DENVER HEALTH MEDICAL PLAN INC.

CHP+

MEMBER HANDBOOK
MANUAL PARA MIEMBROS

CO HCPF CHP+ Child Health Plan Plus

Child Health Plan *Plus*
offered by Denver Health Medical Plan, Inc.
ofrecido por Denver Health Medical Plan, Inc.

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FORMS INCLUDED AT THE END OF HANDBOOK:

- Coordination of Benefits Form
- Appointment of Designated Personal Representative (DPR) Form
- Member Complaint and Appeal Form

LARGE PRINT OR OTHER LANGUAGES:

If you need this handbook in large print, in other formats or languages, read aloud, or need another copy, call 303-602-2100 or 1-800-700-8140. For TTY, call 711. Call Monday to Friday, 8 a.m. to 5 p.m. at no cost to you.

Si usted habla español, tenemos a su disposición servicios de asistencia, gratuitos, en su idioma. Llame al 1-800-700-8140 (State Relay 711).

>> TERMINOLOGY

Appeal: A request for review of an adverse benefit determination, by a CHP+ member, or Provider acting on the member's behalf.

Co-payment: A dollar amount you pay in order to receive a specific service, supply, or prescription medication. A copayment is a predetermined, fixed amount paid at the time the service is rendered.

Durable Medical Equipment (DME): Reusable medical equipment used when there is a medical need for the treatment or therapy for an illness or physical condition. Examples include oxygen, wheelchairs, walkers and bathroom or bedroom safety equipment.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1) 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.
2) Serious impairment to bodily functions.
3) Serious dysfunction of any bodily organ or part.

Emergency Medical Transportation: Ambulance service for an emergency. This includes ambulance and emergency room care.

Emergency Room Care: Is a hospital room or area staffed and equipped for the reception and treatment of persons requiring immediate medical care.

Emergency Services: If you need it, you can get emergency services in any emergency department anywhere in the United States, 24 hours a day, every day of the year. This includes ambulance and emergency room care.

Excluded Services: Are the services or benefits that are not covered by a particular health care policy. In this case DHMP

Grievance: An expression of dissatisfaction about any matter other than an Adverse Benefit Determination, including but not limited to, quality of care or services provided and aspects of interpersonal relationships such as rudeness of Provider or employee, or failure to respect the Member's rights

Habilitation services and devices: Outpatient physical, occupational and speech therapies that help you keep, learn, or improve skills and functioning for daily living. These services are covered for children and youth ages 20 and younger and for some adults. They always require pre-approval. Talk to your provider to find out if you qualify.

Health Insurance: Insurance against expenses incurred through illness of the insured

Health Plan: A group of doctors, hospitals and other providers who work together to get you the health care you need

Home Health Care: Hospital or nursing facility services given in your home for an illness or injury

Hospice Services: Care that focuses on comfort and support for people in the end stage of life

Hospitalization: Placing a patient in a hospital for diagnostic study and treatment

Hospital Outpatient Care: Care at a hospital when you do not stay overnight or care in the emergency room when it is not an emergency

Inpatient Hospitalization: Care at a hospital when you stay overnight

Medically Necessary or "Medical Necessity": Medical necessity means a Medical Assistance program good or service:

- Will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all;
- Is provided in accordance with generally accepted professional standards for health care in the United States;
- Is clinically appropriate in terms of type, frequency, extent, site, and duration;
- Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider;
- Is delivered in the most appropriate setting(s) required by the client's condition;
- Is not experimental or investigational; and
- Is not more costly than other equally effective treatment options.
- Not otherwise subject to an exclusion under this Booklet

The fact that a provider may prescribe, order, recommend, or approve care, treatment, services, or supplies does not itself make such care, treatment, services, or supplies medically necessary.

Network: A group of providers that are contracted to give health care services and products to plan members

Non-participating provider: A provider, facility or supplier that is non-contracted within the network and does not give health care services and products to plan members

Preauthorization: a process during which requests for procedures, services or certain prescription medications are reviewed prior to being rendered, for approval of benefits, length of stay, appropriate location, and medical necessity. For prescription medications, the designated CHP+ State Managed Care Network pharmacy and therapeutics committee defines the medications and criteria for coverage, including the need for preauthorization for certain medications.

Plan: Is a benefit plan to provide health care payment for your health care services

Participating Provider: A provider, facility or supplier who is contracted to provide medical services to the DHMP member's

Premium: Monthly cost of coverage

Physician services: Health care services a licensed medical physician (M.D. Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates

Prescription Drug Coverage: Insurance or plan that helps pay for prescription drugs and medicine

Prescription Drug: Medicines or drugs your doctor prescribes (orders) for you. They treat a condition or illness

Primary Care Physician: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services

Primary Care Provider (PCP): A doctor or nurse practitioner who that helps you get and stay healthy

Provider: Any individual or group physician, Physician practice, Hospital, dentist, pharmacy, Physician assistant, certified nurse practitioner, or other licensed, certified or registered Health Care Professional that has entered into a professional service agreement to serve the DHMP members

Rehabilitation services and devices: Physical, occupational and speech therapies that help you recover from an acute injury, illness or surgery

Skilled Nursing Care: Health care services you need that can only be provided or supervised by a registered nurse or other licensed professional. A doctor must order skilled nursing services. Services may be to improve or keep current health or to stop health from getting worse

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care

>> IMPORTANT PHONE NUMBERS

EMERGENCY: CALL 9-1-1

2-1-1 – for easy access to information about health and human services

Nurse Advice Line: 303-739-1261

Appointment Line:

- To make an appointment for a DHMP provider: 303-436-4949
- Stride Community Health Center: 303-360-6276 or https://stridechc.org/services/new-patients/

DHMP provides free auxiliary aids and services to members with disabilities to communicate effectively with us. For help on sign language as well as oral interpretation services they are available in any language free of charge. For benefits, questions or concerns contact

- Health Plan Services: 303-602-2100
- Toll-Free: 1-800-700-8140
- TTY: 711
- Fax: 303-602-2138

To refill your prescriptions at a Denver Health Pharmacy:

- Prescription Refill Service: 303-389-1390

To check the status of your authorization request:

- DHMP Pharmacy Department: 303-602-2070

Colorado's CHP+ Eligibility and Enrollment:

This number is for all Colorado CHP+ Members, regardless of your CHP+ health plan.

- Health First Colorado Enrollment: 303-839-2120
- Outside Metro Denver: 1-888-367-6557

To get information on State Reviews:

- Office of Administrative Courts: 303-866-2000

Other phone numbers:

- Colorado Medical Assistance Program: 1-800-359-1991
- DentaQuest: 1-888-307-6561
- Department of Health Care Policy and Financing (HCPF): 1-800-221-3943
- Rocky Mountain Poison and Drug Center: 1-800-222-1222

If you have a question, call **Health Plan Services** at **303-602-2100** or toll-free at 1-800-700-8140.

>> WELCOME TO DHMP!

Welcome to Child Health Plan Plus (CHP+) Offered by Denver Health Medical Plan, Inc.!

We are happy you have chosen Denver Health Medical Plan, Inc. (DHMP) under Child Health Plan Plus (CHP+). CHP+ is a low-cost health insurance program for uninsured Colorado children under age 19 as well as an insurance Prenatal Care Program. CHP+ is for children and pregnant women who earn too much to qualify for Medicaid but cannot afford private insurance.

DHMP is a health maintenance organization (HMO) that manages care for members of CHP+ through the Denver Health network. To have DHMP coverage, you must live in Denver, Jefferson, Adams or Arapahoe County. If you move and need to update your address, please call your local county Department of Health Services (DHS) or Colorado Medical Assistance Program at 1-800-359-1991 so your mail can reach you. At DHMP, our main concern is that you or your child gets the proper medical care. If you would like to get more details on the structure and operation of DHMP, please call **Health Plan Services** at **303-602-2100**.

Please watch our New Member Orientation video for important information about the services and benefits that are offered to you through your CHP+ plan. You will find the video at: http://www.denverhealthmedicalplan.org/child-health-plan-plus-chp.

This member handbook does not give detailed information about DHMP providers. Please use the DHMP Provider Directory to get a list of health care providers that work for DHMP and Stride Community Health Center https://stridechc.org/locations/. The Provider Directory shows information like names, locations, the languages the provider speaks and types of doctors. You can find the provider directory at https://www.denverhealthmedicalplan.org/find-doctor. If you would like a hard copy, please call Health Plan Services to request one at 303-602-2100, your request will be provided within (5) business days

This member handbook will help you in getting you or your child the medical care that they need. This handbook explains the benefits you or your child will get as a member of DHMP. This is also your Evidence of Coverage document. You have the right to a new member handbook and all of the facts in the member handbook at any time. You can contact **Health Plan Services** at **303-602-2100** by phone or in writing if you need a new member handbook, provider directory or if you have any questions. Materials will be sent out within (5) business days of the request. DHMP is here to help you. If you cannot find the answers in this book, or have questions, please call **Health Plan Services** at **303-602-2100**. Open 8 a.m. to 5 p.m. Monday to Friday.

This member handbook is also a guide to the CHP+ Prenatal Care Program. This program is more than just prenatal care. It offers many benefits during and after pregnancy, including visits to a doctor when you are sick, prescriptions, vision, dental and mental health services. The coverage is good through 60 days after the end of your pregnancy.

If you get other insurance, become covered by Health First Colorado (Colorado's Medicaid program), or move out of Colorado, you are no longer eligible for CHP+ Prenatal Care Program.

This handbook, and all other member information, is available in other languages, Braille, large print, and audiotapes. Please call **Health Plan Services** at **303-602-2100** if you need this handbook or any other member information in a different language or form at no cost to you.

If you have a question, call **Health Plan Services** at **303-602-2100** or toll-free at 1-800-700-8140.

DHMP provides interpreter services for many languages at no cost to our members. If you would like to use an interpreter during your clinic visits, please tell the **Appointment Center** representative when you make your appointment at **303-436-4949**.

DHMP also offers TTY services for the hearing impaired at no cost to you. The TTY phone number for Health Plan Services is 711. If you need a sign language interpreter or other assistance during your clinic visits, please let the Appointment Center know before your appointment date so arrangements can be made with an interpreter.

Your DHMP ID Card:

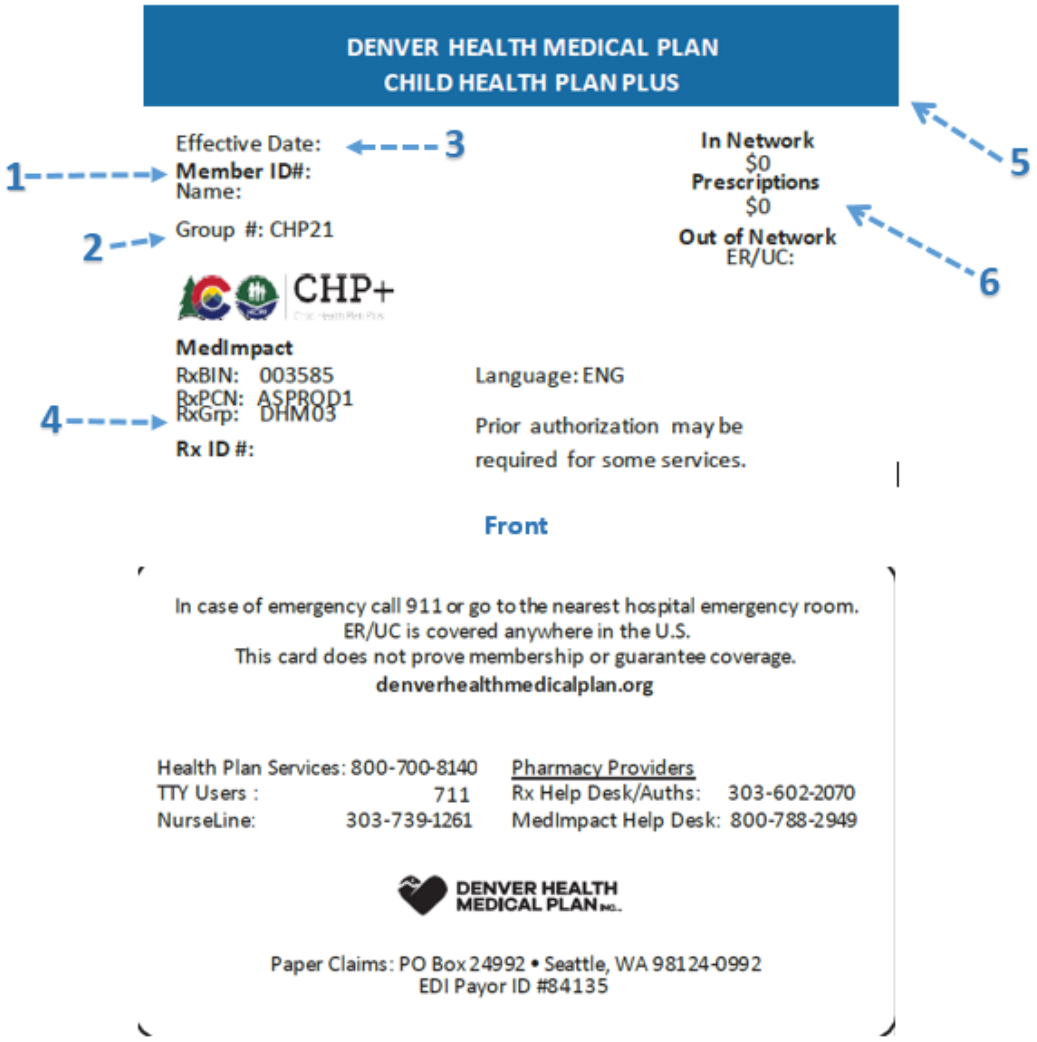
You need your DHMP ID card with you when you see your provider, pick up medicine at the Pharmacy or for any health services. If you lose your ID card, please call Health Plan Services to ask for a new one. The new card will come in the mail in a few weeks

