect, in the absence of immediate medical attention, to result in:

- Placing the health of the individual or, with respect to a pregnant woman, 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.
- Services for the treatment of an emergency are covered. See definition of "Emergency" in the "Definitions" section.

In network: 10% coinsurance per visit, deductible does apply.
Out of network: 10% coinsurance per visit, deductible does apply.

Non-emergency care delivered by an Emergency Department is not covered unless you are referred to the Emergency Department for care by Elevate, the Nurse Line or your personal provider.

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

Ambulance Service

Medically necessary ambulance service, ground or air, related to the treatment of an emergency is covered. Non-emergent transport is covered with provider referral and plan authorization.

In network: 10% coinsurance, deductible does apply.

Out of network: 10% coinsurance, deductible does apply.

Urgent Care Services

Urgent care is immediate outpatient medical treatment for an acute illness or 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 Nurse Line at 303-739-1261 for assistance. Dispatch Health provides urgent care services in the privacy of your own home. They are available seven days a week, 365 days a year, including holidays. Hours of operation are 8am to 10pm for the Denver Metro area. To request care, visit their website at www.dispatchhealth.com or call 303-500-1518.

In network: 10% coinsurance per visit, deductible does apply.

Out of network: 10% coinsurance per visit, deductible does apply.

Eye Examinations and Ophthalmology

Routine visual screening examinations are covered if performed by an Elevate network provider. Self-referral is allowed. Other ophthalmology services are covered as referred by your primary care provider.

Adults 19 and Over

In network: Deductible and 10% coinsurance per visit apply. Glasses, including frames and lenses, and contacts are not covered.

Out of network: Not covered.

Pediatric Vision Benefit

In network: 100% covered for children 18 and under. One pair every 24 months, includes the frames and lenses or contact lenses. Limit of 1 routine eye exam per 12 months.

Out of network: Not covered.

Family Planning Services

You do not need prior authorization from Elevate 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:

- Family planning counseling;
- Information on birth control;
- Diaphragms (and fitting);
- Insertion and removal of intrauterine devices;
- Formulary contraceptives (oral) (see Medicine/Pharmacy). Currently the Food 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.

Tubal ligations and vasectomies are covered. You must receive a referral from an in-network provider, if the service is not provided by your primary care provider.

In network: 100% covered.

Out of network: Not covered.

There are some limitations; please see the "Limitations and Exclusions" section.

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 the process, procedures covered, etc., please contact Health Plan Services at 303-602-2090. See the "Limitations and Exclusions" section for what is not covered.

Hearing Aids

Medically necessary hearing tests and hearing aids prescribed by an in-network provider are covered every five years for children age 18 and under. Hearing tests and fittings for hearing aids are covered under clinic visits and the applicable cost sharing applies. Prior authorization required.

Adults (age 19 and over):

In network: Not covered.

Out of network: Not covered.

Children (age 18 and under):

In network: 100% covered.

Out of network: Not covered.

Home Health Care

Home health care provided by an Elevate network home health care provider is covered. Coverage requires periodic assessment by your primary care 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 Elevate.

Physical, Occupational and Speech Therapy

Physical, occupational and speech therapy, as well as audiology services, in the home are covered when prescribed by your personal 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 referral.

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 with developmental delays and medically necessary physical therapy, occupational therapy and speech therapy for the care and treatment of congenital defects and birth abnormalities for children up to the age of six 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 Elevate (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: 10% coinsurance, deductible does apply.
Out of network: Not covered.
Benefit Maximum: 28 hours per week.

Hospice Care

Inpatient and home hospice services for a terminally ill member are covered when provided by an approved hospice program. Each hospice benefit period has a duration of three months. Hospice services may require prior authorization by Elevate 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, the 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 303-602-2090 for further information.

In network: 10% coinsurance, deductible does apply.
Out of network: Not covered.

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 twelve-month period following death;
- 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 Elevate. 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: 10% coinsurance, deductible does apply.
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 Elevate. Emergency hospitalization should be reported to Elevate at 303-602-2140 as soon as reasonably possible, preferably within one business day.

- 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 are covered when medically necessary. Sitters are covered only 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: 10% coinsurance, deductible does apply.
Out of network: Not covered (emergency admissions covered).

Limitations: If you request a private room, Elevate will pay only what it would pay towards 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, Elevate will pay for the private room.

Immunizations

- There is no cost sharing for covered immunizations. Hepatitis A and B and Meningococcal vaccines are covered at no cost. Some international travel immunizations will only be covered if they are provided at the Public Health Department at Denver Health. Formulary prophylactic drugs for travel will be covered if prescribed by your personal provider. Some immunizations can be received in your personal provider's office, so before visiting the Public Health Department at Denver Health, contact your personal provider for immunizations and prophylactic drugs.
- The HPV vaccine is covered for eligible members in accordance with guidelines of the U.S. Department of Health and Human Services when ordered by your provider.
- Clinic visits for administration of immunization do not require a cost sharing. However, if the visit is a combination of the injection and a nurse, personal provider or specialist visits, the required cost sharing will apply.
- Travel vaccinations recommended by the Centers for Disease Control and Prevention (CDC) only for travel outside of the United States are not covered.

Infertility

- The following services are covered, including x-ray and laboratory procedures: services for diagnosis and treatment of involuntary infertility and artificial insemination, except for donor semen, donor eggs, and services related to their procurement and

storage. See the "Limitations and Exclusions" section for additional details.

In network: 10% coinsurance, deductible does apply.

Out of network: Not covered.

Infusion Services

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

In network: 10% coinsurance, deductible does apply.

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 a cost sharing. However, if the visit is a combination of the injection and a personal provider or specialist visit, the required cost sharing will apply.

In network: 10% coinsurance, deductible does apply.

Out of network: Not covered.

Laboratory and Pathology Services (Outpatient)

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, such as testing to determine risk for developing cancer, are covered and may require prior authorization.

Prenatal diagnosis and screening during pregnancy by 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: 10% coinsurance, deductible does not apply.

Out of network: Not 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, 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.

In network: 100% covered.

Out of network: Not covered.

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 in network facility. 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: 10% coinsurance, deductible does apply.

Out of network: Not covered (emergency admissions covered).

Postpartum: Breastfeeding support and equipment* is available at no cost to the member. Call 303-602-2090 for more information.

