Elevate Medicaid Choice

by Denver Health Medical Plan

Member Handbook

Manual del miembro

ELEVATE MEDICAID CHOICE

Denver Health Medical Plan Inc.™

Health First COLORADO™
Colorado's Medicaid Program
In partnership to better serve you

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When you have a question, call **Health Plan Services** at **303-602-2116** or toll-free at 1-855-281-2418.

BIG PRINT OR OTHER LANGUAGES

If you have questions about this notice, we can help you for free. We can also give it to you in other formats like large print, audio or in other languages. Call 303-602-2116, toll free 1-855-281-2418, or 711 for callers with speech or hearing needs.

Si tiene preguntas acerca de este aviso, podemos ayudarlo sin costo alguno. También podemos ofrecerlo en otros formatos como letras grandes, audio u otros idiomas. Llame al 303-602-2116, sin costo al

1-855-281-2418 o al 711 para personas que llaman con necesidades auditivas o del habla.

>> IMPORTANT PHONE NUMBERS

EMERGENCY CALL 9-1-1

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

Nurse Advice Line 303-739-1261

Appointment Center

- To make a visit 303-436-4949

For help, questions, or concerns

DHMC provides free auxiliary aids and services to members with disabilities to help communicate with us**.** Help with sign language and oral interpretation services are available in any language for free. For benefits, questions or concerns contact:

- Health Plan Services 303-602-2116
- Toll-Free 1-855-281-2418
- TTY 711
- Fax 303-602-2138

To refill your prescriptions at a Denver Health Pharmacy

- Prescription Refill Service 303-436-4488

To check the status of your Pharmacy authorization request

- DHMC Pharmacy Department 303-602-2070

To ask enrollment/disenrollment questions

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

To get facts on state fair hearings

- 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

>> WELCOME TO DHMC!

Welcome to Health First Colorado, Colorado's Medicaid Program administered by Elevate Medicaid Choice, DHMC!

DHMC is happy to have you as a member. This book will help you get the services you need. It is your guide to health care.

You can get more details on the structure and operation of DHMC. Call Health Plan Services to ask for it.

This member handbook does not give in depth facts about DHMC providers. Use the DHMC Provider Directory to get a list of health care providers that work for DHMC. The Provider Directory shows facts like names, locations, the language the provider speaks, and types of doctors at Denver Health. You can find the Provider Directory online at https://www.denverhealthmedicalplan.org/find-doctor. You can ask for a paper Provider Directory by calling **Health Plan Services** at **303-602-2116**.

Watch this video to learn about Denver Health Appointment Center, how to connect with your doctor virtually and how to use MyChart.

Denver Health's Virtual Care

You have the right to a new member handbook and all the facts in the handbook at any time. DHMC will send a copy of the Provider Directory and member handbook to any person who asks for them by phone or in writing, in 5 business days of the request. DHMC is here to help you. When you cannot find the answers in this book, or have questions, call Health Plan Services.

This handbook is available in other languages, Braille, big print, and audiotapes for free. Call **Health Plan Services** at **303-602-2116** when you need this handbook in a different language or form. Any member material can be translated. Call Health Plan Services to ask for your language.

DHMC provides interpreter services for many languages at no cost to our members. When you would like to use an interpreter during your visits, tell the **Appointment Center** when you call at **303-436-4949**. When you need an interpreter for any other health care need, call Health Plan Services.

DHMC also offers TTY services for the hearing impaired. The TTY phone number for Health Plan Services is 711. When you need a sign language interpreter or other help during your clinic visits, let the Appointment Center know before your visit date so arrangements can be made with an interpreter.

MyDHMP Member Portal

MyDHMP is your go-to resource for managing your health plan anytime, anyplace.

The Member Portal User Guide can walk you through the steps to create your portal account. Visit www.DenverHealthMedicalPlan.org/member-resources.

Here are some benefits the portal can offer:

When you have a question, call **Health Plan Services** at **303-602-2116** or toll-free at 1-855-281-2418.

- Look up health care bill status
- View your benefits, coverage, and cost-shares
- View the status of prior authorizations
- Find a network health expert
- Message your plan securely with questions
- Access and download member materials

The portal is currently available in English only. Contact us for translation help.

Download the MyDHMP app in Apple and Google Play stores.

To access your health records, message your provider, schedule a visit, request prescription refill and more, go to Denver health's patient portal MyChart.Denverhealth.org.

Your DHMC ID Card

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

As a DHMC member, you should

- Read this Member Handbook.
- Call your Primary Care Provider, PCP, when you or your child needs heath care.
- Keep visits with your PCP and other providers.
- Give honest facts about your health when asked by your PCP or DHMC staff.
- Work willingly with your PCP.
- Use the DHMC network providers for care 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

As your health plan, we promise to

- Create a medical record for you
- 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.

Watch the New Member Video

Watch our New Member video for important facts about the services and benefits that are available to you through your Elevate Medicaid Choice plan. You will find the video at https://www.denverhealthmedicalplan.org/medicaid-choice.

Your DHMC ID card

You need your DHMC ID card with you when you see your provider, pick up medicine at the pharmacy, or for any health services.

DENVER HEALTH
MEDICAID CHOICE

Effective Date:
Member ID #:
Name:
Group #:

In Network
$0
Out of Network
ER/UC
$0

COLORADO
Department of Health Care Policy & Financing

MedImpact
RxBIN: 003585
RxPCN: ASPROD1
RxGrp: DHM02
Rx ID #:

Language:

Prior authorization may be required for some services.

In case of emergency call 911 or go to the nearest hospital emergency room.
ER/UC is covered anywhere in the U.S.
This card does not prove membership or guarantee coverage.
denverhealthmedicalplan.org

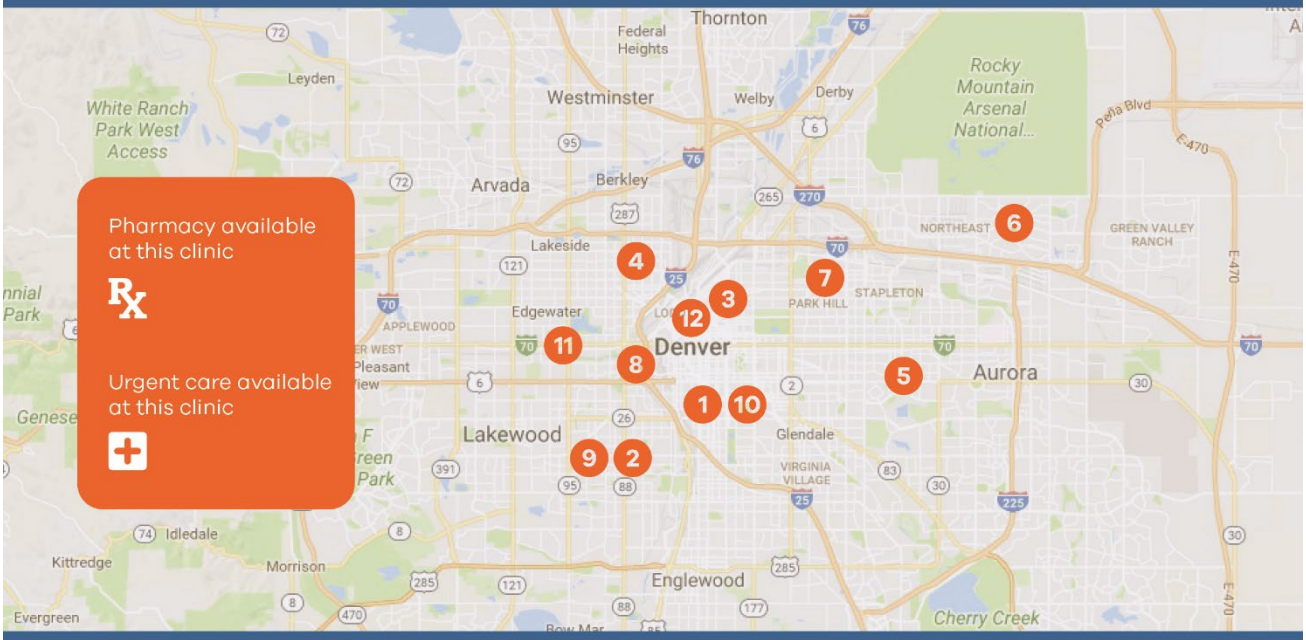
Health Plan Services:	855-281-2418	Pharmacy Providers	
TTY Users:	711	Rx Help Desk/Auths:	303-602-2070
NurseLine:	303-739-1261	MedImpact Help Desk:	800-788-2949

DENVER HEALTH MEDICAL PLAN INC.