As a DHMP member, you should:

- Read this Member Handbook.
- Call your Primary Care Provider (PCP) whenever you or your child needs health care.
- Keep appointments with your PCP and other providers.
- Give honest information about your health when asked by your PCP or the DHMP staff.
- Work willingly with your PCP.
- Use the DHMP network providers for services outside of the PCP's office.
- This will assign you to your medical home and will help you stay healthy and in touch with your PCP
- DH creates a medical record for you as a member of the plan

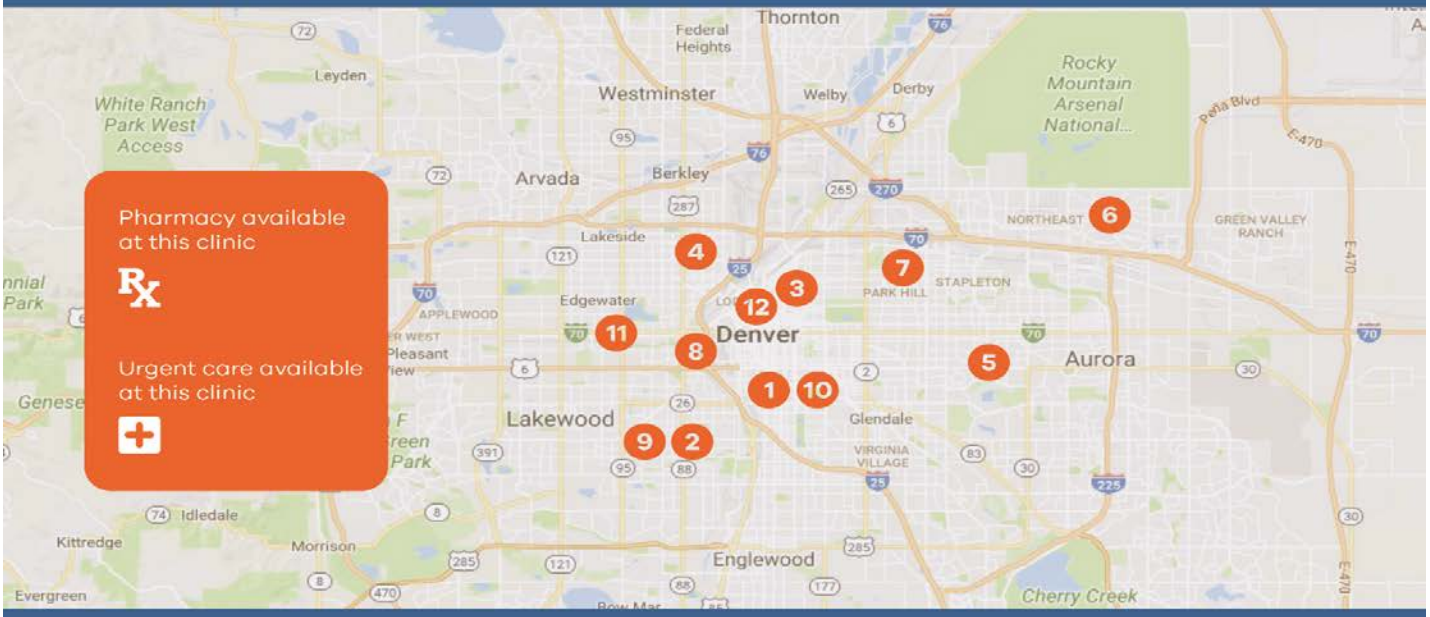
As your health plan, we promise to:

- Solve problems using teamwork and good communication.
- Strive for excellence through continuous improvement.
- Use our time, talent and resources responsibly and effectively
- Treat everyone with courtesy, dignity and respect.



1) **Member ID Number**
2) **Group Number**
3) **Effective Date**
4) **Prescription Group Number**
5) **Plan Name**
6) **Benefit Copays**

DENVER HEALTH est. 1860 NETWORK LOCATIONS



1. Wellington Webb Center for Primary Care
   301 W. 6th Ave.
2. Federico F. Peña Southwest Family Health Center
   1339 S. Federal Blvd.
3. Gipson Eastside Family Health Center
   501 28th St.
4. La Casa/Quigg Newton Family Health Center
   4545 Navajo St.
5. Lowry Family Health Center
   1001 Yosemite St.
6. Montbello Family Health Center
   12600 Albrook Dr.
7. Park Hill Family Health Center
   4995 E. 33rd Ave.
8. Sandos Westside Family Health Center
   1100 Federal Blvd.
9. Westwood Family Health Center
   4320 W. Alaska Ave.
10. Denver Health Medical Center
    777 Bannock St.
11. Sloan's Lake Primary Care Center
    4007 W. Colfax Ave.
12. Downtown Urgent Care
    1545 California St.

If you have a question, call **Health Plan Services** at **303-602-2100** or toll-free at 1-800-700-8140.

This is a list of the Denver Health clinics **where you can get care**. These clinics are part of the contracted DH CHP+ network. In most cases, you must go to these Denver Health Clinics for your health care needs. You may see any Provider in the DH CHP+ Network. Some Specialist providers require a referral first – See "Getting an Approval or Referral to see a Specialist". If you need to make an appointment for a clinic visit, please call the Appointment Center at 303-436-4949.

>> 1) HOW YOUR PLAN WORKS

How to get information about providers:

You can call your provider's office or **Health Plan Services** at **303-602-2100**.

What is a PCP?

A PCP (Primary Care Provider) is your regular provider who cares for you during regularly scheduled visits.

Why is your PCP important?

Your PCP is the first step to getting care. That means that your PCP is the person you can see or talk to first for all of your medical care. Your PCP is the one who:

- Gives you medical care, including check-ups, shots, and prescriptions
- Refers you to a specialist or other services, when needed
- Admits you to the hospital, when needed
- Keeps your medical records

With one PCP, you will get continuity of care. That means you will not have to explain your medical history each time you need care. This is important, especially if you have allergies or special health concerns, as your doctor will already know about you and your needs.

Prenatal Care Program members may choose an OB/GYN as their primary care provider. Your PCP helps you get the care you need. He or she provides a wide range of health care services, including checkups, sick visits, shots, initial diagnosis and treatment, health supervision, management of chronic conditions, referrals to specialist when need one, and ensuring continuity of care.

Choosing or changing your DHMP PCP:

You should choose a PCP or Medical Home right away. To pick a PCP or Medical Home you can check the DHMP Provider Directory for a list of DHMP providers and clinics. Call Health Plan Services to ask for a copy of the DHMP Provider Directory or view online at https://www.denverhealthmedicalplan.org/find-doctor

You must call the **Appointment Center** at **303-436-4949** if you know which PCP or Medical Home you want to see for your care. If you do not pick a PCP or Medical Home, DHMP will assign you to the closest DH family clinic. A list of all the DH clinics is located in this book under "Where You Can Get Care".

You can change your PCP or Medical Home at any time. Please call **Appointment Center** at **303-436-4949** and tell them you need to change your PCP or Medical Home.

Getting an approval or referral to see a specialist:

You need an approval (or referral) from your PCP to see some types of specialists (providers who are experts in one or more areas of health care). An approval, or referral, is what your PCP uses to ask DHMP to approve your visit to some specialists.

An approval from Utilization Management is necessary before you see any providers outside of DHMP. If you do not get a referral from your PCP and an approval from Utilization Management before you see or get services from any outside providers/specialists, you may have to pay for the care you get. Although DHMP does not object to providing services on moral or religious grounds, individual providers may have such objections. You have the right to change providers if an individual provider has objections to performing a service.

You do not need an approval:

- For a routine eye exam with a DHMP eye provider.
- To see a Denver Health OB/GYN (a provider who treats only women for reproductive reasons) for yearly exams.
- For family planning services or family planning providers.
- For emergency or urgent care (in or outside of DHMP).
- Outpatient mental health services – you may self-refer for these services to an in-network provider, Covered service include, but are not limited to:
    - Individual counseling;
    - Family counseling;
    - Group counseling; and
    - Case management services.
- For emergency services for mental health or substance abuse; you are responsible for ensuring that DHMP has been notified of emergency admission.

Please call Health Plan Services to get more information on approvals.

If your benefits, provider or services change:

DHMP will tell you in writing if there is ever a significant (major and important) change to any of these:

- Your disenrollment rights
- Provider information
- Your rights and protections
- Grievance, appeal, and State Review processes
- Benefits available to you through DHMP
- Benefits available to you that are not through DHMP
- How to get your benefits, including authorization requirements and family planning benefits

If you have a question, call **Health Plan Services** at **303-602-2100** or toll-free at 1-800-700-8140.

- Emergency, urgent and post-stabilization care services
- Approvals for specialty care
- Cost sharing

DHMP will let you know about these changes at least thirty (30) days before the intended effective date of these changes.

Enrolling and Disenrolling:

Being a member of DHMP is your choice. You can disenroll from DHMP when:

- You are a new DHMP member and you have been enrolled in DHMP for 90 days or less.
- You are in your Open Enrollment period (see the "Open Enrollment" section in this handbook for details).
- You miss your Open Enrollment period because you lost your CHP+ eligibility for a short time.

Presumptive Eligibility:

The Presumptive Eligibility (PE) program gives children under 19 and pregnant women temporary Health First Colorado or Child Health Plan Plus (CHP+) medical coverage right away. Your temporary medical coverage lasts for at lasts for at least 45 days while your Medical Assistance application is processed. To qualify, you must:

- Be a child under 19 or a pregnant woman,
- Appear to qualify for Child Health Plan Plus (CHP+), and
- Complete an application for Medical Assistance

Note: Dental services are not covered while you are in the Presumptive Eligibility program.

You (or DHMP) can also request to disenroll from DHMP at any time for these reasons:

- You move out of the DHMP network area (Adams, Arapahoe, Jefferson, and Denver Counties);
- You need to get two (2) or more services at the same time, but one of the services is not available in the DHMP network, and your provider tells DHMP that you need to get the services at the same time;
- You are enrolled in DHMP by mistake;
- You feel, and HCPF agrees, that you are getting poor quality of care, lack of access to DHMP services, or lack of access to the types of providers that you need;
- Your PCP leaves the DHMP network; or
- Other reasons that are approved by HCPF.

DHMP may request to disenroll you from the DHMP plan. DHMP can get permission from HCPF to disenroll you for any of these reasons:

- You are no longer a permanent resident in the DHMP service area, or you have been living outside of the DHMP service area for ninety (90) or more days in a row;
- You are put in an institution because of a mental illness, drug addiction;
- You are put in a correctional institution (jail, prison);
- You have health coverage besides CHP+;
- You are in a Medicare plan or other health plan that is not a DHMP plan;
- Child welfare eligibility status;
- Coverage with the CHP+ Prenatal Care Program is terminated 60 days after the last day of the month in which the pregnancy has ended. For example, if you give birth on June 26, your coverage will end on August 30
- Upon the member's death
- You knowingly give DHMP incorrect or incomplete information about yourself, and this information affects your enrollment status; or
- Any other reason given by DHMP that HCPF agrees with.

DHMP may also request to disenroll you from the DHMP plan. Your provider can request to disenroll you for any of these reasons.

- You keep missing appointments that you make to see your provider;
- You do not follow the treatment plan that you and your provider agree on;
- You do not follow the rules of DHMP (listed as your Member Responsibilities in this handbook); or
- You are abusive to your providers, other DHMP staff, or other DHMP members.

DHMP must give you one (1) verbal warning before they can request to disenroll you for these reasons. If you keep acting in the same way, DHMP will send you a written warning. The written warning will tell you the reason you are being warned. It will also tell you that you will be disenrolled from DHMP if you keep acting in the same way.

If you are abusive to your provider, other DHMP staff, or other DHMP members, DHMP will give you a verbal warning and may disenroll you without sending you a warning letter.

To enroll or disenroll from DHMP, you must call **Health First Colorado Enrollment** at **1-888-367-6557**.

Open Enrollment:

You have 90 days (the 90 days before the end of your eligibility period) to switch from DHMP to a different health plan for any reason. These time frames are called your Open Enrollment period.

A reminder letter is sent out when you are in your Open Enrollment period. During this time you can choose to stay in DHMP or choose a different health plan.

When Are You Not Able to be a DHMP Member?

You are not able to get services through DHMP when:

- You lose CHP+ eligibility;
- You move out of Colorado for more than 30 days;
- You join some other health plan; and/or
- You move to a county outside the DHMP service area (Denver, Arapahoe, Adams and Jefferson counties).

Other Insurance:

Being eligible for CHP+ depends on the member not having any other health insurance other than Indigent Care and the Health Care Program for Children with Special Needs (HCP). If the member is covered by any other valid insurance, they will no longer be eligible for CHP+.

If you get any other health insurance, you must tell DHMP. You can call **Health Plan Services** at **303-602-2100** or fill out the form at the back of this handbook and return to the address listed on the form. You can find additional forms online at https://www.denverhealthmedicalplan.org/coordination-benefits. If a DHMP member is found to have other health insurance, their DHMP coverage will be terminated (ended). The exceptions to have double coverage are Medicare and dental insurance.