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

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 is covered if a 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.

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 blended and used with enteral feeding system
- Nutritional supplement puddings High protein powders and mixes
- Non-formulary oral vitamins and minerals

Mental Health Services

Inpatient Psychiatric/Mental Health Services

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

Authorization is required for non-emergent admissions. Notification to the plan should be made as soon as reasonably possible, preferably within one business day of an emergent admission.

In network: 10% coinsurance, deductible does apply.
Out of network: Not covered.

Partial Hospitalization/Day Treatment

"Partial Hospitalization" is defined as continuous treatment at a network facility of at least three 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% coinsurance per visit, deductible does apply.
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 Elevate network without a referral from your personal provider. Cofinity providers are in network for outpatient mental health services only.

In network: 10% coinsurance per visit, deductible does apply.
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 Elevate network without a referral from your personal provider. Cofinity providers are in network for outpatient mental health services only.

In network: 10% coinsurance per visit, deductible does apply.
Out of network: Not covered.

Biologically - Based Mental Illnesses and Mental Disorders

Elevate will provide coverage for the treatment of biologically-based mental illnesses and mental disorders that are no less extensive than for any other physical illness. Biologically-based mental illnesses include: 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. Mental and Behavioral Health Cofinity providers are in network for outpatient mental health services only.

Inpatient:
In network: 10% coinsurance, deductible does apply.

Out of network: Not covered.

Outpatient:
In network: 10% coinsurance per visit, deductible does apply.
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 beyond the first 31 days. The plan covers all medically necessary care and treatment for members with cleft lip, 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, cleft palate or both will continue as long as the member is eligible. All care must be obtained through Elevate 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 designated as outpatient care.

If you are admitted into observation after receiving services in the Emergency Department, you will not have to pay the Emergency Department cost sharing, but you will be responsible for the observational stay cost sharing.

In network: 10% coinsurance per visit, deductible does apply.
Out of network: 10% coinsurance per visit, deductible does apply.

Ostomy Supplies

Colostomy, ileostomy and urostomy supplies are covered.

In network: 10% coinsurance, deductible does apply.
Out of network: Not covered.

Oxygen/Oxygen Equipment

Oxygen and equipment for the administration of oxygen is covered. Applicable cost sharing applies.

There is no benefit maximum. Prior authorization may be required.

In network: 10% coinsurance, deductible does apply.
Out of network: Not covered.

Pharmacy Benefits

Elevate 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. Prescription cost sharing information for your plan is listed in the Pharmacy Benefits chart.

Elevate uses lesser of logic to calculate your cost sharing. This means the plan will never charge you more than your cost sharing and if the pharmacy submits a cost lower than your copay, that savings is passed on to you.

Example: if your copay is $8 and the pharmacy submits a cost of $10, you will pay $8. However, if your copay is $8 and the pharmacy submits a cost of $6, you will only have to pay $6.

Elevate members will not be responsible to pay more than $100 for a 30-day supply of insulin.

Where You Can Fill Your Prescription

- Elevate offers thousands of pharmacies nationwide for you to fill your prescriptions. These pharmacies include any Denver Health Pharmacy, King Soopers, Safeway, Target, Walgreens, and more. A pharmacy locator tool is available at www.denverhealthmedicalplan.org/elevate-pharmacy to help you find a network pharmacy or you can call Health Plan Services at 303-602-2090.
- Elevate members can access Denver Health Pharmacies which are conveniently located in many Denver Health clinics. While you have the choice to fill your prescription at any network pharmacy, filling your prescriptions at Denver Health Pharmacies will give you the lowest cost sharing and allows your Denver Health provider to see your prescription fill information. This helps your provider to give you the most complete care at each visit.

Remember, to fill a prescription at a Denver Health Pharmacy, your prescription must be written by a Denver Health provider.

Denver Health Pharmacies

Denver Health Refill Request Line and Central Pharmacy Call Line
303-389-1390

Denver Health Retail by Mail
(requires credit card and registration/order form)
Monday-Friday, 9am-5pm
303-602-2326

Primary Care Pharmacy
301 West 6th Avenue

Gipson Eastside Pharmacy
501 28th Street

Public Health Pharmacy
605 Bannock Street

La Casa/Quigg Pharmacy
4545 Navajo Street

Lowry Pharmacy
1001 Yosemite Street

Montbello Pharmacy
12600 Albrook Drive

Sandos Westside Pharmacy
1100 Federal Blvd

South West Pharmacy
1339 S. Federal Blvd

Refilling Your Prescription

- It is best to call to refill your prescription 3-5 working days before you need your refill. Non-controlled prescriptions are eligible for refill once 75% has been used. Some examples of non-controlled prescriptions are drugs used for blood pressure, high cholesterol and diabetes. Controlled prescriptions are eligible once 85% has been used. Some examples of controlled prescriptions are opioids, stimulants such as Adderall or Ritalin or benzodiazepines such as diazepam and lorazepam. 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 70% of the day supply your prescription is filled for has passed. For example, you can fill a 30-day prescription after 21 days, a 60-day supply after 42 days and a 90-day prescription after 63 days. Your provider can write you a prescription for an additional bottle for use at a child or adult daycare or school, or you can request this. This is limited to one additional bottle every 90 days, as prescribed by your provider and it should be stated on the prescription the extra bottle is needed for a day care center, school or adult day program.
- For contraceptive (birth control) prescriptions, the first prescription fill quantity may be up to a maximum of a three-month supply. The second prescription fill quantity may be up to a 12-month supply or to the end of your plan year (whichever is shorter).
- You can refill prescriptions filled at the Denver Health Pharmacies by calling the Denver Health Refill Request Line (which is also listed on your prescription bottle) or by visiting www.denverhealthmedicalplan.org/elevate-pharmacy. You can also use the My Chart smartphone app.

Mail Order Pharmacy - Denver Health Pharmacy by Mail

- Save time by signing up to have your prescriptions delivered to your home by mail. Ask your provider to write your prescriptions for a 90-day supply to get your prescriptions by mail. A registration/order form is required to sign up and you must keep a credit card on file to pay for your medications.
- You can print a registration/order form at www.denverhealthmedicalplan.org/elevate-pharmacy. You can also pick up a registration/ order form from any of the Denver Health Pharmacies or call Denver Health Pharmacy by Mail at 303-602-2326.
- Medications are sent through the U.S. Postal Service within the state of Colorado. Medications that need refrigeration can be mailed. Controlled substances cannot be filled by Denver Health Pharmacy by Mail.