Paper Claims: P.O. Box 24711 • Seattle, WA 98124-0711
EDI Payor ID #84133

As a DHMC member, you only need your Denver Health ID card. You should keep your Health First Colorado ID card somewhere safe.

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.

When you have a question, call **Health Plan Services** at **303-602-2116** or toll-free at 1-855-281-2418.

Where you can get care

Above is a list of Denver Health Clinics where you can get care. These clinics are part of the DHMC Network. You may see any Provider in the DHMC Network. In most cases you must go to these Denver Health Clinics for your health care needs. Some specialists need a referral first – See Getting an Approval or Referral to See a Specialist. When you need to make a visit for a clinic visit, call the Appointment Center at 303-436-4949. You can also be seen at a STRIDE clinic.

>> QUICK TIPS FOR GETTING CARE AT DENVER HEALTH

Elevate Medicaid Choice is now your medical home and health plan. A **health plan** is a group of doctors, hospitals and other providers who work together to get you the health care you need. You may choose from any provider in the Elevate Medicaid Choice network. A **network** is a group of providers that are contracted to give health care services and products to health plan members. You can choose from clinics at Denver Health's Main Campus, the community health centers or various school-based health centers to get your health care. See a complete list of clinic locations here https://www.denverhealth.org/locations. You can also be seen at STRIDE.

Urgent Care clinics

1) Adult Urgent Care clinic at Denver Health's Main Campus. 777 Bannock St. open 7 a.m. – 8 p.m. Monday – Friday and 8 a.m. – 7 p.m. on weekends, with reduced Holiday Hours you may find at https://www.denverhealth.org/services/emergency-medicine/adult-urgent-care.
2) Pediatrics Urgent Care clinic at Denver Health's Main Campus. 777 Bannock St. open 24 hours a day, 7 days a week.
3) Adult and Pediatric Urgent Care clinic at the Southwest Family Health Center. 1339 S. Federal Blvd. Open 9 a.m. – 8 p.m. Monday – Friday and 9 a.m. – 4 p.m. on weekends, closed on Holidays.
4) Downtown Urgent Care. 1545 California St. open 7 a.m. – 6 p.m. Monday-Friday and 9 a.m. – 4 p.m. on weekends.
5) Virtual Urgent Care is ready for all Denver Health MyChart users ages 18 and older. It's easy and handy to get the urgent care you need from your home. You can use your smartphone, tablet, or computer. Learn more here denverhealth.org/services/emergency-medicine/urgent-care/virtual-urgent-care or contact Health Plan Services for more help and details.

Emergency Rooms- when you have an emergency, call 9-1-1 or go to the nearest hospital. There is no cost for covered health care for an emergency health problem. For a list of Denver Health Emergency Departments, see below:

- Pediatric Emergency Room. 777 Bannock St.
- Adult Emergency Room. 777 Bannock St.
- Denver Health Nurse Line, free health advice, available by telephone at 303-739-1261.

When you have trouble finding a Primary Care Provider call the **Appointment Center** at **303-436-4949**. You can change your PCP at any time.

New Patients

Call the Denver Health **Appointment Center** at **303-436-4949** to make your first visit.

You can also make a primary care visit with STRIDE. STRIDE Is formerly known as Metro Community Provider Network). They offer medical, behavioral health, and dental care for members. To make a visit, call the main number at 303-360-6267 or go online https://stridechc.org/new-patients

Existing Patients

Once you have been seen at your Denver Health clinic, you can schedule a visit at Denver Health online by registering for MyChart at https://mychart.denverhealth.org/mychart/. MyChart lets you to message your doctor, view test results, refill medications and schedule visits. You can call the Denver Health **Appointment Center** at **303-436-4949** to make future visits too.

When you need to cancel your visit, be sure to call the Appointment Center and let them know. Try to call at least one day before your visit date to cancel.

Bring your Elevate Medicaid Choice ID card and picture ID to all of your visits.

In most cases, you need a referral from your PCP to see a **Specialist**. A specialist is a provider who works in one area of medicine, like a surgeon. You do not need a PCP referral to see a Specialist in Optometry or OB/GYN.

Be 15 minutes early for your visit so you will have time for parking and checking in at the clinic.

All visits can be made through the Denver Health Appointment Center line. This includes Women's Care, Primary Care, Specialty and Eye visits. When you have problems making your visit, call **Health Plan Services** at **303-602-2116**, toll-free at **1-855-281-2418** or TTY 711.

When you have any questions regarding your benefits, call **Health Plan Services** at **303-602-2116**, toll-free at **1-855-281-2418** or TTY 711. Their hours are 8 a.m. – 5 p.m. Monday – Friday.

Thank you for being a member of DHMC! We look forward to helping you meet your health care goals!

>> 1) HOW YOUR PLAN WORKS

How to get facts about providers

When you want to know more about the providers taking care of you, like their title, training, and the license they have, you can call the **Health Plan Services** at **303-602-2116**.

What is a PCP?

Your **primary care provider, PCP,** is a doctor or nurse practitioner who helps you get and stay healthy. Your PCP works with nurses, physician helpers and social workers in the clinic or office. You may see them when you visit. Your PCP is your main contact for all your health care. Your PCP can answer your health questions and help you get the health care you need.

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 health care. Your PCP is the one who:

- Gives you health 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 health history each time you need care. This is important, especially when you have allergies or special health concerns. Your doctor will already know about you and your needs.

Choosing or changing your DHMC PCP

You should choose a PCP or Medical Home right away. You can check the DHMC Provider Directory for a list of DHMC providers and clinics. Call Health Plan Services to ask for a copy of the DHMC Provider Directory or view online at https://www.denverhealth.org/provider-directory. You should choose a provider that is in network. A **non-participating** provider is a provider, facility or supplier that does not give health care services and products to health plan members.

You must call the **Appointment Center** at **303-436-4949** when you know which Denver Health PCP or Medical Home you want to see for your care. When you do not pick a PCP or Medical Home, DHMC will assign you to the closest Denver Health (DH) family clinic. A list of all the DH clinics can be found under Where You Can Get Care.

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

The STRIDE network is also an option for making a PCP health visit. When you would like to see a PCP from the STRIDE network, make a visit at 303-360-6267. You can ask for a health visit online at https://stridechc.org/new-patients

Getting an approval or referral to see a specialist

You need an approval from your PCP to see some types of specialists. An approval, or referral, is what your PCP uses to ask DHMC to approve your visit to some specialists.

An approval from Utilization Management is needed before you see any provider outside of DHMC.

You do not need an approval:

- For a routine eye exam with a DHMC eye provider.
- To see a DHMC OB/GYN. A provider who treats only women for reproductive reasons. For yearly exams.
- For family planning services or family planning providers. In or outside of DHMC.
- For emergency or urgent care in or outside of DHMC.
- Outpatient mental health services – you may self-refer for these services to a network provider, Covered service include, but are not limited to:
    - Individual counseling.
    - Family counseling.
    - Group counseling.
    - Case management services.
- For emergency services for mental health or drug and alcohol use; you are responsible for making sure DHMC knows.

Call Health Plan Services to get more facts on approvals.

When your benefits, provider, or services change

DHMC will tell you in writing when there is ever a major and important change to any of these:

- Your disenrollment rights
- Provider facts
- Your rights and protections
- Complaint, appeal, and State fair hearing processes
- Benefits for you through DHMC
- Benefits for you that are not through DHMC
- How to get your benefits, including pre-approval requirements and family planning benefits
- Emergency, urgent, and post-stabilization care services
- Approvals for specialty care
- Cost sharing
- Moral and religious objections

DHMC will let you know about these changes at least thirty days before the start date of these changes.

Enrolling and Disenrolling

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

- You are a new DHMC member, and you have been enrolled in DHMC for 90 days or less.
- You are in your Open Enrollment period. See the Open Enrollment section.

- You miss your Open Enrollment period because you lost your Medicaid eligibility for a short time.