Medical Bills:

DHMP pays for all your covered benefits. You should never get a bill from a provider if the service is a DHMP covered benefit. You may have to pay for a service you get is not covered or if you get the service from a provider outside of DHMP without getting an approval first (see "Getting an Approval to see a Specialist" for more information). Please call Health Plan Services if you get a bill from a provider.

Protect Yourself and CHP+ from Fraud:

Most people who work with DHMP are honest. Unfortunately, there may be some who are not. Fraud can be committed by both members and providers. Fraud costs CHP+ a lot of money each year. This makes health care cost more for everyone.

Examples of Member Fraud:

- Using someone else's ID card or loaning your ID card to someone not entitled to use it
- Providing false information on an enrollment application to obtain coverage

Examples of Provider Fraud:

- Billing DHMP for services you never got
- Billing DHMP for equipment that is different

You can help fight fraud too!

When you get health care services, you may want to save the receipts you get from providers. Use your receipts to check for mistakes. These include any records that list the services you got or the drug orders you filled. Also, guard your member ID card. Don't let anyone borrow your member ID card or share your information.

If you suspect fraud – report it to DHMP:

By phone: Call our toll-free Values Line at 1-800-273-8452. This number is available 24 hours a day, 7 days a week. You may give your name and number or choose to remain anonymous.

In writing:

Denver Health Enterprise Compliance Services

ATTN: DHMP Compliance

601 Broadway, Mail Code 7776

Denver, Colorado 80204

By email: ComplianceDHMP@dhha.org

When Will You Have to Pay for Your Care?

- If you go to some providers or specialists without approval from DHMP and your PCP;
- If you get health care that is not a covered benefit;
- If you do not follow the pharmacy rules; or
- If there is fraud or the service is against the law.

If you need help deciding if a service or provider is covered by DHMP please call Health Plan Services.

Physician Incentive Plans:

DHMP does not compensate, reward, or incent, financially or otherwise, associates for inappropriate restrictions of care. We do not promote or otherwise provide an incentive to employees or provider reviewers for withholding benefit for approval for medically necessary services to which you are entitled. Utilization review and benefit coverage decisions are based on appropriateness of care and service and the applicable terms of this Booklet. We do not design, calculate, award, or permit financial or other incentives based on the frequency of denials of authorization for coverage, reductions, or limitations on hospital lengths of stay, medical services or charges, or telephone calls or other contacts with health care providers or members.

When Another Party Causes Your Injuries or Illness:

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

- DHMP may collect paid benefits directly from the liable party or the liable party's insurance company.
- You will tell DHMP, within 30 days of becoming injured or ill when another party caused your injury or illness.
- You will tell DHMP the names of the liable party and that party's insurance company.
- You will tell DHMP the name of any lawyer that you hired to collect from the liable party.
- You or your lawyer will notify the liable party's insurance company that:
    - DHMP has paid, and/or is in the process of paying, your medical bills.
    - The insurance company must contact DHMP to discuss payment to DHMP.
    - The insurance company must pay DHMP before it pays you or your lawyer.
- Neither you nor your lawyer will make an agreement with the insurance company that does not provide for full payment to DHMP.
- Neither you nor your lawyer will collect any money from the insurance company until after DHMP is paid in full. This applies even if the insurance money to be paid is referred to as damages for pain and suffering, lost wages, or other damages.
- If the insurance company pays you or your lawyer and not DHMP, you or your lawyer will pay the money over to DHMP up to the amount of benefits paid out. DHMP need not pay your lawyer any attorney's fees or costs for collecting the insurance money.
- DHMP will have an automatic lien (a right to collect) on any insurance money that is owed to you by the insurance company, or that has been paid to your lawyer. DHMP may notify other parties of the lien.
- DHMP may give the insurance company and your lawyer any DHMP records necessary for collection. If asked, you agree to sign a release to provide DHMP records to the insurance company and your lawyer. If asked, you agree to sign any other papers that will help DHMP collect.
- You and your lawyer will give DHMP any information requested about your claim against the liable party. You and your lawyer will notify DHMP of any dealings with, or lawsuits against, the liable party and that party's insurance company.

- You and your lawyer will not do anything to hurt the ability of DHMP to collect paid benefits from the insurance company.
- You will owe DHMP any money that DHMP is unable to collect because of your, or your lawyer's, lack of help or interference. You agree to pay to DHMP any attorney's fees and costs that DHMP must pay in order to collect this money from you. If you or your lawyer do not help, or interfere with, DHMP in collecting paid benefits, then DHMP may contact the State of Colorado and request that you be disenrolled for cause from DHMP and placed in the CHP+ State plan.
- DHMP will not pay any medical bills that should have been paid by another party or insurance company.
- You must follow the rules of the other insurance company to have your medical bills paid. DHMP will not pay any medical bills the other insurance company did not pay because you did not follow their rules.

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

Using a Designated Personal Representative (DPR):

You can choose someone to be in charge of your medical care. This is a Designated Personal Representative (DPR). You can make a friend, family member, a provider, or any other person your DPR. A DPR looks after your interests when you cannot make health care decisions for yourself. You must tell DHMP in writing if you choose a DPR. The DPR's name, address and a phone number must be included in the letter so DHMP knows who to call when needed. A copy of the DPR form is located in the back of this handbook. You can also call Health Plan Services for a copy.

Privacy:

Your privacy is very important. You can expect that your medical records will be kept private. This includes member information like age, race/ethnicity, language and other personal contact information. DHMP will follow its written directions, procedures and laws about the private nature of your records. Member information and medical records will only be used for your treatment and quality of medical care. We will not give this information to anyone without your permission.

A complete description of DHMP's Privacy Practices is given to you when you get services at a Denver Health clinic. You can also call Health Plan Services to ask for a copy of the Privacy Practices at no cost to you.

Being on the Consumer Advisory Committee:

The DHMP Consumer Advisory Committee is a group of DHMP staff, members and other community health workers who meet regularly to talk about the DHMP Plan. When you join the DHMP Consumer Advisory Committee, you help us change DHMP for the better. Do you want to help make your health plan better? Do you have some ideas about how DHMP should change? Or do you just want to share your experiences with DHMP staff? We want to hear everything you have to say. In addition, within our website we ask for your feedback on member materials that are sent to you. Please follow the link and provide us with your feedback at denverhealthmedicalplan.org/child-health-plan-plus-connect-us or call **Health Plan Services** at **303-602-2100** if you wish to be part of the DHMP Consumer Advisory Committee.

DHMP Member Newsletter:

As a member of DHMP, you will get DHMP newsletters during the year. Each newsletter will have important messages from DHMP. The newsletters will tell you about any changes to the plan or its providers, upcoming events, health tips and more.

Requesting the Quality Assessment and Improvement Plan:

As a member of DHMP, you may request a copy of the Quality Assessment and Improvement Plan. Please visit: https://www.denverhealthmedicalplan.org/quality-improvement-program for the most up to date plan.

>> 2) YOUR RIGHTS AND RESPONSIBILITIES

Your Rights:

Denver Health Medical Plan (DHMP) provides access to medical care for all its members. We do not discriminate based on your religion, race, national origin, color, ancestry, handicap, sex, sexual orientation, gender identity or age.

We give care through a partnership that includes your provider, DHMP, other health care staff and you – our member. DHMP is committed to partnering with you and your provider. As a DHMP member, you have all of the following rights:

- To be treated with respect and with consideration to your dignity and privacy.
- To get information from your provider about all of the treatment options and alternatives for your health condition in a way that makes sense to you.
- To participate in decisions regarding your health care, including the right to refuse treatment.
- To get a second opinion (have some other provider review your case) at no cost to you. DHMP will arrange a second opinion with an out-of-network provider if a DHMP provider is not available.
- To make an Advance Directive.
- To get detailed information about Advance Directives from your provider and to be told up front if your provider cannot follow your Advance Directives because of their beliefs.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. (This means that DHMP providers and staff cannot hold you against your will to punish you, get you to do something they want, or get back at you for something you have done).
- To get health care services from providers within the DHMP appointment standards timeframes (in this handbook).
- To see providers who make you comfortable and who meet your cultural needs.
- To use any hospital or other facility for emergency and urgent care services. Emergency and urgent care services do not require prior approval or referral.
- To get health care services outside of the Denver Health Network if you are not able to get them in the Denver Health Network (DHMP must approve non-emergency and non-urgent care services first).
- To request and receive a copy of your medical records, and request that they be changed or corrected.
- To file a grievance, appeal or ask for a State Review.
- To join the DHMP Consumer Advisory Committee.
- To get complete benefit information from DHMP. This information includes covered services, how to get all types of care like emergency care, detailed information about providers and your disenrollment rights.
- To use your rights above, without fear of being treated poorly by DHMP.
- To be provided with health care services in accordance with requirements for access, coverage and coordination of medically necessary services.

Your Responsibilities:

DHMP wants to give every member outstanding care and a great experience every time they come to Denver Health. That is why we expect our members, staff, and providers to treat each other with dignity and respect.

As a DHMP member, you are also responsible for:

- Selecting a Primary Care Physician (PCP) or Medical Home that is in the Denver Health Network.
- Following all of the rules in this member handbook.
- Getting an approval from your PCP before you see a Specialist (unless one is not needed) and an authorization from Utilization Management if care is to be given outside of your contracted network.
- Following the rules of the DHMP appeal and grievance process.
- Calling the Appointment Center to change your PCP.
- Paying for any health care that you get without referral from your PCP (unless the services are emergency, urgent care, or family planning services.)
- Paying for any services that are not covered by DHMP or CHP+.
- Telling DHMP about any other insurance you have besides CHP+.
- Calling the Appointment Center 24 hours before your appointment date if you need to cancel your appointment.

>> 3) HOW TO GET CARE

Emergency Care:

An emergency is when you think a health problem will cause death, serious harm or if you are in very bad pain.

An emergency service is any service you get from an emergency room provider that is needed for an emergency health problem. If you have an emergency call 911 or go to the nearest hospital. There is no cost for covered health care services if you go to the hospital for an emergency health problem. An emergency is when you believe that by not getting health care right away it could result in:

- Your health or the health of your unborn child being harmed.
- Your body not working the right way.
- An organ or part of your body not working the right way.

DHMP will not deny your emergency services if the provider does not contact DHMP within a certain number of days.

Stabilization care is care you get after an emergency so that your health will be stable. DHMP will cover your care for these types of services. Emergency, urgent and stabilization care do not need pre-approval from DHMP. You may see a non-Denver Health provider for emergency, urgent, and stabilization care. Any care you get that is not emergency, or urgent care, or stabilization must be given by a Denver Health provider(unless you have received prior authorization to get care out of network).

Please call Health Plan Services as soon as possible when you or your child is admitted to the hospital for an emergency (unscheduled) situation.

If you need care after hours (after your provider's office is closed) you can call the **Denver Health NurseLine** at **303-739-1261**. The nurse can help you decide if you need to see a provider, go to the emergency room or give you health advice if you are not sure what to do.

Urgent Care:

Sometimes you need urgent care when you need to be seen quickly, but it is not an emergency. If you have an urgent care need, you can go to the nearest urgent care center, or call:

- Your PCP.
- The **Denver Health NurseLine** at **303-739-1261**. This line can connect you to a DHMP nurse 24 hours a day, 7 days a week. The DHMP nurse can help you decide if you should go to the emergency room or urgent care center.
- Virtual Urgent Care is now available for all Denver Health MyChart users. It's easy and convenient to get the urgent care you need from the comfort of your home, using your smartphone, tablet or computer. Please contact Health Plan Services for further assistance and details.

You do not need to get approval from DHMP to go to the nearest urgent care center. You may see any urgent care provider, even if the provider is outside of the DHMP network.

Denver Health has adult and pediatric (children's) urgent care clinics on the main Denver Health hospital campus (777 Bannock St.). These clinics are open 8:30 a.m. – 10 p.m. Monday – Friday and 10 a.m. – 9 p.m. on weekends.

You may use the Denver Health urgent care clinics, but you do not have to use them. Please always use the closest urgent care center to you when you have an urgent care need.

Post-Stabilization Care:

Post-Stabilization care services are covered services that you get after an emergency medical condition and after you are stabilized. A provider may give you Post-Stabilization care to keep you stabilized or improve or resolve your health problem. DHMP will pay for your Post-Stabilization care if you are at Denver Health. If you are at a non-Denver Health hospital for an emergency, your Post-Stabilization care must be pre-approved by DHMP. Once you are stabilized, you or a family member should call DHMP at the number on the back of your member card to notify DHMP of your admission to a non-network hospital.

When a provider at a non-Denver Health hospital is giving you Post-Stabilization care services and DHMP did not pre-approve them, DHMP must still pay for the services if:

- The provider at the non-Denver Health hospital asks DHMP to approve your Post-Stabilization care services, and DHMP does not get back to the non-Denver Health provider within one (1) hour;
- DHMP cannot be contacted; or
- DHMP and the provider at the non-Denver Health hospital cannot agree on how to handle your treatment.

If you are getting Post-Stabilization care services at the non-Denver Health hospital and they were not pre-approved by DHMP, but they are being paid for by DHMP because of the reasons above, DHMP will pay for the services until one of these things happens:

- A DHMP provider who also works at the non-Denver Health hospital takes responsibility for your care;
- The provider at the non-Denver Health hospital tells DHMP you are healthy enough to be transferred, so you are transferred to Denver Health hospital and a DHMP provider takes care of you;
- DHMP and the provider at the non-Denver Health hospital reach an agreement on how to handle your treatment; or
- The non-Denver Health provider decides that you can be discharged from the non-Denver Health hospital.