90-Day Supply at Retail

- Medications are sent through the U.S. Postal Service within the state of Colorado. Medications that need refrigeration can be mailed. Controlled substances cannot be filled by Denver Health Pharmacy by Mail.
- 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 is eligible for this benefit visit 303-602-2326 and click the "Formulary Search" link for your plan or call Health Plan

Services at 303-602-2090. 60-day supplies are also available at most of these pharmacies.

Your Formulary

- The Elevate formulary is a list of covered drugs that shows your drug costs for each tier and prior authorization requirements for each medication. Elevate has selected the tiers and determined the criteria for prior authorization based on efficacy and cost-effectiveness. There is different cost sharing 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. Elevate will review the prior authorization request according to the plan criteria for medical necessity and determine if the drug will be covered.
- 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 www.denverhealthmedicalplan.org/elevate-pharmacy or call Health Plan Services at 303-602-2090 to ask for a printed copy.
- Formulary palliative drugs, in quantities that are within the formulary limits, prescribed for pain control and symptom management of a terminal illness are a covered benefit. You must obtain these drugs from a Plan Pharmacy. Certain drugs are limited to a maximum of a 30-day supply.

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 prior authorizations please contact Health Plan Services at 303-602-2090.
- 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 at 303-602-2090.
- 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 the address set out in the determination letter that explains the plan's decision, or by calling Health Plan Services at 303-602-2090. For expedited requests you will be notified of our determination within 24 hours.

Step Therapy

Step therapy is a protocol that requires you to use a prescription drug or sequence of prescription drugs, other than the drug your provider requests for your treatment, before the plan will cover the requested prescription drug. Your plan will not require you to go through step therapy as long as the prescribed drug is on the drug formulary (list of covered drugs), you have tried the step therapy required prescription drugs while on our plan or a previous health insurance plan, when those required drugs were discontinued due to lack of efficacy or effectiveness or because you had an adverse event. Drug samples are not considered a trial and failure of a required prescription drug when trying to meet a step therapy requirement. When you are trying to meet a step therapy requirement your plan may require documentation from you or your provider to support your request.

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 prescribed 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 on other tiers may also be specialty. To find out if your drug is a specialty drug, please call Health Plan Services at 303-602-2090.
- Most specialty drugs can only be filled at a Denver Health Pharmacy or the preferred specialty pharmacies chosen by Elevate.

- Most specialty drugs can only be filed for a 30-day supply, even if they are sent to you home by mail.

Generic and Brand Name Drugs

- You can save money by using formulary generic drugs which have lower cost sharing. 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 sharing 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 Elevate why the brand is needed. If approved, you will only need to pay the brand cost sharing.

Drug Exclusions (see 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
- Blood or blood plasma (except anti-hemophilic factor VIII and IX are covered 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 www.denverhealthmedicalplan.org/elevate-pharmacy 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 at 303-602-2090

The deductible does not apply for copay-based benefits.
Preventive drugs are $0 at all pharmacies.

	Generic	Preferred Brand	Non-Preferred Brand	Specialty
DH Pharmacy (30-day supply)	$15 copay	$25 copay	$55 copay	$580 copay
DH Pharmacy or DH Pharmacy by Mail (90-day supply)	$30 copay	$50 copay	$110 copay	N/A
National Network Pharmacy (30-day supply) (Examples: King Soopers, Target, etc.)	$30 copay	$50 copay	$110 copay	$580 copay
National Network Pharmacy (90-day supply) (Examples: King Soopers, Target, etc.)	$60 copay	$100 copay	$220 copay	N/A

Preventive Care

Elevate has developed clinical and preventive care guidelines to assist members with common health conditions, including diabetes management, asthma and pregnancy care. For information, please call 303-602-2090 or visit our website at: www.denverhealthmedicalplan.org/elevate-current-members. 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 your cost-sharing that may apply to preventive care services received by a network provider.

All immunizations recommended by the Centers for Disease Control and Prevention are covered at no cost. All preventive services with an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF) as well as those supported by the Health Resources and Services Administration are covered at no cost.

This plan also covers tobacco cessation services, including screening, counseling, cessation attempt services and the seven FDA approved tobacco cessation medications, in addition to the Colorado QuitLine (1-800-QUIT-NOW).

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

Preventive Care Service	You Pay (for services from a Denver Health Provider)	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 • Annual prostate exam	$0 cost sharing per office visit (there is no additional charge for these tests; however, office visit cost sharing may apply).	Not covered.
Well-woman exams including: • Medical history • Physical exam of pelvic organs including PAP test • Vaginal smear • Physical exam of the breasts • Rectal exam including Fecal Occult Blood Test (FOBT) • Consultation for birth control, if requested • Urinalysis	$0 cost sharing per office visit.	Not covered.
Well-child care including routine examinations, blood lead level screenings, and immunizations	$0 cost sharing per office visit.	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.	$0 cost sharing per office visit.	Not covered.
Routine immunizations – ordered by the provider and in accordance with national guidelines. This includes the cervical cancer vaccine for members.	$0 cost sharing per visit (clinic visits for an allergy shot or immunization alone do not require cost sharing. If the visit is a combination of the injection and a nurse, 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.

Cancer Screenings

At Elevate, we believe cancer screenings provide important preventive care that supports our mission: to improve the lives of the people we serve and the health of our communities. We cover cancer screenings as described below. All member cost sharing is listed in the table above.

- Pap Tests - Elevate provides coverage under the preventive care benefits for a routine annual pap test and the related office visit.
- Mammogram Screenings - Elevate provides coverage under the preventive care benefits for routine screening or diagnostic mammogram regardless of age.
- Prostate Cancer Screenings - Elevate provides coverage under the preventive care benefits for routine prostate cancer screening for men.
- Colorectal Cancer Screenings - Several types of colorectal cancer screening methods exist. Elevate provides coverage for routine colorectal cancer screenings, such as fecal occult blood tests, barium enema, sigmoidoscopies and colonoscopies.
- Colorectal cancer screenings are covered under preventive care as long as the services provided are for a preventive screening.

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 and isotopes. This includes MRI, PET scans, radiation therapy and CT scans.