You, or DHMC, can also ask to disenroll at any time for these reasons:

- You move out of the DHMC network area. The network is: Adams, Arapahoe, Jefferson, and Denver Counties.
- DHMC is not able to give you a service because of any moral or religious objections
- You need to get two or more services at the same time, but one of the services is not available in the DHMC network, and your provider tells DHMC that you need to get the services at the same time.
- You are enrolled in DHMC by mistake.
- You feel, and Health First Colorado agrees, that you are getting poor quality of care, lack of access to DHMC services, or lack of access to the types of providers that you need.
- Your PCP leaves the DHMC network
- You are a resident of long-term institutional care. This could be hospice or a skilled nursing facility.
- Your primary health plan is a Medicare plan that is not one of the Denver Health Medicare plans. Your DHMC plan is your secondary health plan.
- You are a foster child
- You are in long-term community-based care. Care that you get at your home or in your community.
- Other reasons that are approved by Health First Colorado

DHMC may ask to disenroll you from the DHMC plan. DHMC can get permission from Health First Colorado to disenroll you for any of these reasons:

- You are no longer a permanent resident in the DHMC service area
- You have been living outside of the DHMC service area for ninety or more days in a row
- You are put in an institution because of a mental illness or drug addiction
- You are put in a correctional institution
- You have health coverage other than Health First Colorado, Colorado's Medicaid Program
- You are in a Medicare plan that is not a DHMC plan
- Child welfare eligibility status or receipt of Medicare benefits
- You give DHMC wrong or incomplete facts about yourself on purpose.
- Any other reason given by DHMC that Health First Colorado agrees with.

Your provider can ask to disenroll you for any of these reasons:

- You keep missing health care visits that you make to see your provider
- You do not follow the care plan that you and your provider agree on
- You do not follow the rules of DHMC. These are listed as your Member Responsibilities.
- You are harmful to your providers, other DHMC staff, or other DHMC members.

DHMC must give you one verbal warning before they can ask to disenroll you for these reasons. When you keep acting in the same way, DHMC 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 DHMC when you keep acting in the same way.

When you are harmful to your provider, other DHMC staff, or other DHMC members, DHMC will give you a verbal warning and may disenroll you without sending you a warning letter.

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

Newborns

When you have a baby, don't forget to add them to your Medicaid case. You can do this over the phone. Call your local county office or the Colorado Medical Assistance Program at 800-359-1991. Adding your baby to your Medicaid case will give them their own Medicaid ID and coverage.

Babies born to a mother on Elevate Medicaid Choice should also be assigned to Elevate Medicaid Choice after they are discharged from the hospital and have gotten a Medicaid ID. Once your baby is assigned to Elevate Medicaid Choice, you have 90 days to either get care at a Denver Health provider or opt out of the Elevate Medicaid Choice network. To get care outside of Denver Health, call Health First Colorado at 303-839-2120 to opt out. When you are unsure on your time limit to opt out, call Health Plan Services and we can help you count how many days you have to opt out.

Open Enrollment

You have the 2 months before your birthday month to switch your plan. You can switch to a different health plan for any reason.This time frame is called your Open Enrollment period.

During this time, you can choose to stay in DHMC or choose a different health plan.

When are you NOT able to be a DHMC member?

You are not able to get services through DHMC when:

- You lose Health First Colorado, Colorado's Medicaid Program eligibility.
- You move out of Colorado for more than thirty days.
- You join another health plan; and/or
- You move to a county outside the DHMC service area. The service area is Denver, Arapahoe, Adams, and Jefferson counties.

Other Health plan

When you have other health plan, or later become a part of another health plan, you must let DHMC know by calling **Health Plan Services** at **303-602-2116.** Fill out the Coordination of Benefits form and return to the address listed on the form. You can find forms online at https://www.denverhealthmedicalplan.org/coordination-benefits. Your enrollment in a health plan other than DHMC, may result in disenrollment from DHMC. The exception to have double coverage is Medicare.

Medical Bills

DHMC pays for all your covered benefits. You should never get a bill from a provider when the service is a DHMC covered benefit. You may have to pay for a service you get when DHMC does not cover the service. Call Health Plan Services when you get a bill from a provider. DHMC does not have any co-pays for covered services. A **co-pay** is a fixed amount you pay when you get a covered health care service.

Protect Yourself and Health First Colorado, Colorado's Medicaid Program, from Billing Fraud

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

These are 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 These are examples of provider fraud:

- Billing DHMC for services you never got
- Billing DHMC for equipment that is not the equipment they gave you

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?

- When you get health care outside of the United States of America.
- When you get health care that is not a covered benefit.
- When you do not follow the pharmacy rules
- When there is fraud, or the service is against the law.

When you need help making sure a service or provider is covered by DHMC call Health Plan Services.

When are you not required to pay for care?

When a provider does not get approval from DHMC when you get care, they cannot ask you to pay for this care. Providers cannot make you pay because they did not get paid from DHMC for the care you got.

Physician Incentive Plans

DHMC does not use a Physician Incentive Plan. This means that DHMC does not pay providers more money to give you less health care services or pay providers less money when they give you more health care services. If you would like more facts about this, call Health Plan Services.

When someone else causes your injuries or illness

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

- Health First Colorado Administered by Elevate Medicaid Choice may collect paid benefits directly from the liable party or the liable party's health plan company.
- You will tell DHMC, in 30 days of your getting injured or ill, when another party caused your injury or illness.
- The names of the liable party and that party's health plan company.
- The name of any lawyer that you hired to collect from the liable party.
- You or your lawyer will notify the liable party's health plan company that, DHMC has paid, and/or is in the process of paying, your medical bills.
- The health plan company must contact DHMC to discuss payment to DHMC.
- The health plan company must pay DHMC before it pays you or your lawyer.
- Neither you nor your lawyer will make an agreement with the health plan company that does not provide for full payment to DHMC.
- Neither you nor your lawyer will collect any money from the health plan company until after DHMC is paid in full. This applies even when the health plan money to be paid is referred to as damages for pain and suffering, lost wages, or other damages.

- When the health plan company pays you or your lawyer and not DHMC, you or your lawyer will pay the money over to DHMC up to the amount of benefits paid out. DHMC will not pay your lawyer any attorney's fees or costs for collecting the health plan money.
- DHMC will have an automatic lien on any health plan money that is owed to you by the health plan company, or that has been paid to your lawyer. DHMC may notify other parties of the lien.
- DHMC may give the health plan company and your lawyer any DHMC records necessary for collection. When asked, you agree to sign a release to provide DHMC records to the health plan company and your lawyer. When asked, you agree to sign any other papers that will help DHMC collect.
- You and your lawyer will give DHMC any facts asked about your health care bill against the liable party. You and your lawyer will notify DHMC of any dealings with, or lawsuits against, the liable party and that party's health plan company.
- You and your lawyer will not do anything to hurt the ability of DHMC to collect paid benefits from the health plan company.
- You will owe DHMC any money that DHMC is unable to collect because of your, or your lawyer's, lack of help or interference. You agree to pay to DHMC any attorney's fees and costs that DHMC must pay to collect this money from you. When you or your lawyer do not help, or interfere with, DHMC in collecting paid benefits, then DHMC may contact the State of Colorado and ask that you be disenrolled for cause from DHMC and placed in Medicaid Fee-for-Service.
- DHMC will not pay any medical bills that should have been paid by another party or health plan company.
- You must follow the rules of the other health plan company to have your medical bills paid. DHMC will not pay any medical bills the other health plan company did not pay because you did not follow their rules.

When you have questions, call **Health Plan Services** at **303-602-2116**.

What are Advance Directives?

Advance directives are written instructions to those caring for you that tell them what to do in case you can't make decisions for yourself. They list the type of care you do or do not want when you become so ill or injured that you cannot speak for yourself.

Directives are only used when a person is not able to make their wishes known. **You do not have to make an Advance Directive.** DHMC will not treat you differently because you do or do not have a Directive on file.

Doing a Directive in 'advance' helps protect your rights to getting the care that you want. It tells your medical providers what kind of care you do and do not want to get. Forms can be easy to fill out, but the facts can be confusing and should be thought about very carefully. It is important to talk to family members, legal, health or other professionals before signing any paperwork.

Here are some types of Advance Directives forms:

- Living Will - this form tells medical providers what types of care you do and do not want to have in life-threatening situations.
- Medical Durable Power of Attorney, MDPOA - this form lets you choose someone to make your health choices when you cannot make choices for yourself.

- Five Wishes - this form lets you think about “five wishes” or areas of care and make choices that are best for you.

Once you have thought about your wishes, write them on one of the forms at https://www.denverhealthmedicalplan.org/medicaid-choice-forms-documents-links and let others know. Make sure to get the filled-out form in your medical record. Keep copies at home and make sure those you have chosen also to have a copy. Look over your wishes from time to time to remind everyone and keep the forms up to date.

When there is reason your doctor cannot carry out your wishes in your directive, you will be told in writing. Denver Health will also help you find a new provider, when needed, who will give you the care you wish to have. You can file a complaint with the Colorado Department of Public Health and Environment when you feel your Advance Directive is not followed.

Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South
Denver, CO 80246-1530

303-692-2000 or **1-800-866-7689**. In-State. for TTY call **303-691-7700**.

If you want more facts about Directives, you may call your health care provider or call **Health Plan Services** at **303-602-2116**. You can also get more facts from your social worker, community agencies, and/or legal professional.