When the provider at the non-Denver Health hospital decides that you are "stable" (meaning you are healthy enough to be transferred to Denver Health for the rest of your care), DHMP will work to safely bring you to Denver Health hospital. Your care will still be covered by DHMP when you get transferred to Denver Health hospital. If you refuse (say no to) this transfer, you will have to pay for the rest of the care you get at the non-Denver Health hospital. You will not be charged any more than what DHMP would charge for services provided by DHMP.

Preventive Care and Routine Care:

You need immunizations, vaccines, check-ups and regular provider visits for good health. Getting routine care is a great way for your PCP to track your health. You should get routine and preventive care so that your PCP can help prevent you from getting sick and also to treat any early signs of sickness before they get worse. Call the Appointment Center to help you get this kind of care. If there are other services you have questions about, please give Health Plan Services a call.

Making an Appointment:

You should call the **Appointment Center** at **303-436-4949**. If you need an interpreter or TTY services when you see your provider, let the Appointment Center representative know when you make your appointment. New patients can schedule an appointment online at www.denverhealth.org. Once you have been seen at any Denver Health clinics you can also schedule an appointment online by registering for MyChart at https://mychart.denverhealth.org/mychart/openscheduling. MyChart allows you to message your doctor, view test results, refill medications as well as schedule a virtual urgent care appointment.

You will get an appointment as quickly as possible, but no later than the times listed in the appointment standards chart listed below:

DHMP Appointment Standards	
Type of Care	**Appointment Standard**
Emergency	24 hours a day, 7 days a week
Urgent	Within 24 hours of your call
Non-Urgent Medical/Non-Emergent Non-Urgent Symptomatic	Within 7 days
Non-Urgent, symptomatic care of substance abuse or behavioral health services	Within 7 calendar days
Non-Symptomatic well-care physical exams/Non-Emergent, Non-Urgent medical problem	Within 30 days
Outpatient Follow-Up Appointments	Within 7 days after discharge from hospitalization
Emergency Behavioral Health care	By phone within fifteen (15) minutes after initial contact, in person within one (1) hour of contact

Pharmacy:

In order for DHMP to pay for your prescription, you must bring your DHMP ID card with you when you go to the pharmacy. If your Denver Health provider writes you a prescription, you can fill it at any of the Denver Health Pharmacies listed below:

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

Primary Care Pharmacy (Webb)
301 W. 6th Ave.
Denver, CO 80204

Eastside Pharmacy
501 28th St.
Denver, CO 80205

Westside Pharmacy
1100 Federal Blvd.
Denver, CO 80204

Southwest Pharmacy
1339 S. Federal Blvd.
Denver, CO 80219

Public Health Pharmacy
605 Bannock St.
Denver, CO 80204

La Casa Pharmacy
4545 Navajo St.
Denver, CO 80211

Lowry Pharmacy
1001 Yosemite St.
Denver, CO 80230

Montbello Pharmacy
12600 Albrook Dr.
Denver, CO 80239

For the Denver Health pharmacy hours, visit https://www.denverhealth.org/services/pharmacy.

You may also take your prescriptions to any other pharmacy that accepts DHMP insurance. Some pharmacies outside of Denver Health take DHMP insurance, like King Soopers, Safeway, Rite-Aid, Walmart and Walgreens. You can go online to http://www.denverhealthmedicalplan.org to log into the Member Portal to find a pharmacy near you.

You may call the phone number on your bottle to order a refill. If you use Denver Health Pharmacies you may order a refill by calling the **Refill Request Line** at **303-389-1390** or by using the MyChart smart phone app. You should always order your refills at least five working days before you run out of your prescription. If your provider tells you to take your prescription in a way that is different from the directions on your prescription bottle, please let your pharmacy know.

If you have questions or need help with your prescriptions outside of the normal business hours, please call the **MedImpact Help Desk** at **1-800-788-2949**.

It is a good idea to get all of your prescriptions filled at the same pharmacy. If you fill your prescriptions at Denver Health, your providers will be able to look in your medical records for a list of your drugs. If you get your prescriptions filled outside of Denver Health, you must tell your providers because pharmacies outside of Denver Health do not update your DHMP medical records.

DHMP has a list of covered drugs. This list is called a formulary. If your provider writes you a prescription for a drug that is not on the formulary there may be a drug on the list that would work just as well for you. Your provider can decide if a formulary drug is right for you. If your provider does not want to change the drug, they

will need to fill out prior authorization form and tell DHMP why that drug is needed. DHMP will let you, your provider and your pharmacy know if DHMP will pay for the drug or not.

Some drugs may not be available at all pharmacies. Formulary over-the-counter drugs can only be filled at Denver Health. Some drugs are not covered at all.

These include drugs for:

- Cosmetic use (anti-wrinkle, hair removal, and hair growth products)
- Non-formulary dietary supplements (vitamins, herbals, etc.)
- Infertility (to help women get pregnant)
- Pigmenting / De-pigmenting (to change skin color)
- Sexual performance/dysfunction (Viagra, Cialis, Levitra etc.)
- Non-formulary therapeutic devices or appliances (machines you use for your health)
- Weight loss
- Investigational or experimental treatments (drugs not approved by the Food and Drug Administration)

Pharmacy by Mail:

DHMP offers Pharmacy by Mail. Pharmacy by Mail saves you time by sending your 90-day supply prescriptions to your home. Since Pharmacy Retail by Mail prescriptions are for a 90-day supply, you will only need to have your prescriptions filled four times a year. You can sign up for Pharmacy by Mail by using the MyChart application or by calling the Pharmacy Call Center at 303-436-4488.

Medications that are covered are $0. You do not need to keep a credit card on file if you only want to have covered medications sent to your home with Pharmacy by Mail. If your address changes call the **Pharmacy Call Center** at **303-436-4488** or fill out and mail a new SIGN-UP FORM to 500 Quivas St., Suite A, Denver, CO 80204. Be sure to mark on the form that this is a change of address. The pharmacy can only ship your prescriptions within the state of Colorado.

Controlled substances or specialty medications cannot be filled through this program. These must be picked up at any of the Denver Health Outpatient pharmacies. To refill Pharmacy by Mail prescriptions call the **Refill Request** Line at **303-389-1390**.

For information about your pharmacy benefits go to http://www.denverhealthmedicalplan.org and click on Child Health Plan Plus. From this website you can:

- Click the Formulary/Drug List link to see the list of covered drugs (the formulary). This link also explains the formulary restrictions, limits or quotas, how your provider can request a prior authorization or exception request, and your plan's process for generic substitution, therapeutic interchange, and step therapies. All together these topics are known as the Pharmaceutical Management Procedures.
- Access the Prior Authorization Form (PAR)/Exception Request Form to start a prior authorization. This is also called an exception request.

- Click the link to the Member Portal (register with your member ID to log in) to:
    - Search the formulary to see if your drug is covered.
    - Locate a pharmacy close to you
    - Search for drug-drug interactions and common drug side effects.

If you have questions about your pharmacy benefits, please call **Health Plan Services** at **303-602-2100** or **1-800-700-8140**. TTY users should call 711.

>> 4) HOW TO GET CARE WHEN YOU ARE AWAY FROM HOME

When you are away from the Denver area you are only covered for emergency and urgent care services.

If you have an emergency or need urgent care when you are away from the Denver area, go to the nearest emergency room or urgent care center.

If the emergency room or urgent care center decides that you must stay overnight in a hospital, the facility will need to call the **DHMP Out-Of-Network Hospitalization Line** at **303-602-2162** as soon as possible to let us know about your hospitalization. DHMP will work with the providers at the hospital to make sure you are getting the care you need. When you are healthy enough, the other hospital providers will allow DHMP to transfer you to Denver Health. If you say no to the transfer to Denver Health, you may have to pay for the rest of the services you get at the other hospital.

Travel outside the Country
Health care services provided outside of the country are covered for emergency care only. If you have an emergency outside of the country, you should go to the nearest medical facility. Let the hospital know that the itemized bill from the hospital must be sent to:

Denver Health CHP+
P.O. Box 24992
Seattle, WA 98124-0992

If the hospital agrees to bill us and accepts payment from us, then the hospital will be reimbursed directly for covered services.

If the hospital will not accept payment from us, then you should pay the hospital. If you have to pay the hospital directly, we encourage you to pay with a credit card because the credit card company will automatically transfer the foreign currency into U.S. dollars. We require proof of payment (for example, a receipt and documentation of the amount paid in the U.S. dollars) to reimburse you directly. Please see the directions listed earlier in this section for more information.

When you return home, contact us. We may require medical records for the services received. You are responsible for providing these medical records and it may be necessary to provide an English translation of the medical records.

If you receive care for services other than emergency care, you may be responsible for payment.

Prescriptions When You Are Away From Home:

Ask for an early refill before you leave on a trip. You can get prescriptions at major pharmacy chains throughout Colorado that accept DHMP insurance. Outside Colorado, prescriptions are only covered for emergency situations for a maximum of a 3 day supply. You will need to have your DHMP ID card to show the pharmacist.

>> 5) WOMEN'S HEALTH CARE

Family Planning:

Services that can help women and men choose if, or when, to become pregnant or to become a parent. Family planning services include different kinds of birth control, like birth control pills and office visits to talk about family planning and how to make healthy decisions about reproduction.

You may go to a DHMP provider or any provider who accepts Health First Colorado (CHP+ Programs) for family planning. You do not need to get a pre-authorization or referral for any provider regardless of whether they are in-network or not. Examples of family planning providers include: a gynecologist or OB/GYN, a certified nurse midwife, a family planning clinic, a nurse practitioner or your regular doctor.

Seeing an OB/GYN (Obstetrics and Gynecology):

You do not need an approval or referral to see a DHMP OB/GYN for pregnancy services or well-woman care. If you are more than three (3) months pregnant and you are a new DHMP member, you may keep seeing your current OB/GYN, even if your OB/GYN is outside of the DHMP network. Call Health Plan Services for more information.

Pregnancy Care:

If you think you are pregnant, make an office visit with your provider right away. Early care when you are pregnant is very important. Your provider will help you get all your care before, during and after the birth of your baby.

How to Sign Your Newborn Up for DHMP:

All babies born to moms in DHMP are covered from the date of birth up to 30 calendar days, or until the last day of the first full month following birth, whichever is sooner. Your child can be enrolled in DHMP, same as mom, and receive their care at Denver Health. You can also call **Child Health Plan Plus (CHP+)** at **1-800-359-1991** to add newborn. Your baby will be covered under your coverage for 30 days only; you will then need to apply for coverage for your newborn child. A CHP+ Eligibility and Enrollment specialist can help you with that process. Most babies born to teen mothers are eligible for Health First Colorado; however, some newborn children may qualify for CHP+.

Adult Members in the Prenatal Care Program
Newborn children of women who are approved for the CHP+ Prenatal Care Program are automatically covered under CHP+ for 12 months from the date of birth. Please contact CHP+ Eligibility and Enrollment at 800-359-1991 to enroll your baby.

>> 6) CHILDREN'S HEALTH CARE

Early Intervention Services (EIS):

Early Intervention Services (EIS) are services that give support to children who have special developmental needs. These services are for children from birth to age 3. These services can help better children's ability to develop and learn. EIS also teaches you and your family how to aid your child's growth. EIS includes education, training and aid in child development, parent education, therapies and other activities. These services are designed to meet the developmental needs of your child. They help your child develop their cognition, speech, communication, physical, motor, vision, hearing, social-emotional and self-help skills.

It is an optional program and does not discriminate based on race, culture, religion, income level or disability.

For more information about EIS, please contact **1-888-777-4041** or visit http://www.eicolorado.org.

Recommended Child Check-ups with Your PCP:

You should get necessary and recommended check-ups so that your PCP can look for early signs of illness. You should also use your check-up visits to make sure that you get all the right immunizations.

DHMP recommends the following check-ups and screenings:

Age	Check-ups/Screenings
0 to 15 months	• Well child/physical – 8 visits • Dental – Every 6 months starting at age 1 • Hearing – 1 check-up in hospital (at birth); 2 check-ups • Vision – 1 check-up
18 months to 2 years	• Well child/physical - 3 visits • Dental – Every 6 months • Hearing – 1 check-up after each middle ear effusion • Vision – 1 check-up at 2 years of age
3 to 20 years	• Well child/physical - 1 visit per year • Dental – Every 6 months • Hearing – 1 check-up at ages 4-6, 8 and 10 • Vision – 1 check-up

Childhood and Adolescent Immunizations:

One of the best things you can do for your child is get regular immunizations or shots. Your child's PCP can give the shots in their office during checkups. Children need these shots to protect them from diseases.