CT/PET Scan/MRI/Advanced Radiology

In network: 10% coinsurance, deductible does apply.
Out of network: Not covered.

X - Ray

In network: 10% coinsurance, deductible does not apply.
Out of network: Not covered.

Renal Dialysis

Renal dialysis is covered if provided at an authorized facility.

In network: 10% coinsurance, deductible does apply.
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 by Elevate is required.

In network: 10% coinsurance, deductible does apply.
Out of network: Not covered.
Benefit Maximum: 100 days per calendar year.

Sleep Studies

Covered if provided at a network facility, if medically necessary and may require prior authorization.

In network: 10% coinsurance, deductible does apply.
Out of network: Not covered.

Tobacco Cessation

Talk to your primary care provider about tobacco cessation. Covered smoking cessation services include screening, counseling, cessation attempt services and the seven FDA approved tobacco cessation medications, as well as coverage for the Colorado QuitLine. 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 tobacco cessation drugs including Chantix, the generic form of Zyban, nicotine patches, gum and lozenges are 100% covered. For more information, please contact Health Plan Services at 303-602-2090.

Substance Use Services

Referral by your primary care provider and prior authorization by Elevate are required, except in the case of an emergency.

Drug and Alcohol Abuse - Detoxification

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

In network: 10% coinsurance, deductible does apply.
Out of network: Not covered.

Inpatient Substance Use Rehabilitation Services

Your admission and treatment must be in a network facility with prior authorized by the Utilization Management Department.

In network: 10% coinsurance, deductible does apply.
Out of network: Not covered.
Exclusions: Maintenance or after care following a rehabilitation program.

Outpatient Substance Use Services

7. Benefits/Coverage (What is Covered)

Substance use 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 within the Elevate network. Cofinity providers are in network for outpatient mental health providers are in network for outpatient mental health services only.

In network: 10% coinsurance per visit, deductible does apply.
Out of network: Not covered.

Surgery Services

Inpatient Surgery

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

In network: 10% coinsurance, deductible does apply.
Out of network: Not covered.

Outpatient Surgery

Surgical services at an Elevate 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 Elevate.

In network: 10% coinsurance, deductible does apply.
Out of network: Not 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, is covered for a dependent child if:

- The child has a physical, mental or medically compromising condition;
- The child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations or allergy;
- 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 pre-authorized by Elevate 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, cleft palate or both, see the "Newborn Care" section.

Exclusions: Dental services not described above, dental ancillary services, occlusal splints, overbite or under bite, 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 plan physician determines they 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 reconstructions of the affected and non-affected side, by a network provider, as well as internal prosthetic devices are covered with prior authorization from Elevate. Medically necessary breast reduction is covered with prior authorization from Elevate. 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 personal provider and pre-authorized by Utilization Management, is covered.

Transplants

Corneal, kidney, kidney-pancreas, heart, lung, heart- lung, liver 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 pre-authorized by the Elevate 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 an Elevate member.

Transplant services must be provided at an approved facility.

Elevate does not assume responsibility for the furnishing of donors, organs or facility capacity.

In network: 10% coinsurance, deductible does apply.
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 a 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% coinsurance, deductible does apply.
Out of network: Not covered.

Benefit Maximum: 20 visits per calendar year for each of physical therapy, occupational therapy and speech therapy to learn skills for the first time or maintain current skills.

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 three with developmental delays are covered without regard to maximum medical improvement. See the "Early Intervention Services" section. In addition, medically necessary physical therapy, occupational therapy and speech therapy for the care and treatment of congenital defects and birth abnormalities for children up to the age of six are covered even if the purpose of the therapy is to maintain functional capacity.

In network: 10% coinsurance, deductible does apply.
Out of network: Not covered.
Benefit Maximum: 20 visits per calendar year for each of physical therapy, occupational therapy and speech therapy. See the "Early Intervention Services" section for the benefit maximum for therapies for children up to age three.

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% coinsurance, deductible does apply.
Out of network: Not covered.

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% coinsurance, deductible does apply.
Out of network: Not covered. All accommodations, care, services, equipment, medication or supplies furnished for the following are expressly excluded from coverage (regardless of medical necessity).

Out of Network Providers

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

- Provided under prior written referral by a participating primary care provider and with prior authorization from 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 one business day.

General Exclusions

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

Abortion, Elective: Elective abortions are not covered. Non-elective abortions are covered in cases of life endangerment, rape and incest.

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

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

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 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) the service is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; (3) services and interventions, not in widespread use, are based on scientific evidence.

Chiropractic Care: Hypnotherapy, behavior training, sleep therapy, weight loss programs, services not related to the treatment of the musculoskeletal system, vocational rehabilitation services, thermography, air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices and appliances or transportation costs. This includes local ambulance charges, prescription drugs, vitamins, minerals, food supplements or other similar products, educational programs, non-medical self-care or self-help training, all diagnostic testing related to these excluded services, MRI and/or other types of diagnostic radiology, physical or massage therapy that is not a part of the chiropractic treatment, durable medical equipment (DME) and supplies for use in the home.

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 under bite, osteotomies, TMJ (except as a result of trauma or fracture), hard or soft tissue surgery and maxillary, mandibular or other orthogenic conditions unless certified by a participating primary care practitioner (personal provider) as medically necessary as a result of trauma. The following services for TMJ may be covered if a plan 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 insurance.

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 (for example, D.O.T. Exams).

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 (except anti-hemophilic factor VIII and IX are covered 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), prescription vitamins (unless listed in the formulary), investigational or experimental treatments. Travel vaccinations recommended by the Centers for Disease Control and Prevention (CDC) only for travel outside of the United States (covered vaccines are listed in the formulary).

Experimental Procedures and Drugs: Medical care, procedures, equipment, supplies and/or pharmaceuticals determined by Elevate 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 described under "Hospice Services"), maintenance care, chronic care and private duty nursing.

Eyewear: Glasses, contacts, all eyewear for adults age 19 and over and replacement of lost or broken lenses or frames for children age 18 and under.

Family Planning and Infertility: Reversal of voluntarily induced infertility (sterilization), procedures considered to be experimental, in vitro Fertilization, the Gamete Intrafallopian Transfer (GIFT), surrogate parents (unless the surrogate is also the member), drug therapy for infertility and the cost of services related to each of these procedures and 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 and 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 and services or items for which an Elevate member has no legal obligation to pay.