Proxy Decision-Maker

Adults have a right to make their own health decisions. When you have an illness, injury or life-threatening injury and cannot make your own decisions, doctors and other health providers will look to see when you have an Advance Directive in your medical record. When you do, they follow the wishes you expressed in your Directive.

When you did not fill out an Advance Directive, Colorado law lets a proxy decision-maker act on your behalf. A proxy is someone who appoints themselves to make decisions about the services and care you get when you cannot tell your doctor about them for yourself. A proxy can be any competent adult who has a relationship with you like a spouse, a parent, an adult child, a sibling or even a close friend. A proxy decision-maker can make health decisions for you but only when you cannot make them on your own. Once you can tell your wishes to providers, a proxy is no longer needed.

Using a Designated Personal Representative, DPR

You can choose someone to be in charge of your health care. This is a Designated Personal Representative. 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 DHMC in writing when you choose a DPR. The DPR’s name, address and a phone number must be included in the letter, so DHMC knows who to call when needed. You can call Health Plan Services for a copy of the form.

Privacy

Your privacy is very important. Denver Health creates a medical record for you as a member of the plan. You can expect that your medical records will be kept private. This includes facts like age, race/ethnicity, language, and other personal contact facts. DHMC will follow its written directions, procedures, and laws about the private nature of your records. Facts and medical records will only be used for your care and quality of health care. We will not give this record to anyone without your permission.

A complete description of DHMC'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 Member Advisory Committee

The DHMC Member Advisory Committee is a group of DHMC staff, members, and other community health workers who meet regularly to talk about the DHMC Plan. Call **Health Plan Services** at **303-602-2116** when you want to join.

DHMC Member Newsletter

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

>> 2) YOUR RIGHTS AND RESPONSIBILITIES

Your Rights

Elevate Medicaid Choice gives access to health 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, DHMC, other health care staff, and you – our member. DHMC is invested to partnering with you and your provider. As a DHMC member, you have all of these rights:

- To be given health care in accordance with requirements for access, coverage, and coordination of medically necessary services.
- To be treated with respect and with thought to your worth and privacy.
- To get facts from your provider about all the care options for your health issue in a way that makes sense to you.
- To take part in choices on your health care, including the right to say no to care.
- To get a second opinion at no cost to you. DHMC will arrange a second opinion with an out-of-network provider when a DHMC provider is not able to.
- To make an Advance Directive.
- To get detailed facts about Advance Directives from your provider and to be told up front when your provider cannot follow your Advance Directives because of their values.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. This means that DHMC 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 from providers in the DHMC visit standards time limits. In this handbook.
- To see providers who make you comfortable and who meet your cultural needs.
- To use any hospital or urgent care for emergency and urgent care needs. Emergency and urgent care do not need prior approval or referral.
- To get available and accessible services under the Contract.
- To get health care outside of the Denver Health Network when you are not able to get them in the Denver Health Network. DHMC must approve non-emergency and non-urgent care first.
- To get family planning care from any family planning provider, network, or out-of-network, without DHMC approval or referral.
- To ask for a copy of your medical records and ask that they be changed or fixed.
- To file a complaint, appeal or ask for a State fair hearing.
- To join the DHMC Member Advisory Committee.
- To get all benefit facts from DHMC. This fact includes covered services, how to get all types of care like emergency care, detailed facts about providers, and your disenrollment rights.

- To use your rights above, without fear of being treated poorly by DHMC, network providers or the State Agency.

Your Responsibilities

DHMC wants to give all members the best 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 DHMC member, you are also in charge of

- Choosing a Primary Care Physician, PCP, or Medical Home that is in the DHMC Network.
- Following all of the rules in this member handbook.
- Getting an approval from your PCP before you see a Specialist. See "**Getting an approval or referral to see a specialist"**.
- Following the rules of the DHMC appeal and complaint process.
- Calling the Denver Health Appointment Center to change your PCP.
- Paying for any health care that you get without referral from your PCP. Emergency or urgent care servicesorWrap-Around benefits are not included in this.
- Paying for any services that are not covered by DHMC or Health First Colorado.
- Telling DHMC about any other health plan you have other than Health First Colorado.
- Calling the Appointment Center 24 hours before your visit date when you need to cancel your visit.
- Telling us your new address when you move.

>> 3) HOW TO GET CARE

Emergency Care

An **emergency** is when an illness or injury is very serious. So serious that your or your unborn baby's health, bodily functions, body organs or body parts may be in danger. Get medical care right away. This includes childbirth labor and delivery.

An emergency service is any care you get from an emergency room provider that is needed for an emergency health problem. When you have an emergency, call 911 or go to the nearest hospital. There is no cost for covered health care services when you go to the hospital for an emergency health problem. The emergency provider may do a health check to decide when your issue is an emergency. Go to an Emergency room if you believe that by not getting health care right away could result in:

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

DHMC will not deny your emergency care when the provider does not tell DHMC in a certain number of days.

Stabilization care is care you get after an emergency so that your health will be stable. DHMC will cover your care for these types of services. Emergency, urgent and stabilization care do not need pre-approval from DHMC. 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, stabilization or family planning must be given by a provider in the DHMC network.

When you need care after hours, after your provider's office is closed, you can call the **Denver Health Nurse Line** at **303-739-1261**. The nurse can help you decide when you need to see a provider, go to the emergency room, or give you health advice when 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. **Urgent care** is for a sickness or injury that needs medical care quickly. When you have an urgent care need, you can go to the nearest urgent care center, or call:

- Your PCP.
- The **Denver Health Nurse Line** at **303-739-1261**. This line can link you to a DHMC nurse 24 hours a day, 7 days a week. The DHMC nurse can help you decide when you should go to the emergency room or urgent care center.

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

Denver Health has adult and pediatric urgent care clinics on the main Denver Health hospital campus: 777 Bannock St. There is also an urgent care clinic at Southwest Family Health Center: 1339 S. Federal Blvd. and the Downtown Urgent Care: 1545 California St. The hours for these locations can be found above on Page 7.

You may use the Denver Health urgent care clinics, but you do not have to use them. 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 health 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. DHMC will pay for your Post-Stabilization care when you are at Denver Health. When you are at a non-Denver Health hospital for an emergency, your Post-Stabilization care must be pre-approved by DHMC. Once you are stabilized, you or a family person should call DHMC at the number on the back of your member card to notify DHMC 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 DHMC did not pre-approve them, DHMC must still pay for the services when:

- The provider at the non-Denver Health hospital asks DHMC to approve your Post-Stabilization care services, and DHMC does not get back to the non-Denver Health provider in one hour.
- DHMC cannot be contacted; or
- DHMC and the provider at the non-Denver Health hospital cannot agree on how to handle your care and a limited managed care initiative physician is not available for consultation.

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

- A DHMC provider who also works at the non-Denver Health hospital takes responsibility for your care.
- The provider at the non-Denver Health hospital tells DHMC you are healthy enough to be transferred, so you are transferred to Denver Health hospital and a DHMC provider takes care of you.
- DHMC and the provider at the non-Denver Health hospital reach an agreement on how to handle your care; 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. DHMC will work to safely bring you to Denver Health hospital. Your care will still be covered by DHMC when you get transferred to Denver Health hospital. When you 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 DHMC would charge for care provided by DHMC.

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. When there are other services, you have questions about, give Health Plan Services a call.

Making a Visit

You should call the **Appointment Center** at **303-436-4949**. When you need an interpreter or TTY services when you see your provider, let the Appointment Center agent know when you make your visit.

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

DHMC Appointment Standards

Type of Care	Visit Standard
Emergency	24 hours a day, 7 days a week
Urgent	In 24 hours of your call
Non-Urgent and Non-Symptomatic Well Care Visit	In 30 days
Non-Urgent, Symptomatic Care Visit	In 7 days
Well Care Visit	In 1 month* *Unless a visit is required sooner to ensure the provision of screenings in accordance with the Department's accepted Bright Futures schedule

Pharmacy

When you are having an issue at the Pharmacy, call us before paying out of pocket. We can verify what is covered and what is not. If you are having an eligibility issue, call us. We can help you if you have another health plan and don't know which one is primary. **Prescription drugs** are medicines or drugs your doctor orders for you. They treat or prevent a condition or illness. In order for DHMC to pay for your prescription, you must bring your DHMC ID card with you when you go to the pharmacy. Your Denver Health provider may write 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 303-436-4488

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

Outpatient Medical Center
660 Bannock St.