Schedule for Immunizations:

Age	Shots
Birth to 1 year	• Hepatitis B • DTaP (prevents diphtheria, tetanus and whooping cough) • IPV - Polio • Hib (Haemophilus influenza Type b) • PCV - Pneumococcal (prevents pneumonia) • RV - Rotavirus (stomach virus) • Influenza – seasonal flu (starting at 6 months old)
1 to 3 years	• Hepatitis A • Hepatitis B • Hib • Polio • MMR (prevents measles, mumps & rubella) • Varicella (prevents Chicken Pox) (if child has not had chicken pox) • DTaP • Pneumococcal • Meningococcal (prevents meningitis) • Influenza (every 6 months)
4 to 6 years	• DTaP • Polio • MMR • Varicella (Chicken Pox) • Influenza (every 6 months)
11 to 12 years	• Tdap (prevents tetanus, diphtheria, pertussis) • HPV - Human Papillomavirus (prevents genital warts) • Meningococcal (prevents meningitis) • Influenza (yearly)
13 to 21 years	• All shots above that have not been done will need to be completed. • Influenza (yearly)
Adult	• Td (prevents tetanus & diphtheria) – every 10 years • Influenza – yearly

Pediatric and Adolescent Immunizations:

Pediatric and adolescent immunizations (shots) are covered as recommended by the American Academy of Pediatrics. All recommended shots are a covered benefit by a network provider or contracted pharmacy at no cost to the member

The HPV vaccine is covered for eligible girls and boys and is strongly recommended to avoid cervical cancer (for girls) or genital warts.

It is recommended that children receive a flu shot yearly. The best time to get a flu shot is in October or November. DHMP especially suggests the flu shot for the following people:

- All high-risk children
- Children with long lasting health problems or a problem with the immune system or children with asthma
- Children 6 months to 59 months (4 years 11 months)
- Children with brothers and sisters under 6 months of age
- Anyone who will be around people with health problems like asthma, heart and/or lung disease
- Pregnant women who are more than 3 months pregnant during flu season (if you will have a baby between December and May)

Please see the "Schedule for Immunizations" table in this handbook for more information on shots.

>> 7) SPECIAL HEALTH CARE PROGRAMS

DHMP has many services to help you if you have special health care needs. Here are some examples of health problems that are special health care needs:

- Health problems that last for longer than a year (high blood pressure, asthma)
- Health problems that require you to use special devices (like wheelchairs or oxygen tanks)
- Health problems that seriously limit your emotional, physical, or learning activities

Call Health Plan Services to learn more. You can also talk to your PCP if you have special health needs.

Denver Health offers maternal care classes. To access the classes, call 303-602-5526 or to learn more visit https://www.denverhealth.org/services/womens-health/maternity-pregnancy.

Special Health Care Programs for New Members and Members with Special Health Needs:

If you are a new member with special needs, you can keep seeing your non-DHMP provider for up to sixty (60) days after you join DHMP. Your non-DHMP provider must agree to work with DHMP during these 60 days.

If you are in your 2nd or 3rd trimester of your pregnancy and you are a new DHMP member, you may keep seeing your current OB/GYN thru your completion of care up to delivery, even if your OB/GYN is outside of the DHMP network. If you have an out of network provider, they will need to submit a prior authorization for services and

should contact Health Plan Service for more information. You will have 90 days from enrollment date to request to disenroll and join another Managed Care Organization plan if you wish to do so.

You may also keep your Home Health or DME (durable medical equipment) provider for up to seventy-five (75) days after you join DHMP. Your DME provider must also agree to work with DHMP during these 75 days.

You must let DHMP know who these providers are. You must also tell us that you want to keep seeing these providers until your care is transferred. You can call Health Plan Services to get more information.

If you have a special health condition that requires you to see a specialist (a doctor that is an expert in one or more areas of health care), you will need an approval for a certain number of visits to see the specialist, or use this doctor as your PCP.

If the specialist that you have to see is in the Denver Health network, no authorization is needed. If the specialist that you see is outside of the Denver Health Network, your PCP can refer you and Utilization Management will review the request.

Care Management Services:

At DHMP, we understand that people can face many challenges living with complex diagnoses. Denver Health Medical Plan provides patients with Care Management and Care Coordination services. As part of these services, patients can expect the following:

- Receive a Patient Centered Medical Home (PCMH) and Care Team to address all your special health care needs
- Help you understand the health care system including access to primary care, specialty services and community resources
- Make individual care plans to help you better manage and meet your health-related goals
- Connect you with the right level of health care at the right time including emergency, urgent care and hospitalizations
- Provide ongoing support when you have a major health care event like a hospitalization or birth of a child
- Coordinate your health care with your different doctors in and outside of Denver Health's network
- Manage your mental health needs
- Insurance Benefit support and knowledge

Your PCP or a member of your care team can initiate Care Management Services. If you are interested in any of these services, please contact your PCMH (Patient Centered Medical Home).

Utilization Management:

Utilization Management reviews referral requests from your PCP and grants authorization approval when it is medically necessary for you to receive care outside of your contracted network. Authorizations are required for payment of services and treatment that are either not available at Denver Health or have a limit on the benefit.

Examples of things that require authorization include home health services, durable medical equipment (DME) and care at a non-Denver Health facility. See the section, "Your DHMP Benefits" in this handbook to find out

which covered services require DHMP authorization. Your provider will work with Utilization Management staff to get an authorization if it is needed.

Utilization Management works directly with the hospitals, doctors, home health agencies, DME companies and other providers to make sure you get the right care in the right setting.

If you have questions about a service, treatment, or a specific decision that is made, you can call Health Plan Services. You can also file an appeal if you do not agree with a decision that Utilization Management makes about your care. See the "What is an Appeal?" section in this handbook for more information.

You can call Health Plan Services if you want to know what information DHMP uses when making authorization decisions or how we ensure that you are getting quality care.

Medically Necessary:

DHMP decides which services will be covered based on if they are medically necessary. Throughout this handbook, you might see the term "medically necessary" or "needed for treatment" used when talking about what benefits will be covered for you under this plan. This means that DHMP will only provide care that is needed to diagnose, treat, or monitor a condition. It means that not getting medical care could negatively affect your health.

If a service is not medically necessary, like a cosmetic surgery for example, then DHMP will not pay for it.

Clinical Practice Guidelines:

Clinical Practice Guidelines can help you and your doctors make good choices about your care. Guidelines are based on lots of research and list the best treatment options for certain conditions. Denver Health uses guidelines to make sure you always get the best care at all of your doctor visits. This helps make sure that you are not given services that you do not need or that would not help your health status.

To view more information on Clinical Practice Guidelines you may find it at https://www.denverhealthmedicalplan.org/quality-improvement-program. You can also request to get a copy of any of these guidelines at no cost to you by calling Health Plan Services

>> 8) YOUR DHMP BENEFITS

This is a list of your Child Health Plan Plus (CHP+) benefits with DHMP. If you need a service that is not covered, you or your PCP can work with DHMP to see if it is medically necessary. The act that a provider prescribes, orders, recommends, or approves service, treatment, or supply does not guarantee payment by us.

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Health Maintenance Organization (HMO)
2. OUT-OF-NETWORK CARE COVERED?	Only for emergency, urgent care, or family planning
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available only in the following areas: Denver, Jefferson, Arapahoe and Adams Counties

PART B: SUMMARY OF BENEFITS

IMPORTANT NOTE: This form is not a contract. It is only a summary. Your plan may exclude coverage for certain treatments, diagnoses or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g. plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the Member Handbook to determine the exact terms and conditions of coverage.

	IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)
DEDUCTIBLE TYPE out-of-pocket maximum?	No deductible applies
ANNUAL DEDUCTIBLE a) [Individual] [Single] b) [Family] [Non-Single]	 a) No deductible applies b) No deductible applies
OUT-OF-POCKET ANNUAL MAXIMUM a) Individual b) Family c) Is deductible included in the out-of-pocket?	 a) No out-of-pocket annual maximum applies b) No out-of-pocket annual maximum applies c) No deductible applies
LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum except for Major Organ Transplants
COVERED PROVIDERS	Denver Health and Hospital Authority providers, Denver Health Medical Center and Stride Community Health Centers. See provider directory for a complete list of current providers.
With respect to network plans, are all the providers listed above accessible to me through my primary care physician?	Yes
PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED	Not applicable; Plan does not impose limitation periods for pre-existing conditions.

WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. List of exclusions available immediately upon request or in the Member Handbook. Review them to see if a service or treatment you need may be excluded from the policy.

	Inclusions and Exclusions: IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)
	✓ This check mark means that the service is a covered benefit × This "x" mark means that the service is not a covered benefit
Ambulance and Transportation Services	No copay (100% covered) DHMP offers ambulance services for medical emergencies. Ambulance vehicles must be designed for and licensed to transport sick or injured people. ***Not-Covered Services:*** × Commercial transport, private aviation or automobile, air taxi, or wheelchair ambulance × Ambulance transportation if there is no emergency × If you call for an ambulance and decide to not take the transportation, then you will have to pay for the charges × Ambulance transportation from the emergency back to your home
Dental Care	Dental services are not covered by DHMP, except for some cases that will be described below. DHMP provides medical coverage and should not be considered a dental service provider. ***CHP+ members are eligible for dental coverage through DentaQuest. Effective October 01, 2019 dental services will also be available for Child Health Plan Plus (CHP+) prenatal women. Please Contact DentaQuest at 1-888-307-6561 for specific dental related benefits.*** Cases where DHMP will cover certain dental services (must be pre-authorized): ✓ Accident-related dental services; includes repairs to sound teeth (whole, healthy teeth not in need of treatment other than the accident) or related body tissue within 72 hours of an accident ✓ Inpatient admission for dental care: does not include charges for dental services, only if the member has a non-dental related physical condition that make the hospitalization medically necessary ✓ Fluoride varnish application up to 2 times a year for children ages 0 to 4 ✓ Cleft palate and cleft lip procedures with medical basis (see list of procedure below) Cleft palate/cleft lip procedures that are medically necessary (member must not have any other dental insurance): • Oral and facial surgery and related services, including follow-up care • Prosthetic treatment • Medically necessary orthodontic treatment • Otolaryngology treatment ***Not-Covered Services*** × Restoring of teeth, mouth or jaws from biting or chewing × Restorations that are not medically necessary

	× Inpatient or outpatient dental services (except the situation described above) × Upper or lower jaw augmentation or reduction × Artificial implanted devices and bone graft for denture wear × Temporomandibular (TMJ) joint therapy or surgery unless it has a medical basis
Early Intervention Services	No copay (100% covered) Early Intervention Services, or EIS, are services that give support to children who have special developmental needs. See the "Early Intervention Services" section in this handbook for more information. The following are some services offered unlimited through EIS for children ages 0-3 otherwise up to 30 visits per calendar year per diagnosis ✓ Physical Therapy ✓ Speech Therapy ✓ Occupational Therapy
Emergency, Urgent and After-Hours Care Services	No copay (100% covered). No pre-authorization required in or out-of-network. See the "Emergency" and "Urgent Care" sections in this handbook for more information about these services.
Family Planning/reproductive Health	No copay (100% covered). No pre-authorization or referral for any provider regardless of whether they are in-network or not. This could be a PCP or and OB/GYN ✓ Injection (shot) of Depo-Provera for birth control purposes ✓ Fitting of a diaphragm or cervical cap ✓ Surgical implantation and removal of an implantable contraceptive device ✓ Fitting, inserting, or removing Intrauterine Device (IUD) ✓ Tests to diagnose a possible genetic illness/disease ✓ STI (Sexually Transmitted Infections) and HIV testing and treatment ***Not-Covered Services*** × Surgical sterilization (for example, tubal ligation or vasectomy) and related services × Reversal of sterilization procedures × Over-the-counter contraceptive products such as condoms and spermicide × Preconception, paternity, or court-ordered genetic counseling and testing (for example, tests to determine the sex or physical characteristics of an unborn child) × Elective termination of pregnancy, unless the elective termination is to save the life of the mother or if the pregnancy is the result of an act of rape or incest
Food and Nutrition Services	No copay (100% covered). An in-network licensed therapist has to provide the nutrition services. All services must be pre-authorized. ✓ Enteral therapy and Parenteral Nutrition (TPN) – these services are usually provided through a home health agency

	✓ Medical foods for home use for inherited enzymatic disorders involved in the metabolism of amino, organic and fatty acids ✓ Diabetic nutrition counseling ✓ Nutritional services in hospice care – nutritional assessment, counseling and feeding as determined medically necessary ✓ Formulas for metabolic disorders ✓ Nutritional assessment and therapy when medically necessary ✓ Feeding appliances and feeding evaluations that are necessary where normal food intake is not possible ✓ Obesity/overweight nutritional assessment ✓ Human breast milk when required for survival of infant Any equipment related to Nutrition Services will be subject to the DME limit (see "Medical Equipment and Supplies" section in this table). ***Not-Covered Services:*** × Tube feeding, enteral feeding or any type of food or meals that are not medically necessary or for the reasons provided above × Weight loss, exercise or gym programs × Breast feeding education or baby formula (except for metabolic disorders) × Feeding clinics
Health Education	No copay (100% covered). Health education provided by your child's PCP is covered. This may include information on achieving and keeping physical and mental health and avoiding illness and injury. Your child's doctor may ask age-appropriate questions during your child's health visit. This will help the PCP decide on topics to talk about during your child's health education discussion. Maternal Care education is also provided in our Women's Clinic.
Hearing (Audiology) Care Services	No copay (100% covered) ✓ Age appropriate hearing screenings for preventive care ✓ Newborn hearing screening and follow-up for failed screen ✓ Hearing aids, when medically necessary
Home Health Care	No copay (100% covered) Pre-authorization required. This benefit applies to home health and home infusion therapy (IV therapy) and includes all services, supplies and/or therapies that are medically needed for treatment due to illness or injury. Prior hospitalization is not required. All services have to be ordered by your PCP or another provider from the DHMP network (works for DHMP). DHMP must authorize all services and may review treatment plans for home health at any time. Services include, but are not limited to: ✓ Nursing services ✓ Physical, Occupational, Respiratory, and Speech and other therapies ✓ Medical supplies (including respiratory supplies), durable medical equipment (rental or purchase), oxygen, appliance, prostheses, and orthopedic appliances