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

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

Maternity Care: 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: Commercial weight loss programs or exercise programs.

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 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 for 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 for items listed on the drug formulary) 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 listed in the Elevate formulary.

Paternity Testing

Pet Therapy

Plastic Surgery: Plastic surgery for cosmetic purposes, removal of tattoos and scars, chemical peels or skin abrasion for acne.

Prosthetics: Dental prosthesis (except for medically necessary prosthodontic treatment of cleft lip and cleft palate in members), 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 and IQ testing.

Refractive Surgery: Vision correction surgery such as LASIK.

Transplants: Organ transplants not listed in the "Benefits/Coverage" section and donor-related expenses for Elevate members who are donating to an individual who is not an Elevate 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 and 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.

About Your Medical Benefits

All services covered by Elevate must satisfy certain basic requirements. The services you seek must be medically necessary; you must use Elevate 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.

If a covered member receives covered services at an in network facility from an out of network provider, then Elevate will pay the out of network provider directly, as regulated by the state of CO. When the claim is processed, Elevate will notify the out of network provider and the member of any deductible, copayment or coinsurance required.

Premium Payment

Monthly premiums are due the 25th of the month prior to coverage (for example, February's premium would be due the 25th of January). To make a payment over the phone, please call Health Plan Services at 303-602-2090. To make a payment by check or a money order, please submit payment to:

Elevate
P.O. Box 5363
Denver, CO 80217

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 Schedule 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 Elevate on the number of visits per calendar year, services per lifetime or a max dollar amount paid by the plan within a specified time period.

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.

Out of Pocket Maximum

This is the maximum amount you are responsible for in a given plan year. Deductibles, coinsurance and copays apply to the out of pocket maximum.

Grace Period

- The Patient Protection and Affordable Care Act (PPACA) requires health insurance plans to provide a three-month grace period before terminating coverage for certain individuals enrolled in a health plan purchased through the Individual Health Insurance Marketplace. The grace period applies to those who receive federal subsidy assistance in the form of an APTC and who have paid at least one full month's premium within the benefit year. It is triggered when a member that receives federal subsidies does not pay their portion of the monthly premium. During month one, the plan will pay claims. During months two and three of the grace period, claims will not be processed and paid unless the member's full premium payment is received by the end of the three-month grace period. If premiums are paid in full within the three-month grace period, claims will be released for processing. If the premium is not paid in full by the end of the grace period, the member's enrollment will be retroactively terminated at the end of the first month. Any claims for services received during the second and third months of the grace period will be denied.
- For persons who are not receiving a subsidy under the federal act, the policyholder is entitled to a 31-day grace period for the payment of any premium due other than the first premium. Coverage continues during the first 31-day grace period only. If payment is not made , then the member will be terminated as of the 31st day after the grace period began.

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, where to call for prior authorizations and tells them how they can bill Elevate for the care you receive.

In most cases, your provider will bill Elevate directly for the services you receive. You are responsible for any copay, 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 Elevate network, you may be asked to pay the entire bill or a portion of the bill at the time of service. Elevate will reimburse you up to the limits noted in the "Schedule of Benefits" section. If you are required to pay at the time of service, please mail your receipt, including your name, home mailing address and member ID number to the following address:

Elevate Health Plans Attn: Claims Department
P.O. Box 24631
Seattle, WA 98124-0631

To be reimbursed for pediatric hearing aids, please use the reimbursement form, Attachment D, at the end of this handbook. Elevate will mail a reimbursement check payable to the subscriber, to the address on file. 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, Elevate may make payment to any individual or organization that has assumed care or principal support for the member. Elevate may honor benefit assignments made prior to the member's death with regard to remaining benefits payable by Elevate. Payments made in accordance with an assignment are made in good faith and release Elevate from further obligation for payments due.

For Pharmacy Service

Present your Elevate 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 need assistance locating a network pharmacy, please call the Health Plan Services at 303-602-2090 for information on how to get your prescription filled.

Claims Investigation

If you have questions or concerns about how a claim is processed, please call Health Plan Services at 303-602-2090. If you disagree with the manner in which Elevate has processed a claim or if you disagree with a denial of a claim payment, you may file a written or verbal grievance/complaint. See Attachment A at the back of the handbook for a copy of this form. You may also obtain a complaint form or file a complaint verbally over the telephone by calling 303-602-2261. You may also write to:

Elevate
Attention: Grievance Coordinator 938 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 the "Appeals and Complaints" section.

Claims Time Frames

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.

Elevate follows all OIG regulations for fraud, waste or abuse for your protection. Elevate is required to document and track any settlements or malpractice lawsuits that involve our members. If you are in this situation or think you are in this situation, please notify Elevate.

When Another Party Causes Your Injuries or Illness

10. Claims Procedure (How to File a Claim)

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:

- Elevate 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 Elevate, 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 Elevate is paying your medical bills.
- The insurance company must contact Elevate to discuss payment.
- The insurance company must pay Elevate before it pays you or your lawyer.
- Neither you nor your lawyer will collect any money from an insurance company until after Elevate 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 Elevate, you or your lawyer will reimburse Elevate up to the amount of benefits paid out. Elevate will not pay your lawyer any attorney's fees or costs for collecting the insurance money.
- Elevate 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. Elevate may notify other parties of its lien and direct right of reimbursement.
- Elevate may give an insurance company and your lawyer any Elevate records necessary for collection. If asked, you agree to sign a release allowing Elevate records to be provided to an insurance company and your lawyer. If asked, you agree to sign any other papers that will help Elevate collect money due.
- You and your lawyer will give Elevate any information requested about your claim against the liable party.
- You and your lawyer will notify Elevate of any dealings with, or lawsuits against, the liable party.
- You and your lawyer will not do anything to hurt the ability of Elevate to collect paid benefits from the liable party or an insurance company.
- You will owe Elevate any money that the plan is unable to collect because of you or your lawyer's, lack of help or interference. You agree to pay to elevate any attorney's fees and costs that the plan must pay in order to collect this money from you.
- Elevate will not pay any medical bills that should have been paid by another party or insurance company.
- If you have questions, please call Health Plan Services at 303-602-2090.