Pavilion L 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 the DHMC health plan. Some pharmacies outside of Denver Health take DHMC health plan, like King Soopers, Safeway, Rite-Aid, Walmart, and Walgreens. You can go online to

https://www.denverhealthmedicalplan.org/medicaid-choice-pharmacy to log in to the Member Portal to register with your ID to find a pharmacy near you.

When you use Denver Health pharmacies you may order your prescriptions by calling **the Denver Health Refill Request Line** at **303-436-4488**, or by visiting https://mychart.denverhealth.org/MyChart/. You can also use the MyChart smart phone app. You should always order your refills at least five working days before you run out of your prescription. When your provider tells you to take your prescription in a way that is different from the directions on your prescription bottle, let your pharmacy know. The pharmacy may need extra time to talk to your provider to get a new prescription or permission to fill it early. For more facts about how to refill your prescription, visit the DHMC website.

When you have questions or need help with your prescriptions outside of normal business hours at your plan, 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. When you fill your prescriptions at Denver Health, your providers will be able to look in your medical records for a list of your drugs. When you get your prescriptions filled outside of Denver Health, you must tell your providers because pharmacies outside of Denver Health do not update your DHMC medical records.

DHMC has a list of covered drugs. This list is called a formulary. When your provider writes a prescription for a drug that is not on the list there may be a drug on the list that would work just as well for you. Your provider can decide when a formulary drug is right for you. When your provider does not want to change the drug, they will need to fill out a pre-approval form and tell DHMC why that drug is needed. DHMC will let you, your provider and your pharmacy know when DHMC will pay for the drug or not.

When the pharmacy tells you your drug is not covered by DHMC, do not pay out of pocket. It is best to contact DHMC Pharmacy Call Center at 303-602-2070. DHMC does not provide payments/reimbursements directly to members when you pay out of pocket for medications, even though the pharmacy may tell you this.

When your provider gives you drug samples to start care, find out when the medication is on the list. When you take samples before you ask DHMC to pay for the drug first, it does not mean that DHMC will pay for that non-list drug.

Some drugs are not covered at all. These are drugs for:

- Cosmetic use. Things like anti-wrinkle, hair removal, and hair growth products.
- Non-formulary dietary supplements. Things like vitamins, herbals, etc.
- Infertility to help women get pregnant.
- Pigmenting / De-pigmenting- to change skin color
- Sexual performance/dysfunction. Drugs like Viagra, Cialis, Levitra etc.
- Non-forumlary therapeutic devices or appliances. Machines you use for your health.
- Weight loss
- Investigational or experimental care
- Prescription drugs not approved by the Food and Drug Administration, FDA, for any disease.
- Travel vaccines recommended by the Centers for Disease Control and Prevention only for travel outside of the United States. Covered vaccines are listed under Benefits.

Some drugs may not be on hand at all pharmacies. List over-the-counter drugs can only be filled at Denver Health pharmacies.

You can get a 90-day supply of maintenance medications. Maintenance medications are drugs used to treat a chronic illness or symptom of a chronic illness.

You will need to ask your provider to write your prescription for a 90-day supply. The pharmacy cannot give you a 90-day supply without the provider's permission. The pharmacy can always give you less than what the provider requested but never more. When your provider wrote the prescription for a 90-day supply, the pharmacy can still give you a 30-day supply when you ask.

Pharmacy by Mail

DHMC offers Pharmacy by Mail. Pharmacy by Mail saves you time by sending your 90-day supply prescriptions to your home. Because Pharmacy by Mail prescriptions are for a 90-day supply, you will only need to have your prescriptions filled 4 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 by DHMC are $0. You do not need to keep a credit card on file when you only want to have medications that are covered by DHMC sent to your home with Pharmacy by Mail. When 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 in the state of Colorado.

Controlled substances or specialty medications cannot be filled through the Denver Health Retail by Mail Program. To refill by Mail prescriptions, call the **Denver Health Refill Request Line** at **303-436-4488**.

You can use your local pharmacy to have maintenance medications sent to you through the mail, as long as they are in DHMC's pharmacy network. Ask your pharmacy when they offer prescription delivery through the mail.

For facts about your pharmacy benefits go to https://www.denverhealthmedicalplan.org/medicaid-choice-pharmacy. From this website you can:

- Click the Formulary/Drug List link to see the list of covered drugs. This link also explains the formulary restrictions, limits, or quotas, how your provider can request a pre-approval 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 Pre-Approval Form/Exception Request Form to start a pre-approval. This is also called an exception request.
- Click the link to the member portal. Register with your ID to log in to:
    - Search the list to see when your drug is covered.
    - Locate a pharmacy close to you.
    - Search for drug-drug interactions and common drug side effects.

When you have questions about your pharmacy benefits, call **Health Plan Services** at **303-602-2116** or **1-855-281-2418**. TTY users should call 711.

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

When you are away from home, you are only covered for emergency and urgent care.

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

DHMC 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 DHMC to bring you to Denver Health or another hospital. When you say no to being brought to Denver Health, you may have to pay for the rest of the care you get at the other hospital.

When you get care for services other than emergency or urgent care services, you may be responsible for payment.

You do not have health care benefits outside of the U.S. This includes Puerto Rico, Guam, U.S. Virgin Islands or American Samoa.

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 DHMC health plan. You will need to have your DHMC ID card to show the pharmacist. Prescriptions are only covered outside of Colorado for urgent or emergency situations. Prescriptions are only covered outside of Colorado for urgent or emergency situations for a maximum of a 3-day supply.

>> 5) WOMEN'S HEALTH CARE

Seeing an OB/GYN, Obstetrics and Gynecology

You do not need an approval or referral to see a DHMC OB/GYN for pregnancy care or well-woman care.

When you are more than three months pregnant and you are a new DHMC member, you may keep seeing your OB/GYN, even when your OB/GYN is outside of the DHMC network. When you have an out of network provider, they will need to submit a pre-approval for care, and should contact Health Plan Services for more facts.

Family Planning

Family planning care can help people choose when to become pregnant or to become a parent. Family planning care include different kinds of birth control, like birth control pills or intrauterine devices, and office visits to talk about family planning and how to make healthy choices about reproduction. You can choose what kind of family planning works best for you.

You may go to a DHMC provider or any provider who accepts Health First Colorado for family planning. You do not have to get approval from DHMC first. 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.

Cervical Cancer Testing

Women between 18 and 64 years of age should have Pap smears once a year. DHMC covers this. The Pap smear can help find cancer at an early stage. Be sure to ask your doctor or OB/GYN for this test.

Breast Cancer Testing

A mammogram is a test that doctors use to screen for breast cancer. Mammograms are covered by DHMC. Most women start getting mammograms around 40 years old and continue to get mammograms until they are 69 years old. Women who are more at risk for breast cancer may get mammograms earlier or more often than others. It is important that you talk with your provider about your family history of breast cancer and any concerns you have. Talk with your doctor about when you should have your next breast cancer screening.

Pregnancy Care

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

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.

>> 6) CHILDREN'S HEALTH CARE

Childhood and Adolescent Immunizations

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

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.

Age	Shots
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.

EPSDT

EPSDT stand for Early and Periodic Screening, Diagnostic and Treatment. EPSDT is a Health First Colorado benefit that covers prevention, diagnostic and care services for persons ages 20 and under. This program is set up to find health problems early. The program goal is for children to get the physical, mental, vision, hearing and dental care they need for their health.

Your child can get this care at no cost to you. This includes:

- Speech
- Well Child Check-ups
- Immunizations
- Physical or Occupational Therapies
- Home Health Services
- Substance Use Disorders Care
- Vision and Eyeglasses
- Hearing
- Dental Care

The American Academy of Pediatrics Bright Future Schedule is a list of needed care and how often you need to get care.

In addition, children that have not had Lead Testing need to get one at 12 and 24 months or between the ages of 36 and 72 months.

You can get this care through your PCP. Your PCP may refer you to other special services available at Denver Health. EPSDT screening services do not need approval from DHMC. Diagnostic services are provided when screening suggests more evaluation or care is needed. Services are medically necessary, the least costly, effective, acceptable health practice. Services needed to treat, fix, or prevent illness and conditions found by screening or diagnostic tests are covered, and DHMC will not limits on the number of allowed visits for EPSDT services. Maintenance care may also be covered when needed.

Members may self-refer for the following EPSDT program services:

- Well Child Checks
- Immunizations
- Vision Screening/Eyeglasses
- Hearing Screening

EPSDT services that require a PCP referral and/or pre-approval:

- Speech therapy needs a PCP referral.
- Physical Therapy/Occupational Therapy needs a PCP referral
- Home Health needs a PCP referral and pre-approval
- Substance Use Disorders Care needs PCP referral and pre-approval

Special Considerations or Limitations

There are some services that are not covered for EPSDT members. These services are listed below.