	✓ Intravenous (IV) medications and other prescription medications that are not ordinarily available through a retail pharmacy ✓ Nutritional services (see "Food and Nutrition Services" section) for certain disorders ***Not-Covered Services:*** × Custodial care × Care that is provided by a nurse that normally lives in the member's home or that is an immediate family member of the patient × Services or supplies for personal comfort or convenience × Food services, meals or formulas not medically needed for approved disorders × Religious or spiritual counseling
Hospice Care	No copay (100% covered). Pre-authorization required. This includes all services, supplies and/or therapies that are medically needed for treatment. ✓ Provider visits ✓ Skilled nursing and licensed nursing ✓ Physical, Occupational, Respiratory, and Speech and other therapies ✓ Nutritional services (see "Food and Nutrition Services" section) for certain disorders ✓ Respite care provided for up to five (5) continuous days for every 60 days of hospice care To be eligible for home or inpatient hospice benefits, the member must have a life expectancy of six months or less, as certified by the attending physician. DHMP initially approves hospice care for a period of three months. Once this period has been exhausted, DHMP will work with your PCP and the hospice provider to determine if continuing hospice care is appropriate. DHMP may review treatment plans for home health at any time. ***Not-Covered Services:*** × Food services, meals or formulas not medically needed for approved disorders × Services or supplies for personal comfort or convenience × Private duty nursing × Religious or spiritual counseling × Grief counseling for family members outside of hospice care
Human Organ and Tissue Transplant Services	No copay (100% covered). Limited coverage. Coverage is available for transplant services that are medically necessary and that are not experimental procedures. All transplants must be performed at approved transplant facilities. Services are covered based on standards established by the medical community and DHMP; and are only provided with a referral from your PCP. A member is eligible for the covered services contained in this section if the following guidelines are met: • All transplant services must be performed at a hospital chosen and approved by DHMP

	• DHMP and the approved hospital have to determine that the member is a candidate for these services • All transplants must be pre-authorized; DHMP will make the decision to authorize the service or not • If transplant services are needed because of an emergency, the services can be performed without pre-authorization. DHMP must be notified within one (1) business day after admission ***Covered Transplants (when pre-authorized by DHMP):*** ✓ Heart ✓ Lung (single or double) for end stage pulmonary disease only ✓ Heart-Lung ✓ Kidney ✓ Kidney-Pancreas ✓ Liver ✓ Bone marrow for a member with Hodgkin's disease, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II or III breast cancer or Wiskott-Aldrich syndrome ✓ Peripheral bone stem cell for the same procedures listed under bone marrow ✓ Cornea ***Covered Services (Hospital, Medical, Surgical, Other):*** ✓ Room and board for semi-private room, unless a private room is medically necessary ✓ Services, supplies, medications, therapies needed; this includes operating services (Only one complete surgical procedure is covered at a time; multiple surgical procedures cannot be performed at once) ✓ Anesthesia ✓ Care provided in a special care unit ✓ Inpatient and/or outpatient services ✓ Medical care, monitoring or consultation by more than one physician, if medically necessary ✓ Home, office and other outpatient medical care visits for check-up and treatment of the member ✓ Evaluation, surgical removal, transportation of the donor organ or tissue ✓ Transportation costs to and from the hospital for the recipient (the person getting the transplant) and for one adult (see "Travel and Lodging" below) ***Donor Covered Services:*** • Donor means a person who donates, or gives, a human organ or human tissue for transplantation. If a donor provides this to a member, the following will be true: • When the recipient is a DHMP member or if both the recipient and the donor are DHMP members, both the donor and the recipient will be covered for all of the covered services listed in this section • The donor benefits are limited to those that are not available to the donor from any other source

	• If the donor is a DHMP member and the recipient is not a DHMP member, benefits will not be provided for the donor or recipient expenses ***Travel and Lodging:*** If the member must temporarily relocate (go outside of the city where you live) to receive a covered transplant, coverage is available for travel to the city where the transplant will be performed. This benefit will also cover reasonable lodging (hotel) expenses for the member and one adult. These expenses are limited to a lifetime maximum (they cannot go over) $10,000 per transplant. Lodging (hotel) cannot be over $100 per day. Travel costs for the donor does not apply towards the member's lifetime traveling expense limit, but it does apply to the overall maximum lifetime benefit for transplants. ***Maximum Lifetime Benefit:*** Coverage for all covered organ transplants and all transplant-related services (including travel, lodging and donor expenses and procurement) is limited to a maximum lifetime benefit for major organ transplants of $1,000,000 per member. Amounts applied to the maximum lifetime benefit include all covered charges for transplant-related services, treatments and supplies received during the transplant benefit period – the benefit period is up to five (5) days before or within one year after the transplant. Exception: However, pre-transplant evaluations may be received more than five (5) days before the transplant and may be considered transplant-related services. The pre-transplant evaluation does not cover travel expenses and does count towards the maximum lifetime benefit. If a member receives a covered transplant under DHMP and later requires another transplant of the same type, the covered charges for the new transplant are applied to the remaining (if any) maximum lifetime benefit available to the member. Payments for the transplant benefit are not applied to other specified benefit maximums. Expenses for covered transplant-related services that are over the maximum lifetime benefit for organ transplants are not payable under this or any other benefit in this handbook. ***Not-Covered Services:*** × Services performed at a hospital that was not approved by DHMP × Services performed if the hospital that DHMP has approved determines that the member is not a suitable transplant candidate × Services for donor searching or tissue matching, or any expenses related to this × Experimental or investigational transplants, or any services related to this × Transplants of organs/tissues other than the ones listed in this section as covered × Services and supplies related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices
Inpatient Facility Services (Hospital and Surgical Services)	No copay (100% covered). Pre-authorization required. Inpatient services are services that you get when you stay in a hospital for one day or more. Inpatient services are covered when they are pre-authorized or if you need them due to an emergency. This includes all services and/or supplies that are

	medically needed for treatment of your condition and include, but are not limited to: ✓ Semi-private room, board, and general nursing services; includes room in a special care unit approved by DHMP ✓ Physician, clinician and surgical services ✓ Any medical supplies, medication and/or treatments medically necessary; this includes charges for anesthesia ✓ Rehabilitation medically needed to bring back or better lost functions after illness or injury; 30-day limit per calendar year and have to be received within six months of the date of illness or injury ✓ Consultation for second opinion ✓ Chemotherapy and radiation services ✓ Reconstructive surgery is only covered if medically necessary or if after a mastectomy (removal of one or both breasts) ***Not-Covered Services*** × Private room expenses, unless one is medically necessary × Admissions related to non-covered services or procedures × Nursing home services × Procedures to correct further illness or injury resulting from a member not following prescribed medical treatment × Facility room and board charges for the day of discharge
Laboratory, X-rays and Other Imaging Services	No copay (100% covered). Laboratory, X-ray and other imaging services are covered when they are needed to diagnose or monitor a symptom, disease or condition. No authorization required if performed at Denver Health facility. If care is out of network, authorization is required. These services include, but are not limited to: ✓ X-ray and other radiology services ✓ Lab and pathology services ✓ Ultrasound for non-pregnancy-related conditions. (See "Maternity and Newborn Care" in this table for information about pregnancy ultrasounds) ✓ Allergy tests: direct skin and patch allergy tests and RAST tests, charges for allergy serum ✓ Hearing and vision tests required for diagnosis and/or treatment of an injury or illness ***Not-Covered Services:*** × Laboratory, X-ray or any other imaging service related to a service that is not covered

Maternity and Newborn Care	No-copay (100% covered). No pre-auth if done in-network Benefits are provided for maternity and newborn childcare. You may self-refer to any prenatal provider in the DHMP network. Maternity and newborn services include: ✓ Inpatient, outpatient or physician office services (including prenatal care) for vaginal delivery, cesarean section and complications of pregnancy (includes anesthesia) ✓ Routine nursery care for newborns, includes physician services ✓ For newborns, all medically necessary care and treatment of injury and sickness including medically diagnosed congenital defect and birth abnormalities ✓ Tests to diagnose possible genetic illness ✓ Circumcision of a covered newborn male ✓ Spontaneous termination (ending) of pregnancy prior to full term ✓ Elective termination of pregnancy, only if necessary, to save the life of the mother or if the pregnancy is the result of an act of rape or incest ✓ Two antenatal ultrasounds per pregnancy, unless more are medically needed and pre-authorized ✓ At-home post-delivery follow-up visits are covered if performed no later than 72 hours after your and your newborn's discharge from the hospital o Parent education o Physical assessments o Assessment of the home support system o Assistance and training in breast or bottle feeding ✓ Performance of any maternal or neonatal test routinely performed during the usual course of inpatient care for the mother or newborn child, including the collection of an adequate sample for the hereditary disease and metabolic newborn screening. At the mother's discretion, this visit may occur at the physician's office ✓ We cover services performed by a participating certified nurse-midwife or a direct-entry midwife. The following services are covered benefits: o Advising, attending, or assisting of a woman during pregnancy, labor, and natural childbirth at home, and during the postpartum period in accordance with C.R.S 12-27-101 et.al.seq. that includes one metabolic screening, one postpartum visit, one prescreening visit, and the actual delivery and labor ✓ We will not limit coverage for a hospital stay related to childbirth for the mother and newborn child to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. If the delivery occurs between 8:00 p.m. and 8:00 a.m., coverage will continue until 8:00 a.m. on the morning following the 48-hour or 96-hour coverage period. The mother's attending provider, after consulting with the mother, may discharge the mother and newborn child earlier, if appropriate.

	Not-Covered Services: × Maternity care and/or deliveries outside of the service area within five weeks of the anticipated delivery date, except in an emergency × Storage costs for umbilical blood × Preconception, paternity, or genetic testing or counseling × Testing for inherited disorders or screening for disorders/diseases or to determine physical characteristics of an unborn child × Elective termination of pregnancy (abortion), unless it is needed to save the mother's life or if the pregnancy is a result of rape or incest
Medical Equipment and Supplies	No-copay (100% covered). Authorization required. Medical supplies and equipment are covered but must be supplied by an in-network provider (provider that works for DHMP) and/or pre-authorized by DHMP. ✓ Disposable items needed for treatment of illness or injury like syringes, needles, splints, and surgical dressings. ✓ Oxygen and the rental of the equipment needed to administer the oxygen (one stationary and one portable per member) ✓ Durable medical equipment (DME) like crutches, wheelchairs, and hospital beds ✓ Orthopedic appliances, like a knee brace ✓ Prosthetic devices To receive DME, the member must be prescribed the equipment needed. The DME will be either rented or purchased and DHMP will pay for repairs, maintenance or adjustments needed due to normal usage for approved DME or DME that would have been approved by DHMP. Maximum benefit for DME is $2,000 per calendar year, except for medical and surgical supplies. The following items will not count towards the $2,000 DME limit if your PCP has ordered this item for you: • Durable medical equipment owned by the facility and medical supplies used during a covered admission or during a covered outpatient visit • Medical supplies used during outpatient visits • Surgically implanted prosthetics or devices authorized by DHMP before the member receives the device • including cochlear implants • Insulin pumps and related supplies ***Not-Covered Services/Equipment:*** × Comfort, luxury or convenience items or equipment × Any item available without a prescription; over-the-counter items × Air conditions, purifiers, humidifiers, dehumidifiers, special lighting or other environmental modifiers × Self-help devices that are not medical in nature × Dental, hair/cranial, penile prostheses; or any prostheses for cosmetic purposes × Home exercise and therapy equipment

	× Consumer or adjustable beds or waterbeds × Repairs or replacements due to misuse or abuse of item × Orthopedic shoes not attached to a brace (except for members with diabetes)
Mental Health and Substance Abuse Care	✓ No-copay (100% covered). You can self-refer (no approval needed) for these outpatient behavioral health services: individual, family, or group counseling and case management to providers in our contracted network. Any care with a provider outside of our contracted network requires prior authorization. Outpatient mental health services, which are services you get outside of a hospital or residential facility. Covered outpatient treatments do not require pre-authorization if the provider is in-network with DHMP. Covered services include but are not limited to: Individual, family, group counseling and case management services. ✓ Biologically based mental illness care is covered and is no less extensive than the coverage provided for any other physical illness ✓ Coverage is also for non-biologically based conditions identified as a mental disorder ✓ All Inpatient admissions for Mental health conditions at Denver Health Hospital is covered without prior authorization. Any inpatient stay not occurring at Denver Health Hospital requires prior authorization and review. Inpatient is valid for semi-private room, group psychotherapy, medication management, ancillary services and provider visits. ✓ Residential treatment (you will be staying 24 hours a day) requires prior authorization by DHMP. You must need 24-hour supervision to qualify for this level of care. ✓ Autism related treatment ✓ Outpatient substance abuse treatment and services is considered a mental health condition for the purpose of this benefit and is covered ✓ Substance abuse detoxification services ***Not-Covered Services:*** × Private room expenses × Biofeedback × Psychoanalysis or psychotherapy that a member may use towards getting a degree or furthering their education × Applied Behavioral Analysis (ABA) therapy × Hypnotherapy × Religious, marital, and social counseling × Residential treatment services for anorexia nervosa or bulimia nervosa × Therapies or programs not medically necessary × Cost of damage to facilities caused by member × Court or police-ordered treatment that would otherwise not be covered × Services not authorized by DHMP