Disclosure of Health and Billing Information to Third Parties

Elevate may disclose your health and billing information to third parties for the adjudication and subrogation of health benefit claims. This includes providing Elevate'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 Elevate 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

Elevate 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 www.denverhealthmedicalplan.org/elevate-current-members or you may call Health Plan Services at 303-602-2090 and request a hard copy be mailed to you.

Complete privacy information is also available on our website at www.denverhealthmedicalplan.org/elevate-current-members 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.

Elevate (DHMP) hereinafter referred to collectively as the "Company," respect 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 www.denverhealthmedicalplan.org/elevate-current-members 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 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 worker's 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 include 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 303-602-7025, via email at privacy@dhha.org, or by US mail or walk-in at:

Elevate Attn: Privacy Officer
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; and
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. 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 303-602-7025, via email at privacy@dhha.org, or by US mail or walk-in at:

Denver Health
Attn: Privacy Officer
777 Bannock St, Mail Code 1919
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.

As a Member of Elevate

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

Member's Rights

Members have the right to:

- 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.
- Request and receive 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 Elevate Quality Improvement program.
- Receive information about Elevate, 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 Elevate network. This includes how to get services during regular hours, emergency care, after- hours care, out-of-area care, exclusions and limits on covered services.
- Learn more about your primary care provider and his/her qualifications, such as medical school attended or residency, go to www.denverhealthmedicalplan.org/elevate-current-members and click on "Find a Provider" or call Health Plan Services at 303-602-2090.
- Express your opinion about Elevate 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 Elevate 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, seven 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 applies.
- Expect that referrals approved by Elevate cannot be changed after prior authorization or retrospectively denied except for fraud, abuse or change in eligibility status at the time of service.
- Receive a standing referral, from a primary care provider to see an Elevate network specialty treatment center, for an illness or injury that requires ongoing care.
- Make recommendations regarding Elevate's Member's Rights and Responsibilities policies.
- Voice a complaint about or appeal a decision concerning the Elevate organization or the care provided and receive a reply according to the grievance/appeal process.

Member's Rights for Pregnancy and Special Needs:

- Receive family planning services from any licensed physician or clinic in the Elevate network.
- To go to any participating OB/GYN in the Elevate 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 Elevate during your second or third trimester. This is dependent upon the non-network provider agreeing to accept Elevate's arrangements.

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

Member's Responsibilities:

- To treat providers and 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, have your Elevate 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 get a referral from your primary care provider before you see a specialist.
- 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 Elevate 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.
- Learn and know about Elevate benefits (which services are covered and non-covered) and to contact an Elevate Health Plan Services representative with any questions.
- Inform providers or a representative from Elevate when not pleased with care or service.

Elevate Records

You have the right to examine, without charge, Elevate'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 Health Plan Services. Elevate may charge a reasonable fee for the copies. You are also entitled to receive a summary of Elevate's annual financial report.

Member Medical Records

Elevate maintains and preserves the confidentiality of any and all medical records of the members in accordance with all applicable state and federal laws, including HIPAA. In accordance with HIPAA, Elevate may use any and all of members' 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 Elevate'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, Elevate 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.

11. General Policy Provisions

Elevate 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 Elevate.

To make a request, call Health Plan Services at 303-602-2090. Members also have the right to inspect and obtain copies of their medical records maintained by Elevate network providers. Please contact the individual provider for more details.

Notice of Privacy Practices

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

The Elevate Notice of Privacy Practices is available on the Elevate website at http://www.denverhealthmedicalplan.org/elevate-current-members. 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 303-602-2090.

Administration of Covered Benefits

Under federal law, individuals responsible for the operation of Elevate must perform their duties in a careful and conscientious manner and with the interest of all members taken into consideration. Elevate 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 the "Definitions" section) and applicable state and federal laws. Elevate 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 Elevate, 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 Elevate network unless otherwise directed by your personal provider and authorized by Elevate.

Affirmative Statement about Incentives

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

Elevate 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 Health Plan Services at 303-602-2090 should you have questions regarding this practice.

Relationship Between Elevate and Network Providers

All providers in the Elevate network are independent contractors. These providers are not agents or employees of Elevate. Elevate 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.

DHMP does not use quality measures, member experience measures, patient safety measures or cost- related measures to select hospitals for our network.

Statement of Appropriate Care

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

- Elevate does not reward staff or providers for issuing denials.
- Elevate does not offer incentives to encourage underutilization.

If you feel that an Elevate representative or network provider has violated any of the above principles, you can contact the Health Plan Services department at 303-602-2090.

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

Elevate continually strives to improve the quality of care and service to our members by ongoing monitoring of services. Elevate'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 www.denverhealthmedicalplan.org/elevate-current-members or call Health Plan Services at 303-602-2090 to learn more about our Quality Improvement Program, such as program goals, progress towards goals, processes, outcomes and specific measurements.

Pediatric Dental Services

This policy does not include coverage of pediatric dental services as required under The Patient Protection and Affordable Care Act, Pub, L. 111-148 and the Health Care and Education Reconciliation Act of 2010, Pub, L. 111-152. Coverage of pediatric dental services is available for purchase in the State of Colorado and can be purchased as a stand-alone plan. Please contact your insurance carrier, agent or Connect for Health Colorado to purchase either a plan that includes pediatric dental coverage or an Exchange-certified stand-alone dental plan that includes pediatric dental coverage.

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" section for details.)

If you would like more information on WHCRA benefits, please call Health Plan Services at 303-602-2090.

Reinstatement

If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy.

The reinstated policy shall cover claims for covered services as may be sustained after the date of reinstatement. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

New Technologies

As new technologies or new indications for current technologies are identified that may have broad applicability for Elevate 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

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

Fraud, Waste, and Abuse Prevention Program

Elevate 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, Elevate is committed to fulfilling its duties with honesty, integrity and high ethical standards. Elevate 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 Elevate 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 Elevate. Audits are performed on a routine, scheduled basis, to monitor for compliance with regulatory requirements.

Elevate uses a third 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 on identified 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. Elevate 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 Elevate and the member for the same service or billing both Elevate 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); and
- 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 (Values Line), you will be provided with a call identification number and a call back date. This will allow you to 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	303-602-2025
Mailing Address or In-Person	Denver Health Enterprise Compliance Services Attn: Compliance Manager 601 Broadway, MC 7776 Denver, CO 80204

Termination of Coverage by Enrollee

An enrollee may terminate their policy with 14 days notice under certain conditions. The Exchange must permit an enrollee to terminate their coverage in a Qualified Health Plan (QHP) if they obtain other minimum essential coverage and for other reasons in accordance with the rules of the Exchange.