- Experimental care and methods.
- Care or items that are not accepted in the health care community.
- Over-the-counter drugs unless needed for care and are approved.

There are some services that have special considerations. These are:

- Eyeglasses are a benefit when ordered by an eye doctor. Eyesight benefits are fixed to single or multi-focal clear plastic lenses and one standard frame.
- Contact lenses or eyesight care shall be a benefit when needed.
- Orthodontic is a benefit for children with congenital, bad developmental or acquired handicapping malocclusions when confirmed by a case review. The Dentist will ask for approval for care.
- Early Language care for children from birth to age three with a hearing loss may be given by audiologists, speech therapists, speech pathologists and Colorado Home Intervention Program CHIP doctors. CHIP is a program to help children who are deaf or hard of hearing.

Some EPSDT services are not covered by DHMC. These are still a benefit to you through Health First Colorado. This kind of care is called a Wrap Around benefit. See the Wrap Around Benefit section in this handbook for more facts.

Most EPSDT services will be available in Denver Health. Your doctor may also refer you to services outside Denver Health. When you have questions about EPSDT services, you or your doctor may call **Health Plan Services** at **303-602-2116**.

Flu Shots

Flu shots and other vaccines are a covered benefit for DHMC members.

There is no cost to members for flu shots. The best time to get a flu shot is in October or November. DHMC recommends flu shots for the following people:

- All high-risk children
- Children with long lasting health problems or a problem immune system; children 6 months to 59 months old; and older children with brothers and sisters under 6 months of age.
- People who are 50 or older.
- A person with health problems like diabetes, heart disease, lung disease and asthma.
- People who are around people with health problems like asthma, heart, and lung disease.
- Pregnant women who are more than three months pregnant during flu season. New parents that have a baby between December and May.

Call the Appointment Center to make a visit or ask about a free flu shot.

See a list of recommended shots under Childhood and Adolescent Immunizations.

Early Intervention Services

Early Intervention Services, EIS, are services that give support to children who have special developmental needs. This care is for children from birth to age three. 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.

>> 7) SPECIAL HEALTH CARE PROGRAMS

DHMC has many services to help you when 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. Problems like high blood pressure, asthma.
- Health problems that require you to use special devices. Things 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 when you have special health needs.

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

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

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

You must let DHMC 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 facts.

When you have a special health condition that requires you to see a specialist often, then you could be eligible for a standing referral. This means that you will be allowed to access this specialist at any time, get approval for a certain number of visits to see the specialist, or use this doctor as your PCP.

Call Health Plan Services when you have any questions about standing referrals.

Case Management

DHMP Care Management offers specific programs to help members manage these chronic health issues:

- Our **Blood Pressure Program** focuses on improving blood pressure control through education, support, monitoring, and visit coordination.

- Our **Diabetes Program** is designed to help the health of members with diabetes through education and support, better engagement with health care doctors, lifestyle and behavior changes, access to mental health services, and referrals to peer support programs and other community-based support.

- Our **High-Risk Maternal Care Program** is available to Medicaid Choice Members and helps members improve access of early prenatal care, provides education and support, coordinates community-based referrals, and helps with rides to provider visits. DHMP's Care Management Team works directly with the Women's High-Risk Clinic at Denver Health Hospital Authority to provide screening and access to mental health and other services in the clinic.

- Our **Special Health Care Needs Program** focuses on coordination of benefits and care for members with special health care needs. The program supports access to care, coordination of waivers and other benefits, access to private duty nursing, PDN, and pediatric long term home health services, PLTHH,

access to community-based resources and support with getting rides to provider visits. Care Managers work directly with members to create a member-driven care plan.

- Our **Foster Care Program** is designed to support the specific needs of members in foster care. Care Managers work directly with DHHA's foster care clinic to improve access to services, including safety exams for members entering foster care. Care Managers provide wrap-around services to support the unique needs of members in foster care.

Care Management Programs are offered at no-cost to the member. Members may opt in through self-referral and may opt out at any time. Members who would like to self-refer to a Condition Management program may call **303-602-2184** or email Care Management at **DHMPCC@dhha.org**.

Care Coordination Services

Care Coordination Services are offered to members who would like support in taking charge of their health care, but who may not fall into other program in Care Management. Services include:

- Applications/membership Support
- Community resource support
- Disease management
- Education
- Health needs assessment
- Medication management
- Health care provider coordination
- Help with getting rides to provider visits
- Visit reminders
- Support with food security

Care Coordination is a no-cost service to the member. Members may opt in through self-referral and may opt out of services at any time. Members who would like to self-refer to Care Coordination Services may call **303-602-2184** or email Care Management at **DHMPCC@dhha.org**.

Utilization Management

Utilization Management reviews requests for care. Pre-approval is getting approval for services before you use them. Requests are required for payment of services and care that are either not available at Denver Health or have a limit on the benefit.

Examples of things that require pre-approval include home health services, durable medical equipment, and care at all non-Denver Health facilities. See the section "Your DHMC Benefits" in this handbook to find out which covered services require DHMC pre-approval. Your provider will work with Utilization Management staff to get a pre-approval when 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.

When you have questions about a service, care, or a specific decision that is made, you can call Health Plan Services. You can also file an appeal when 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 facts.

You can also call Health Plan Services when you want to get a free copy of the documents DHMC uses when making authorization decisions or how we ensure that you are getting quality care.

Medically Necessary

DHMC decides which services will be covered based on national standards. Throughout this handbook, you might see the term medically necessary or needed for care. These words are used when talking about what benefits and services will be covered for you under this plan. **Medically necessary** services include any covered program, product or service that is delivered in the most appropriate setting required by the member's condition and does not cost more than other equally effective care choices.

They include services that will or are reasonably expected to prevent, diagnose, cure, correct or improve the following and are provided in a manner consistent with accepted standards of medical practice such as:

- Pain and suffering
- Physical, mental, cognitive, or developmental effects of an illness, injury, or disability
- These services may also include care that is observation only.
- Medically necessary services do not include
- Care that are untested or still being tested
- Services or items not generally accepted as effective
- Services outside the normal course and length of care
- Services that don't have clinical guidelines
- Services for member, caregiver, or provider convenience
- For EPSDT rules, see 10 CCR 2505-10, Section 8.280.4.E.

This means that DHMC will only provide care that is needed to find, treat, or keep track of a condition in the most appropriate place, by the most appropriate provider. For example, when a member has a social event coming up, an urgent, out of network visit to treat acne would not be medically necessary.

When a service is not medically necessary, like a cosmetic surgery for example, then DHMC will not pay for it. An authorization denial letter will be sent to you and your provider.

Clinical Guidelines

Clinical Practice Guidelines can help you and your doctors make good choices about your care. Guidelines are based on lots of research done nationally and list the best care options for certain conditions. Denver Health uses the 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 keep you healthy.

To view more info 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 DHMC BENEFITS

This is a list of your Health First Colorado benefits with DHMC. When you need a service that is not covered, you or your PCP can work with DHMC to get it covered.

Benefits	Covered Services	What is Needed?
Abortion	Covered only in these events: • When the pregnancy is the result of an act of rape or incest • In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, place the woman in danger of death unless an abortion is performed	Written letter from the physician certifying the danger to mother's life, when applicable.
Ambulance Services	Covered when it is an emergency.	
Birth of Baby in Hospital	Covered in full.	
Dental Care for Adults with an existing health condition worsened by a condition in your mouth	Allowable existing health conditions include: • Disease requiring chemotherapy or radiation. • Organ transplants • Pregnancy • A health condition worsened by an oral condition. Emergency care can be provided when you would be hospitalized when no immediate care is provided.	This is a wraparound benefit. See wraparound benefits section in this handbook for more facts.
Durable Medical Equipment and Supplies- Reusable medical equipment when there is a medical need for the care or therapy for an illness or physical condition. Examples include oxygen, wheelchairs, walkers and some bathroom or bedroom safety equipment	• Wheelchairs • Crutches • Other supplies	Equipment to be provided by a contracted provider. Approval from DHMC is needed. Call Health Plan Services for details.

Benefits	Covered Services	What is Needed?
Emergency Services	Covered.	In emergencies, no pre-approval from DHMC is needed. When you have an emergency, call 9-1-1 or go to the nearest hospital.
EPSDT Benefits	See EPSDT section in this handbook for a list of covered services.	Child must be 20 years or younger to qualify for EPSDT services.
Family Planning Services	• Family planning counseling, care, and follow-up • Birth control pills • Insertion and removal of approved contraceptive devices • Measurement for diaphragms • Male/female surgical sterilization	For sterilization, you must • Be at least 21 years old. • Be mentally competent. You have never been declared mentally incompetent by a federal, state, or local court. • Give your informed consent. You do this by filling out the form your provider will give you 30 days before your sterilization procedure. *There are exceptions to this. Ask your provider or call **Health Plan Services** at **303-602-2116** for details.