Physician (doctor) Routine Medical Office Visits	No copay (100% covered). Office visits are covered for both PCP and specialists. You should see your PCP for all services, unless you have a separate OB/GYN, are getting vision services or have a referral to a specialist. Referrals are needed for visits with most specialists. Benefits include: ✓ Medical care, consultations and second opinions (second opinions require a referral from your PCP; DHMP may request a second opinion in certain cases) ✓ Office-based surgical services, includes anesthesia and supplies (subject to pre-authorization guidelines) ✓ Kidney dialysis is considered a benefit as a medical office visit ***Not-Covered Services:*** × Expenses for obtaining medical reports or transfer of files × Treatment of hair loss, except when caused by alopecia areata × Routine foot care (except for members with diabetes) × Treatment for sexual dysfunction × Infertility services × Genetic Counseling
Outpatient/Ambulatory Facility Services	No copay (100% covered). Pre-authorization required if not done at Denver Health. Outpatient services are services that you receive and get to leave that same day. You can get these services at facilities like an acute hospital outpatient department, ambulatory surgery center, radiology center, and dialysis center and outpatient clinics. The benefit includes all services and/or supplies that are medically needed for treatment of your condition and include, but are not limited to: ✓ Physician, clinician and surgical services ✓ Any medical supplies, medication and/or treatments medically necessary; this includes charges for anesthesia ✓ Chemotherapy and radiation services ✓ Consultations for second opinions ***Not-Covered Services*** × See "Inpatient Facility Services" not-covered services in this table and "General Exclusions" section
Outpatient Therapy Services	No copay (100% covered). Outpatient rehabilitation therapies include: ✓ Physical therapy ✓ Speech therapy ✓ Occupation therapy ✓ Cardiac rehabilitation programs Maximum benefit is 30 visits per calendar year per diagnosis, if medically necessary additional services can be provided with a prior authorization. There is no limit for these therapies for children from birth up to the child's third birthday. There is no limit for speech therapies to treat cleft lip or cleft palate. Services must be received six months from the date the injury or illness occurred.

<table>
<tr><td></td><td>Not-Covered Services:
× Maintenance therapy or care provided after you have reached your rehabilitative potential as determined by DHMP
× Therapies for learning disorders, stuttering, voice disorders or rhythm disorders, unless the child is 3 years old or younger and the treatment is needed for congenital defects or birth abnormalities
× Non-specific diagnoses relating to developmental delay and learning disorders
× Any therapeutic or rehabilitative services received in health spa or fitness center; this includes membership at such facilities
× Chiropractic or acupuncture services
× Therapies not listed above or in this benefits section
× Holistic medicine and other wellness programs</td></tr>
<tr><td>Prescription Drugs</td><td>No copay (100% covered).
If a Denver Health provider writes you a prescription, you can fill it at any one of the Denver Health pharmacies. You may also take your prescription to any other pharmacy that accepts DHMP insurance (see the “Pharmacy” section in this handbook for more details).
• All medications approved by the Food and Drug Administration (FDA) for the treatment of substance abuse disorders (SUD) are covered without any prior authorization and/or step therapy requirements.
• Medications approved by the FDA for the treatment of SUD are not excluded from coverage solely on the grounds of being court ordered.
• Medication management of mental health conditions by a psychiatrist, medical provider or nurse with prescriptive authority (this is a nurse that is legally allowed to write prescriptions).</td></tr>
<tr><td>Preventive, Routine and Family Planning Services</td><td>No co-pay (100% covered).
Preventive Care Services are covered only if your child’s PCP delivers the service, unless it is a reproductive health service. You can have a different doctor for reproductive health services. Annual check-ups and immunizations are covered. These services include, but are not limited to:
✓ Annual child check-ups and/or women gynecological well-exams
✓ Annual Vaccines (immunizations)
o Please see the section “Schedule for Immunizations” in this handbook to understand which vaccines your child should get at different ages.
✓ Age appropriate vision and hearing screening exams
As recommended by the American Academy of Pediatrics, your child should get a well-child check-up at the ages listed below in the table:
<table>
<tr><th>INFANCY</th><th>EARLY CHILDHOOD</th><th>MIDDLE CHILDHOOD</th><th>ADOLESCENCE</th></tr>
<tr><td>Prenatal</td><td>12 months</td><td>5 years</td><td>11 years</td></tr>
<tr><td>Newborn</td><td>15 months</td><td>6 years</td><td>12 years</td></tr>
<tr><td>First Week</td><td>18 months</td><td>7 years</td><td>13 years</td></tr>
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<tr><td></td><td>
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<tr><td>1 month</td><td>24 months</td><td>8 years</td><td>14 years</td></tr>
<tr><td>2 months</td><td>30 months</td><td>9 years</td><td>15 years</td></tr>
<tr><td>4 months</td><td>3 years</td><td>10 years</td><td>16 years</td></tr>
<tr><td>6 months</td><td>4 years</td><td></td><td>17 years</td></tr>
<tr><td>9 months</td><td></td><td></td><td>18 years</td></tr>
</table>

Please see the “Recommended Child Check-ups” section in this handbook for more information about preventive care for your child.
Family Planning Services
The following services are covered for family planning:
✓ Birth control, including injection of Depo-Provera
✓ Fitting for a diaphragm or cervical cap
✓ Surgical implantation or removal of NORPLANT device
✓ Tests to diagnose possible genetic illness
✓ STD/HIV testing and treatment
Not-Covered Services:
× Immunizations for international travel
× Surgical sterilization or any related services
× Court-ordered testing or counseling
</td></tr>
<tr><td>Skilled Nursing Facility Care</td><td>No copay (100% covered). Pre-authorization required.
These are therapies and protective supervision for patients who have uncontrolled, unstable, or chronic conditions. Coverage for medically necessary skilled nursing facility provided only if there is a reasonable expectation of measurable improvement in the member’s health status.
✓ 100 days of skilled nursing facility services per calendar year or until maximum medical improvement is reached
Not-Covered Services:
× Custodial or maintenance care
× Skilled nursing care once member has reached maximum medical improvement and no more improvement is expected</td></tr>
<tr><td>Vision Services</td><td>Limited Coverage.
Covered vision services include:
✓ Age appropriate vision screening and routine eye exam or vision screenings to diagnose a medical condition
✓ A $150 credit per member per calendar year towards the purchase of lenses, frames and/or certain types of contacts
✓ Specialty vision services with a pre-authorization from the member’s PCP
Eye exams must be received from a DHMP participating provider; eyewear can be purchased from any vision provider.
Not-Covered Services:
× Vision therapy
× Specialty services without a pre-authorization
× Services related to any procedure designed to correct vision (Lasik)</td></tr>
</table>

General Exclusions	The following list of exclusions is not a complete list of all services, supplies, condition, or situations that are not covered services. Other specific limitations, conditions and exclusions may also apply. **REMEMBER:** • You may be billed for services that are not covered. Even if you receive a referral from your PCP, services will not be covered if the service is an exclusion or not a covered benefit. • If the service is not covered, then all services performed in conjunction with that service are not covered. • CHP+ HMO is the final authority for determining if services and supplies are medically necessary for the purpose of payment ***Not-Covered Services:*** × Acupuncture × Alternative or complementary medicines (holistic medicine, homeopathy, hypnosis, reike therapy, and aromatherapy are examples of alternative medicine) × Adoption or surrogate expenses × Artificial conception × Applied Behavioral Analysis (ABA Therapy) × Before effective date (no coverage for services received before the member's effective date of coverage) × Biofeedback × Chelating agents, unless it is used for heavy metal poisoning × Chiropractic services × Chronic Pain × Clinical research × Convalescent care, unless the care is normally received for a specific condition × Convenience, luxury, deluxe services, or equipment (this includes services that are used for member's comfort or convenience and are not medically necessary) × Cosmetic services (face lifts, botox and breast augmentation are examples of cosmetic procedures) × Court-ordered services rendered under parole or probation, unless those series would otherwise be covered under the benefits section of the handbook. × Custodial care (this includes assisting the member in daily living activities or in meeting personal rather than medical needs; meal preparation and assistance with bathing are examples of custodial care) × Dental services (see "Dental Care" section in this table) × Discharge against medical advice at a hospital or other facility services if you leave a hospital or other facility against the medical advice of your provider. × Discharge day expense room and board charges related to a discharge day. × Discharge from facility (services received beyond the preauthorized discharge date) that are provided after discharge date indicated in the preauthorization from CHP+

	HMO. The appropriate discharge date is determined based on managed care guidelines × Domiciliary care (this includes care provided in a non-treatment facility, halfway house or school) × Double coverage (it is not acceptable for the member to have double insurance coverage, except for dental or Medicare) × Elective termination of pregnancy, unless the elective termination is to save the life of the mother or if the pregnancy is the result of rape or incest × Experimental/Investigation procedures × Genetic testing/counseling (genetic tests to evaluate risks of disorders for certain conditions may be covered, DHMP must pre-approve) × Government operated facility (no coverage for services and supplies for all disabilities connected to military service that are performed by a military medical facility; unless DHMP authorizes payment in writing before the services are performed) × Hair loss treatments, except for alopecia areata × Hypnosis – services related to hypnosis, whether for medical or anesthesia purposes. × Illegal conduct (services needed due to engagement in illegal activity by member) × Infant formula, unless specifically allowed as a benefit in this booklet × Learning deficiency services, unless the child is 3 years old or younger and the treatment is needed for congenital defects or birth abnormalities × Maintenance therapy × Medically unnecessary services (DHMP will determine whether or not a service or supply is medically necessary) × Medical nutrition therapy (vitamins, without a prescription, dietary/nutritional supplements and special foods are examples, except for metabolic disorders) × Missed appointments charges × Non-covered providers of service (services prescribed or administered by: health spa or fitness center; school infirmary; halfway house; massage therapist; nursing home; residential institution; dental or medical department sponsored by or for an employer, mutual benefit association, labor union, trustee or similar person or group; the member, by a family member or by a person who normally resides in the member's household) × Non-medical expenses × Orthotics, except for members with diabetes × Over-the-counter products × Post-termination benefits (no coverage for services received after termination of coverage) × Private duty nursing services × Radiology services (no coverage for Ultrafast CT scan, whole body CT scan or more than two ultrasounds per pregnancy, unless more ultrasounds are medically necessary)

	× Reduction mammoplasty (breast reduction), unless provided in conjunction with mastectomy reconstruction and diagnosis of cancer × Sexual dysfunction treatment(s) × Sex-change operations × Taxes imposed by law that apply to covered services under this plan. × Therapies (other) The following are some of the therapies that are not covered: recreational, sex, primal scream, sleep, Z therapies; self-help, stress management and weight-loss programs; transactional analysis, encounter groups and transcendental meditation; sensitivity and assertiveness training and rolfing; vision therapy × Religious counseling × Temporomandibular joint (TMJ) surgery or services, unless it has a medical basis × Orthognathic surgery × Third-party liability (for services that are reimbursed by a third party, see the "When Another Party Causes Your Injury or Illness" section in this handbook for more information) × Travel expenses, except as provided under the "Human Organ and Tissue Transplant" benefits (in this table) × Tubal ligation × Vasectomies × Vision (only the vision services described in the "Vision Services" section of this table are covered; no coverage for any surgical, medical or hospital service or supply rendered in connection with any procedure designed to correct vision) × War-related conditions × Weight-loss programs × Workers' compensation (no coverage for work-related accidents or illness; the only exception is for those individuals who are not required to maintain or be covered by workers' compensation insurance as defined by worker's compensation laws)

Additional benefits offered by Denver Health Medical Plan:

Medical Care:

- NO COST or copays for office visits, diagnostic tests, emergency/urgent care (in-network or out-of-network) for children and adults of DHMP

Eye Care:

- A $150 credit towards eyeglasses and/or certain contacts

Pharmacy:

- NO COPAYS for covered prescriptions on the DHMP formulary
- NO COST for certain over-the-counter (OTC) drugs when a prescription for the OTC drug is written by a Denver Health provider and filled at a Denver Health pharmacy
- 90-day supplies of some drugs on the DHMP formulary, at NO COST to you. See the DHMP formulary for details

>> 9) EXTRA SERVICES

Denver Health NurseLine:

The Denver Health NurseLine is a phone service that can answer your questions and give you advice. You can call the Denver Health NurseLine and speak to a registered nurse about any health questions - no matter how big or small. The NurseLine can give you quick medical information and also help you get medical care. The NurseLine is available 24 hours a day, 7 days a week.

You can call the **Denver Health NurseLine** at **303-739-1261** if:

- You think you need an urgent appointment
- You are not sure if you need to see a doctor
- You have questions about medicine or treatment
- You have health education questions

Call the **Denver Health NurseLine** at **303-739-1261** after your PCP's office is closed or whenever you need answers to your health questions.

Please remember that if you have a medical emergency or need care urgently, go to the nearest hospital or urgent care clinic. You do not have to call the NurseLine before you get emergency or urgent care.

Dental

Routine dental is a covered benefit through DentaQuest. For questions on this benefit, please contact DentaQuest directly at 1-888-307-6561 or Health Plan Services at 303-602-2100

>> 10) QUALITY

DHMP wants to make sure you get the care you need when it is needed. Our Quality Program does this by:

- Asking our members and providers questions to see if they are happy with DHMP services;
- Looking at member and provider concerns and grievances to improve DHMP services;
- Reminding members about services to keep them healthy;
- Looking at how you access care to see if there are differences by race, ethnicity, or language.