Termination of Coverage by Elevate

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

Non-Payment of Premiums

If a member does not pay required premiums or does not make satisfactory arrangements to pay premiums, Elevate may terminate the member with not less than 31 days written notice. Coverage remains in effect during the first 31 days of the grace period.

The Patient Protection and Affordable Care Act (PPACA) requires health insurance plans to provide a three-month grace period before terminating coverage for certain individuals enrolled in a health plan purchased through the Individual Health Insurance Marketplace. The grace period applies to those who receive federal subsidy assistance in the form of an APTC and who have paid at least one full month's premium within the benefit year. It is triggered when a member that receives federal subsidies does not pay their portion of the monthly premium. During month one, the plan will pay claims. During months two and three, claims will not be processed and paid unless the member's full premium payment is received by the end of the three-month grace period. If premiums are paid in full within the three-month grace period, then claims will be released for processing. If the premium is not paid in full by the end of the grace period, the member's health plan will be retroactively terminated at the end of the first month. Any claims for services received during the second and third months of the grace period will be denied.

For persons who are not receiving a subsidy under the federal act, the policyholder is entitled to a 31-day grace period for the payment of any premium due other than the first premium. Coverage continues during the first 31-day grace period only. If payment is not made, then the member will be terminated as of the 31st day after the grace period began.

Rescission

We may terminate your membership retroactively in the event of fraud or material misrepresentation of a material fact. 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.

False or Misleading Information -

If a member attempts to obtain benefits under Elevate by means of false, misleading or fraudulent information or acts of omissions for themselves or others, Elevate may terminate the member's coverage upon 30 days written notification prior to termination that includes reason for termination.

Misuse of Identification Card

Your Elevate 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 Elevate identification card by any other person, Elevate may terminate the member's coverage upon 30 days written notification prior to termination that includes reason for termination.

Payment for services received as a result of the improper use of an Elevate identification card is the responsibility of the individual who received the services.

Discontinue

If Elevate decides to discontinue offering this plan, in which case we will provide notice to you of the decision not to renew at least 90 days before the nonrenewal, will offer you the option to purchase any other health benefit plan currently offered by us in this state and provide information on the special enrollment periods.

Notice Refund and Payments

You will receive 30 days prior written notice if we terminate your membership. The notice will include: an explanation of why and when your membership will end. If you have paid monthly dues beyond the termination date, you may be eligible for a refund. Any amount due to you for claims while you were a member will be paid to you. Any amounts you owe us will be deducted from any payment we make to you

As a member of Elevate, you have the right to file a complaint (also known as a grievance) or appeal 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 copay or coinsurance, 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: a denial of a preauthorization for a service; 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 a denial of a request for services on the ground that the service is experimental or investigational.

b. A denial for a service that is not a covered benefit for which you are able to present evidence from a medical professional that there is a reasonable medical basis that the exclusion does not apply to the denied service. This is known as a benefit exclusion.

c. Terminate your coverage by the plan retroactively, except as the result of non-payment of premiums (also known as rescission or cancellation).

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

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 by calling Health Plan Services at 303-602-. 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.

Elevate
Attn: Grievance and Appeal Department 938 Bannock Street, Mail Code 6000
Denver, Colorado 80204
Telephone: (303) 602-2261
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 send your request to the Utilization Management Department by fax at 303-602-2128 or by mail at:

938 Bannock Street, Mail Code 6000

Denver, CO 80204

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

Appeal Review Meetings

- **Non-Urgent 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 will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner but no later than 60 calendar days of received your request. You will be notified in writing of the meeting time at least 20 calendar days in advance of the review date. You may request a postponement of the review with DHMP.

  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 notice will tell you why we denied your appeal and will include information regarding any further processes, including any external review that may be available to you.

13. Appeals and Complaints

- **Urgent Appeal**

  Within 180 days after you receive our adverse benefit determinations 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

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 five working day period ends.

Appeal For Retroactive Termination of Membership (Rescission)

We may terminate your membership retroactively in the event of fraud or material misrepresentation of material fact. 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.

If you have general questions about retroactive membership terminations or appeals, please call Health Plan Services at 303-602-2090.

All commercial insurance policies offered by Elevate are written for a 12-month period, January 1st through December 31st of any given year. No benefit or rate changes will be made during this time.

Renewability

Members will be notified of all benefit and rate changes taking effect for the next calendar year no less than 60 days before the new policy begins on January 1st.

Policy will automatically renew at the end of a benefit year unless member contacts the plan or the Exchange to disenroll.

Amendment or Termination of this Plan

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

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, which 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 Elevate.

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.
   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.

Calendar 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.

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.

Complications of Pregnancy:

1. Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician- prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of A difficult pregnancy not constituting a nosologically distinct complication of pregnancy;

2. Non-elective cesarean section, ectopic pregnancy, which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Copayment: The predetermined amount, stated as a percentage or a fixed dollar, an enrollee must pay to receive a specific service or benefit. Copayment is 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 and 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 calendar year or benefit year) before the carrier will cover expenses. The specific expenses that are subject to deductible may vary by policy.

Denver Health and Hospital Authority (DHHA): 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. Elevate 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.

Domestic Partner: An adult with whom the employee is in an exclusive committed relationship, who is not related to the employee and who shares basic living expenses with the intent for the relationship to last indefinitely. A domestic partner cannot be related by blood to a degree which would prevent marriage in Colorado and cannot be married to another person.

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 layperson having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.

Experimental or Investigational Services: 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.

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 Elevate 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 is considered the same as any other sickness, injury, disease or condition.

Individual Deductible: 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 Elevate and for whom the monthly premium is paid to Elevate.

Network: 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 coverage under the plan, or that the plan may encourage you to use. You may have a lower cost share 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 healthcare provider who is contracted to be a provider in the Elevate 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 healthcare 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. This amount includes copays, deductibles and coinsurance. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy.

Partial Hospitalization/Day Treatment: A continuous treatment at a network facility of at least three hours per day, but not exceeding 12 hours per day.

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.) or any other person who is licensed or otherwise authorized in this state to furnish health care services.