Gender Affirming Care	Covered services include behavioral health, hormone therapy and surgical procedures. The following requirements apply to all covered gender affirming care: ✓ Member has a clinical diagnosis of gender dysphoria. ✓ Requested service is medically necessary. ✓ Any co-existing physical and behavioral health conditions do not interfere with diagnostic clarity or capacity to consent. Associated risks and benefits have been discussed. ✓ The Member has given informed consent for the service. ✓ The Subject to the exceptions in C.R.S. § 13-22-103, when member is under 18 years of age, member's parent or legal guardian has given informed consent for the service. **Hormone Therapy** Gonadotropin-Releasing Hormone Therapy, GnRH ✓ Meets the Member Eligibility criteria listed above, ✓ Meets the applicable pharmacy criteria at section 8.800, and, ✓ Has reached Tanner Stage 2 Gender Affirming Hormone Therapy ✓ Meets the Member Eligibility criteria listed above.	

	✓ Meets the applicable pharmacy criteria at section 8.800. ✓ Has been informed of the possible reproductive effects of hormone therapy, including the potential loss of fertility, and the available options to preserve fertility. ✓ Has reached Tanner Stage 2 ✓ When under 18 years of age, demonstrates the emotional and cognitive maturity required to get the potential impacts of the care. Other Gender-Affirming Hormone Therapy requirements include: ✓ Prior to beginning gender-affirming hormone therapy, a licensed health care professional who has competencies in the assessment of transgender and gender diverse people must determine that any behavioral health conditions that could negatively impact the outcome of care have been assessed and the risks and benefits have been discussed with the member, and ✓ For the first twelve months of gender-affirming hormone therapy member must receive medical assessments at a frequency determined to be clinically appropriate by the prescribing provider. Surgical Procedures	

	Gender-Affirming Surgery means a surgery to change primary or secondary sex characteristics to affirm a person's gender identity. This is also known as gender confirmation surgery or sex reassignment surgery. Covered surgical procedures are benefits to a member who: ✓ Meets the Member Eligibility criteria listed above, ✓ Is 18 years of age or older, ✓ Has completed six continuous months of hormone therapy, unless hormone therapy is not clinically indicated or is inconsistent with the client's desires, goals, or expressions of individual gender identity, o This requirement does not apply to mastectomy surgeries, o Twelve continuous months of hormone therapy are required for mammoplasty, unless hormone therapy is not clinically indicated or is inconsistent with the client's desires, goals, or expressions of gender-identity, ✓ Gets the potential effect of the gender-affirming surgery on fertility. Requests for medically necessary gender-affirming surgeries will be	

	reviewed by the MCO Utilization Management Director. The following are examples of surgeries that may be covered when the criteria above are met. This list is not exhaustive. ✓ Genital Surgeries ✓ Breast/Chest Surgeries ✓ Facial and Neck Surgeries **Non-Covered Services** The following services are not covered under the gender-affirming care benefit. ✓ Reversal of covered surgical procedures. ✓ Any items or services excluded from coverage under 10 CCR 2505-10 8.011.1 **Gender-Specific Procedures** Many procedures that are restricted to a member's assigned sex at birth will still be medically necessary after legally changing their gender. **Pre-approval Requests** For ***all covered services***, general requirements for pre-approval requests include: ✓ Member has a clinical diagnosis of gender dysphoria. ✓ Requested service is medically necessary. ✓ Any co-existing physical and behavioral health conditions do not interfere with diagnostic clarity or capacity to consent, and associated risks and benefits have been discussed. ✓ Member has given informed consent for the service.	

Benefits	Covered Services	What is Needed?
	✓ Subject to the exceptions in C.R.S. § 13-22-103, when member is under 18 years of age, member's parent or legal guardian has given informed consent for the service. For ***surgical procedures***, in addition to the above general requirements, pre-approval requests must provide documentation demonstrating that the member: ✓ Is 18 years of age or older. ✓ Has completed six continuous months of hormone therapy, unless hormone therapy is not clinically indicated or is inconsistent with the client's desires, goals, or expressions of individual gender identity, ○ This requirement does not apply to mastectomy surgeries ○ Twelve continuous months of hormone therapy are required for mammoplasty, unless hormone therapy is not clinically indicated or is inconsistent with the client's desires, goals, or expressions of gender-identity • Gets the potential effect of the gender-affirming surgery on fertility	

Benefits	Covered Services	What is Needed?
Home Health Care Services- Skilled nursing services, certified nurse aide services, CNA, physical therapy, occupational therapy, and speech/language pathology services given in your home by a licensed and certified home health agency.	DHMC covers Home Health services for the first 60 days in a row. After the 60 days, Home Health services are covered as a wraparound benefit by Health First Colorado.	Must be ordered by a DHMC provider. Approval from DHMC is needed.
Hospital Services and Inpatient Admissions	Hospitalization must be at Denver Health Medical Center.	Must be ordered by a DHMC provider. Any chosen procedures or inpatient admissions not done at Denver Health must be approved by DHMC. DHMC will approve inpatient stay for a specific number of days and will review any cases where more days are needed. When DHMC finds that more days are needed then an approval will be made. You may have to pay for any inpatient stays that are not pre-approved by DHMC.
Immunizations for Persons 21 years of age and older	• TD. Stops tetanus and diphtheria. Every 10 years. • Influenza. Yearly • Pneumococcal. After the age of 65 years • Zoster. Stops shingles after the age of 65 years	Provided by a DHMC provider.
Immunizations for Persons under 21 years of age	All recommended immunizations.	Provided by a DHMC provider.
Inpatient Substance Abuse Care	See the section below on Behavioral Health Services	
Nursing Home	This is a wraparound benefit and is covered by Health First Colorado after certification is approved. See wrap around benefits section in this handbook.	Must be referred by a DHMC provider.

Benefits	Covered Services	What is Needed?
Oral Surgery for Adults	Limited to treating certain conditions, such as • Accidental injury to jawbones or surrounding areas • Fixing a problem with your mouth, which causes a problem for use like care for lumps on the jaws, cheeks, lips, tongue, roof, or floor of mouth.	Must be referred by a DHMC provider. Approval from DHMC is needed.
Outpatient Substance Abuse Care	See the section below on Behavioral Health Services	
Over-The-Counter (OTC) Medications	DHMC pays for some OTC medications. Your DHMC provider must write you a prescription for any OTC medication to be covered and it must be filled at a Denver Health pharmacy.	Pre-approval needed only for drugs not on the drug formulary.
Pharmacy – Changing from Generic to Brand Name	You can get a Brand Name drug when a Generic is ordered.	You can ask the pharmacy for a Brand Name drug even when your provider ordered a Generic, but you will have to pay part of the drug cost. DHMC will only pay for the Brand Name drug when your provider fills out a pre-approval form and tells DHMC why the Brand Name drug is needed. See the Pharmacy section in this handbook.
Prenatal Care	Covered in full.	Provided by your DHMC OB/GYN When you are new to DHMC and more than 3 months pregnant, you may continue to see your non-DHMC provider until your baby is born. Your provider will need to submit a pre-approval. See the Women's Health Care section in this handbook.

Benefits	Covered Services	What is Needed?
Prescription Drugs	Prescription drugs that are on the DHMC formulary are covered. There is no copay to member on any covered DHMC prescription drug. Members may use any Denver Health pharmacy or any other pharmacy that accepts DHMC health plan.	Some prescription drugs are not on the DHMC formulary. Your provider must ask DHMC to pay for a prescription drug when it is not on the DHMC formulary. See the Pharmacy section in this handbook.
Primary and Preventive Care	Covered in full – physicals, health screenings like mammograms, prostate screening, flu shots, etc.	Given by your DHMC PCP
Specialty Care	Special types of care covered by participating providers.	Must be referred by a DHMC PCP. Must be offered by a DHMC specialist. When not offered by DHMC providers, approval is required.
Substance Abuse Care	Limited to medical care of drug effects. Medications to treat this are a covered benefit.	Must be referred by a DHMC PCP. Approval from DHMC is needed.
Tobacco Cessation	Includes all FDA approved prescription medications and over-the-counter tobacco cessation products. Does not include any group or individual counseling services. Group or individual counseling services and all FDA approved prescription medications and OTC products related to tobacco cessation are available for pregnant women as a wraparound benefit.	Medications related to tobacco cessationare provided through a prescription from your PCP. Services provided to pregnant women are a wraparound benefit.
• **Rehabilitation services and devices — Physical, occupational and speech therapies and devices that you need for a short time to help you recover from a serious injury, illness or surgery**	• Speech therapy • Occupational therapy • Physical therapy • Cardiac rehabilitation	Must have DHMC PCP referral. Any therapy done outside of DHMC needs approval.
Vision Therapy	Eye exercises	Referral from a provider needed for adults and children.