We offer a variety of health and wellness and prevention programs, all of which can be found here: https://www.denverhealthmedicalplan.org/quality-improvement-program.

>> 11) GRIEVANCES

What is a Grievance?

A grievance is when you are not happy with something that DHMP does. This could be when you are not happy with:

- The quality of care or service you get;
- The way DHMP treats you; and/or
- Things DHMP does that you are not happy with.

You can file a grievance at any time to tell us (verbal or written) when you are not happy with your service or care.

What to do if you have a Grievance:

If you have a grievance, you or your Designated Personal Representative (DPR) can call Grievance & Appeals at 303-602-2261 You or your DPR can also write to Grievance and Appeals. Please be sure to include your name, CHP+ identification (ID) number, address and phone number in your letter if you write to DHMP Grievance and Appeals. You may also fill out the Complaints and Appeal form in the back of this handbook and send it in.

Send your written grievance to this address:
Denver Health Medical Plan, Inc.
Attn: Grievance and Appeals Department
938 Bannock St., MC 6000
Denver, CO 80204-4507

You will not lose your CHP+ benefits by filing a grievance. It is the law!

After You File a Grievance:

After you file your grievance, DHMP will send you a letter within two (2) working days to let you know that your grievance was received.

DHMP will look into the details of your grievance and will decide how to handle it (in other words, DHMP will try to resolve your grievance). The DHMP staff members who make decisions on your grievance will not be the same people who you are filing your grievance about. If you file a grievance because you feel you got poor medical care or because DHMP denied your expedited appeal request (see member handbook section called "What is an Appeal?"), a DHMP staff member with appropriate medical training will look into your grievance.

DHMP will make a decision on your grievance and send you written notice as soon as your health condition requires, but no later than fifteen (15) working days from the day you file your grievance. The written notice will explain the results of DHMP's decision on your grievance and the date DHMP made that decision.

You or DHMP can extend the timeframe that DHMP has to make a decision on your grievance. If you ask for more days or if DHMP believes that more facts are needed to make a decision on your grievance, DHMP may add fourteen (14) more calendar days. DHMP will only extend this timeframe if it is in your best interest. If DHMP extends the timeframe to decide on your grievance and you did not ask for the extension, DHMP will send you written notice of the reason for the delay.

If You Need Help Filing a Grievance:

DHMP will help you file a grievance. If you need help filling out any forms or taking any of the steps to file a grievance, including using an interpreter or TTY services, call **Health Plan Services** at **303-602-2100**.

If You are Still Not Happy With the Outcome of Your Grievance:

If you are still unhappy with how DHMP handles your grievance you can bring your grievance to the Department of Health Care Policy & Financing ruling is final. You can call them at **1-800-221-3943** (no charge) or you can write them at:

Department of Health Care Policy & Financing
Attn: DHMP Medicaid Choice Contract Manager
1570 Grant St.
Denver, CO 80203-1714

If You Need to File a Complaint About Access to Behavioral Health Care:

DHMP is subject to the Mental Health Parity Addiction Equity Act of 2008. This means that your covered behavioral health benefits cannot be more difficult to access than physical health benefits. A denial, restriction, or withholding of behavioral health services could be a potential violation of the parity act. File a complaint with the Behavioral Health Ombudsman Office of Colorado if you have a parity concern.

Behavioral Health Ombudsman Office of Colorado
Call: 303-866-2789
Email: ombuds@bhoco.org
Online: bhoco.org

A representative of the Ombudsman Office will call or reply to you directly. You can also ask your behavioral health provider or guardian/legal representative to file a complaint for you.

>> 12) APPEALS

What is a Notice of Adverse Benefit Determination Letter?

This is a letter that DHMP sends you if DHMP makes an Adverse Benefit Determination for any part of your DHMP services. An Adverse Benefit Determination is:

- When DHMP denies or limits a type or level of service you ask for;
- When DHMP reduces, suspends, or stops authorizing a service that you have been getting;
- When DHMP denies full or partial payment or your services;
- When DHMP does not give you a service in a timely manner;
- When DHMP does not resolve your appeal or grievance within the required timeframes
- For a resident of a rural area with only one Managed Care Organization, a denial of your request to exercise your right to obtain services outside of the network;
- The denial of your request to dispute your cost for medical services

A Notice of Adverse Benefit Determination Letter Includes:

- The Adverse Benefit Determination that DHMP plans to take;
- The reason for the Adverse Benefit Determination including your right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your Adverse Benefit Determination. Such information includes medical necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits;
- Your right to appeal this Adverse Benefit Determination and an explanation of your rights to the grievance and appeal process;
- The date when you need to appeal by;
- Your right to ask for a State Review;
- How to ask for a State Review;
- When you can ask to speed up the appeal process;
- How to keep getting services while the appeal or State Review is being decided; and,
- When you might have to pay for those services you got while a final ruling was pending
- Your right to the appeals process that is available under the Child Mental Health Treatment Act (CMHTA), when applicable

Advance Notice of Adverse Benefit Determination:

DHMP must let you know about an Adverse Benefit Determination before the action happens. If DHMP plans to stop paying for or reducing any services you have been getting, it has to send you a Notice of Adverse Benefit Determination letter 10 calendar days before the date it stops paying for or reducing services. DHMP can shorten the timeframe to 5 calendar days if:

- There is fraud;
- DHMP must give notice by the date of the adverse benefit determination if:
- The Member has passed away;
- The Member is institutionalized and is not eligible for Medical Assistance services;
- The Member's whereabouts are unknown and there is no forwarding address;
- The Member has moved out of state or outside metropolitan Denver or has become eligible for CHP+ benefits outside of state;
- The Member's doctor orders a change in the level of care;
- You must be transferred to another facility quickly;
- DHMP gets a signed letter from you saying that you no longer want the services. DHMP gets a signed letter from you that requires termination or reduction of services and says that you understand that service termination or reduction will occur.

What is an Appeal?

An appeal is a request that you or your DPR can make to review an Adverse Benefit Determination taken by DHMP. If you think an Adverse Benefit Determination taken by DHMP is not right, you or your DPR can call or write us to appeal the Adverse Benefit Determination. A provider may file an appeal for you if you make them your DPR. If you are still unhappy after your appeal decision, then you can ask for a State Review after you

have completed all the proper steps in the DHMP appeal process. This hearing is explained under the section "State Review" in this handbook.

How to File an Appeal:

You have 60 calendar days to file an appeal after you get a notice of Adverse Benefit Determination letter.

To appeal an Adverse Benefit Determination you may:

- Call **Grievances and Appeals** at **303-602-2261** TTY users should call 711.
- Fill out the Complaints and Appeal form in the back of this handbook and **fax to 303-602-2078** or mail to **DHMP Grievance and Appeals, 938 Bannock St., MC 6000, Denver, CO 80204**

Filing an Expedited (Quick) Appeal:

If your life or health is in danger and you need DHMP to make a decision on your appeal right away, you can call **Grievance and Appeal Department** at **303-602-2261** to file an expedited appeal. If DHMP approves your request for an expedited appeal, DHMP will make a decision on your appeal no later than 72 hours from the receipt of your request.

If DHMP denies your request for an expedited appeal, DHMP will call you as soon as possible to let you know your request was denied. DHMP will also send you a letter within two calendar days of your request to let you know that your request was denied. The letter will let you know that you have the right to file a grievance if you are unhappy with DHMP's decision.

You will get a written version of your appeal with this denial letter (if you filed your appeal verbally) that you must sign and send back to DHMP.

DHMP will then review your appeal in the standard timeframe explained in the next section.

After You File an Appeal:

After you file an appeal, DHMP will send you a letter within two working days (unless you file an expedited appeal) to let you know your appeal was received.

DHMP will look into the details of your appeal and will decide to either accept your appeal (overturn DHMP's Adverse Benefit Determination) or deny your appeal (uphold DHMP's Adverse Benefit Determination). DHMP will use different grievance and appeal department members to review this Adverse Benefit Determination. If you appeal an Adverse Benefit Determination that uses the reason "lack of medical necessity," a DHMP staff member will review with a medical professional to make a decision on your appeal.

At any time during the appeal process, you or your DPR may provide DHMP (in person or in writing) any evidence or other information to help your case. Please note that if your appeal is expedited, you have a shorter amount of time to give DHMP this information. You or your DPR may also look at your case file before and during the appeal process. Your case file includes your medical records and any other information that DHMP is using to decide on your appeal.

For standard appeals, DHMP will make a decision and send you written notice of the decision no later than 10 working days from the receipt your standard appeal. For expedited appeals, DHMP will make a decision and send you written notice of the decision no later than 72 hours from the date you file your expedited appeal. DHMP will also try to notify you of the decision over the phone for expedited appeals.

The written notice will tell you the outcome of DHMP's decision on your appeal and the date that it was completed. If the outcome is not in your favor, the written notice will also give you information on:

- Your right to request a State Review and how to request one.

Extending Appeal Timeframes:

You or DHMP can extend the timeframe for DHMP to make a decision on your expedited or standard appeal. If you ask for more days or if DHMP believes that more facts are needed to make a decision on your appeal, DHMP may add 14 more calendar days. DHMP will only extend this timeframe if it is in your best interest. If DHMP extends the timeframe to decide on your appeal and you did not ask for the extension, DHMP will send you written notice of the reason for the delay. This written notice will also explain that you have the right to file a grievance if you do not agree with DHMP's decision to extend the timeframe. During the extended timeframe, DHMP will make a decision and send you written notice of the decision by the end of the extension time frame.

Getting Help Filing an Appeal:

To get help filing your appeal, you can:

- Call **Grievances and Appeals** at **303-602-2261**; TTY users should call 711.

You will not lose your CHP+ benefits if you appeal an action. It is the law!

State Review:

If you are unhappy with an action that DHMP takes, you MUST go through the appeal process explained above. At any time within 120 calendar days after you get a Notice of Appeal Resolution letter, you or your DPR have the choice to ask for an Administrative Law Judge to review an action taken by DHMP. Your provider can also ask for a review if you make them your DPR. This review is called a State Review. You may request a State Review when:

- Services you seek are denied or the ruling to approve services is not acted upon in a timely manner;
- You believe the action taken is wrong.

To request a State Review, you, your DPR, or your subscribing provider must send a letter to the Office of Administrative Courts. The writing should contain:

- Your name, address and DHMP identification number;
- The action, denial or failure to act quickly on which the request appeal is based; and
- The reason for appealing the action, denial or failure to act quickly.

At the State Review, you can represent yourself or use a provider, legal guide, a relative, a friend, or other spokesperson. You or your representative will have a chance to present evidence to the Administrative Law Judge to support your case. You or your representative may also ask for records that pertain to your appeal.

If you would like someone else to represent you, you must fill out the State Review written consent form called "Non-Attorney Authorization". This form is on the State of Colorado's website under the Department of Personnel and Administration, Office of Administrative Courts. The person you put on the form is called your authorized representative. You have to request a State Review within 120 calendar days from the notice of appeal resolution to:

Office of Administrative Courts
1525 Sherman St., 4th Floor
Denver, CO 80203

If you need help requesting a State Review, DHMP will help you. Just call **Grievances and Appeals** at **303-602-2261** and ask for help. You can also call the **Office of Administrative Courts** at **303-866-2000**. Any ruling made in a State Review is final.

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Notice of Non-Discrimination

Denver Health Medical Plan, Inc., hereinafter referred to as the "Company," complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Company does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, health status, or need for health care services.

The Company

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, please contact the Company toll-free at 1-800-700-8140, for TTY please contact 711.

If you believe that the Company failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, health status, or need for health care services, you can file a grievance with the Company's Grievance and Appeal Department at 938 Bannock Street, Mail Code 6000, Denver, CO 80204, telephone 303-602-2261. You can file a grievance by mail or telephone. If you need help filing a grievance, the Grievance and Appeal Specialist is available to help you.

You can also file a civil right complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
TDD: 800-537-7697

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

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-700-8140 (TTY/TDD: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-700-8140 (TTY: 711).

注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-800-700-8140（TTY: 711）

주의: 한국어를사용하시는경우, 언어지원서비스를무료로이용하실수있습니다.
1-800-700-8140 (TTY: 711) 번으로전화해주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-700-8140 (телетайп: 711).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-700-8140 (መስማት ለተሳናቸው: 711).

لحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم

1-800-700-8140 (رقم هاتف الصم والبكم :711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-700-8140 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-700-8140 (ATS : 711).

यानदिनुहोस्: तपा् इलेनेपाल बोल्नुहुन्छभनेतपा् इकोनि् तिभाषासह
यतासे हिĠनि ्ल्कĠप ा पलब् छ ान ् नुहोस् 1-800-700-8140 (ाि इ: 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-700-8140 (TTY: 711).

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。
1-800-700-8140（TTY: 711）まで、お電話にてご連絡ください。

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-700-8140 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
با 1-800-700-8140 (TTY: 711) تماس بگیرید.

If you have a question, call **Health Plan Services** at **303-602-2100** or toll-free at 1-800-700-8140.

Dè ɖɛ nià kɛ dyéɖé gbo: Ɔ jǔ ké m̀ [Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀] jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Đá 1-800-700-8140 (TTY: 711)

Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-800-700-8140 (TTY: 711).

AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-800-700-8140 (TTY: 711).