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 Elevate network To supervise, coordinate and provide initial and basic care to you. The personal provider initiates referrals for specialist care and 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 designated 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.

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

Qualifying Life Change Event (QLCE): For continuation coverage, an event (termination of employment, reduction in hours, etc.) affecting an individual's eligibility for coverage.

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

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

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 ten 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 use 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 personal provider to a network specialist or specialty treatment center in the Elevate network for illness or injury that requires ongoing care.

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

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

Telehealth: A mode of delivery of healthcare 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 Elevate's service area, but intends to return within a reasonable period of time, such as a vacation trip (side of the U.S.is not covered).

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.

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: 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 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. The hospital copayment applies to mother and well-baby together; there are not separate copayments, unless mother and baby are discharged separately.

Language Access Services

(Spanish) Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Denver Health Medical Plan, Inc. tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-855-823-8872.

(Vietnamese) Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Denver Health Medical Plan, Inc. quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-855-823-8872.

(Chinese) 如果您或您正在幫助的人有關於Denver Health Medical Plan, Inc. 方面的問題您有權利免費以您的母語得到幫助和訊息想要跟一位翻譯員通話請致電 1-855-823-8872.

(Korean) 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이Denver Health Medical Plan, Inc. 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는1---855---823---8872로 전화하십시오.

(Russian) Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Denver Health Medical Plan, Inc. то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-855-823-8872.

(Amharic) እርስዎ፣ ወይም እርስዎየሚያግዙት ግለሰብ፣ ስለ Denver Health Medical Plan, Inc. ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-855-823-8872 ይደውሉ።

(Arabic) كلكيبيدفا Denver Health Medical Plan, Inc. ننكا لكلكيبيددلا أأوو ىدلا ىشصص خ ددهه عاسة نلةسأأ و وص ص صخبد ةوورريبيررضلااا تتتماووومعلووالا ددةقلمساعاا ىعلا وول لصحاالا نإيفة ن ! لكلكبلغةتنن مه ددوونن ةاابيتكلفة. تثثددللتحدمع مهجررمتدل لصاالاتبـ 823---8872. 1---855

(German) Falls Sie oder jemand, dem Sie helfen, Fragen zum Denver Health Medical Plan, Inc. haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-855-823-8872 an.

(French) Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Denver Health Medical Plan, Inc. vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-855-823- 8872.

(Nepali) यदि तपाईं आफ्ना लागि आपैंि आवेदनको काम गदैं, वा कसैलाई मद्दत गदैं हुनुहुन्छ, Denver Health Medical Plan, Inc. बारे प्रश्नहरू छन् भने आफ्नो मातृभाषामा निःशुल्क सहायता वा जानकारी पाउने अधिकार छ । दोभाषे (इन्टरप्रेटर) सँग कुरा गनर्ुपरे 1-855-823-8872 मा फोन गनर्ुहोस् ।

(Tagalog) Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Denver Health Medical Plan, Inc. may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-855-823-8872.
(Japanese) ご本人様、またはお客様の身の回りの方でもDenver Health Medical Plan, Inc.

についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料 金はかかりません。通訳とお話される場合、1-855-823-8872 までお電話ください。

(Cushite) Isin yookan namni biraa isin deeggartan Denver Health Medical Plan, Inc. irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-855-823-8872 tiin bilbilaa.

(Persian) Denver Health Medical Plan, ددماييينز. ر د دوم دورر ا ل لوس ,, ددكنيييمير كككم ااوو بهه شما كهه يكس ايير ,,شما ررگاهه تتشددااا يبددباش قحد اايين ررا ددااررييدد كهه ككم وو تتتعلاا اطط بهه ددماييينز 1---855---823---8872 لل صحا سس نما تتتررييافدد نن گارراايير طوورر بهه ررا ووددخ نن بازز

(Kru) I bale we, tole mut u ye hola, a gwee mbarga inyu Denver Health Medical Plan, Inc. U gwee Kunde I kosna mahola ni biniiguene i hop wong nni nsaa wogui wo. I Nyu ipot ni mut a nla koblene we hop, sebel 1-855-823-8872.

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
Attn: Grievance and Appeal Department
938 Bannock Street
Denver, CO 80204
Fax: 303-602-2078
www.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 HighPoint HDHP
O HighPoint DHMO

City & County of Denver/
Denver Employee Retirement Plan (DERP)
O HighPoint HDHP
O HighPoint 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? O Yes O No

If yes, please provide the Claim #: _____

Date(s) of Service: _____

Provider Name: _____

Is this in regards to a denied medical service or treatment? O Yes O 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 8:00 a.m. to 5:00 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: _____ O Complaint O Appeal Received By: _____

Type: O Clinical O Potential QOCC O Benefit O Pharmacy O Claim O Other

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DENVER HEALTH MEDICAL PLAN INC.™

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 available, Handbook, Explanation of Benefits)
- ◯ Enrollment/Benefits
- ◯ Pharmacy Information
- ◯ Claims
- ◯ Grievance and Appeals
- ◯ All documents and information 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: Health Plan Services
938 Bannock Street, MC 6000
Denver, CO 80204

Secured Fax #:
303-602-2138

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: Health Plan Services
938 Bannock Street, MC 6000
Denver, CO 80204
Fax: 303-602-2138

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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 Use** (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./Denver Health Medicaid Choice.

◯ 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./ Denver Health Medicaid Choice.

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

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

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 #:** ( ) -

SECTION G: SIGNATURE/DATE

Please read the following carefully before you sign.

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./Denver Health Medicaid Choice in writing; (3) if I do revoke this authorization, my revocation will have no effect on any action Denver Health Medical Plan Inc./Denver Health Medicaid Choice took according to this authorization before Denver Health Medical Plan Inc./Denver Health Medicaid Choice 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./Denver Health Medicaid Choice.

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./Denver Health Medicaid Choice.

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

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Member Reimbursement Form

Elevate Health Plans

2020

Member's Name: _____

Mailing Address: _____

Member's I.D. Number: _____

Date(s) of Service: _____

Procedure Code(s): _____

Diagnosis Code(s): _____

FOR PEDIATRIC HEARING AID IN-NETWORK:

_____ under 19 years of age

Please NOTE: All necessary receipts must be submitted with reimbursement request form.

Mail Claims to: Elevate Health Plan
Attn: Claims Department
P.O. Box 24631
Seattle, WA 98124-0631