Benefits	Covered Services	What is Needed?
Vision Buy Ups	Frames for glasses that cost more than Health First Colorado pays.	You pay the difference between approved glasses and the more costly glasses.
Vision Adult ages 48 and older	Routine exams and eyeglasses. Exams and eyeglasses are covered once every year with a provider.	No provider approval is needed for Denver Health Eye Clinic and other vision service providers in the DHMC Provider Directory.
Vision Adult ages 21 – 47	Regular check-ups and eyeglasses. Exams are covered once every two years with a provider.	No provider approval is needed for Denver Health Eye Clinic and other vision service providers in the DHMC Provider Directory.
Vision Children ages 0 – 20	Routine checks and eyeglasses covered. Contact lenses or vision therapy care services shall be a benefit when needed for care and shall require approval submitted by an eye doctor.	No provider approval is needed for Denver Health Eye Clinic and other vision service providers in the DHMC Provider Directory.

Benefits	There are some things DHMC does not cover, like:
Services Not Covered	• Acupuncture • Ambulatory surgical procedures not listed on the State approved list • Chiropractic Procedures • Cosmetic Surgery • Custodial care in a nursing home • Exercise Programs • Experimental services or pharmaceuticals • Holistic or homeopathic care • Hypnosis • Immunizations related to foreign travel • Infertility services • Personal items like Health club memberships or toothpaste in a nursing home • Physical exams for employment, school, camp, sports, or licensing • Rehabilitation at work

When you have questions about a service being included or excluded, call **Health Plan Services** at **303-602-2116.**

<u>Additional benefits offered by Health First Colorado Administered by Elevate Medicaid Choice</u>

Medical Care

- NO COST or copays for office visits and diagnostic tests. No COST or copays for Emergency/urgent care in network or out of network for children and adults of DHMC.

- NO COST for non-emergency medical transportation. These are rides to and from your clinic visits. See Transportation section of this handbook to learn more.

Eye Care

- Eyeglasses for children and adults at NO COST to you.

Pharmacy

- NO COPAYS for covered prescriptions on the DHMC list.
- NO COST for certain over-the-counter 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 many drugs you take every day, at NO COST to you. See the DHMC list for details.

>> 9) EXTRA SERVICES

Behavioral Health Services

- DHMC partners with Colorado Access to give full health care benefits to members. DHMC handles physical health. Colorado Access handles behavioral health.
- Behavioral and physical health care are both important. You need both to be healthy. Colorado Access can help you with things like mental health or substance use care.
- Elevate Medicaid Choice handles physical health care. They can help you with things like where to get a flu shot or getting a yearly checkup.

Call 800-511-5010 to talk to a Colorado Access care coordinator for behavioral health. They are on hand 8 – 5, Monday through Friday. You can also find their provider directory online at coadirectory.info/search-member.

Basic mental health and substance use care benefits are listed below.

Benefits with a star * may need preapproval.

- Alcohol and drug screening counseling, group counseling by a provider, targeted case management*
- Behavioral health assessment*
- Emergency and crisis services
- Inpatient psychiatric hospital services for a mental health diagnosis*
- Medication-helped care*
- Outpatient day care, nonresidential*
- Pharmacologic management of a patient's medication*
- Psychotherapy family, group or individual*
- School-based mental health services*
- Social ambulatory detoxification*

When you have a mental health or substance use crisis, or you or someone you know is thinking of suicide, and you cannot reach your provider, call Colorado Crisis Services at 844-493-TALK or 844-493-8255. State Relay 711. Or text TALK to 38255*. You can call or text 24 hours a day, every day of the year.

- How to file a Complaint about access to behavioral health care:
  Your health plan is subject to the Mental Health Parity and Addiction Equity Act of 2008. This means that your covered behavioral health benefits cannot be harder to use than physical health benefits. A denial, restriction, or withholding of behavioral health services could be a violation of the parity act. File a complaint with the Behavioral Health Ombudsman Office of Colorado when you have a parity concern.
- Behavioral Health Ombudsman Office of Colorado:
  - Call 303-866-2789
  - Email ombuds@bhoco.org
  - Online bhoco.org
  - An agent of the Ombudsman Office will call or reply to you. You can also ask your behavioral health provider or guardian/legal agent to file a complaint for you.

Transportation

Non-Emergency Medical Transportation (NEMT) is a benefit for all DHMC members. You can use NEMT at no cost to you when you need rides to your health care visits.

Intelliride may need pre-approval before rides can be scheduled. Call Intelliride to find out when your trip needs to be pre-approved. Intelliride is a benefit to anyone who has Health First Colorado.

To set up a ride to your next health care visit, call

Intelliride 1-855-489-4999. Call 48 hours before your visit.

Denver Health Nurse Line

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

You can call the **Denver Health Nurse Line** at **303-739-1261** when:

- You think you need an urgent visit
- You are not sure when you need to see a doctor
- You have questions about medicine or care
- You have health education questions

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

Keep in mind that when you have a health emergency or need care urgently, go to the nearest hospital or urgent care clinic. You do not have to call the Nurse Line before you get emergency or urgent care.

Wrap Around Benefits

Some care is not covered by DHMC but is still a benefit to your through Health First Colorado. This kind of care is called a wraparound benefit. You can be a DHMC member and still get wrap around benefits. Wrap around benefits include:

- Hearing aids, training, testing, and evaluation for children.
- Dental care for children ages 0 to 21.
- Dental care for adults. Diagnostic procedures, preventative procedures, restorative procedures, periodontal care, endodontic care and oral surgery.
- Extra EPSDT Home Health Services. See the EPSDT section in this handbook for more on these and other EPSDT services.
- Some Home and Community-Based, HCBS, services.
- Hospice care – Care that focuses on comfort and support for people in the end stage of life. You may still get all of your other non-hospice care with DHMC, but you may also disenroll from DHMC. You can call **Health First Colorado Enrollment** at **303-839-2120** or toll-free at **1-888-367-6557**.
- Home Health care after 60 days are covered by Health First Colorado. First 60 days are covered by DHMC.

When you have a question, call **Health Plan Services** at **303-602-2116** or toll-free at 1-855-281-2418.

- Some inpatient substance abuse rehab stays.
- Intestinal transplants
- Non-emergency medical transportation. See Transportation section of this handbook.
- Pediatric Behavioral Therapies
- Skilled Nursing Services- 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.
- Some Skilled Nursing Facility services
- Tobacco Cessation - group or individual counseling services and all FDA approved prescription medications and over-the-counter products related to Tobacco Cessation are an option for pregnant women.

When you need any of the care listed above, call **Health First Colorado Enrollment** at **1-800-221-3943** outside of the Denver metro area. A Health First Colorado Enrollment agent will help you get your wrap around benefits. When you would like more facts, visit https://www.healthfirstcolorado.com. You can find the Health First Colorado Member Handbook there too!

>> 10) QUALITY

DHMC 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 when they are happy with DHMC services.
- Looking at member and provider concerns and complaints to improve DHMC services.
- Reminding members about services to keep them healthy.
- Looking at how you get care to see when there are differences by race, ethnicity, or language.

To view the quality program for DHMC, visit https://www.denverhealthmedicalplan.org/medicaid-choice-chp-quality-improvement-program-description. Call Health Plan Services for feedback questions or concerns about our Quality Program. When you have an ethics concern, contact the Values Line by calling 1-800-273-8452. This is a private line and you do not have to give your name.

>> 11) COMPLAINTS

What is a Complaint?

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

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

You can file a complaint at any time when you are not happy. You can send a letter or let us know over the phone.

What to do when you have a Complaint

When you have a complaint, you or your Designated Personal Representative (DPR) can call **Complaint and Appeals** at **303-602-2261**. You or your DPR can also write to Complaint and Appeals. Be sure to add your name and Medicaid ID number (a letter and 6 numbers) found on your card. Also include address and phone number to your letter when you write to DHMC Complaint and Appeals. You may also fill out the Complaint and Appeal form in the back of this handbook and send it in. The member portal has a form you can fill out online.

Send your written complaint to this address
Denver Health Medical Plan, Inc.
Attn Complaint and Appeals Department
777 Bannock St., MC 6000
Denver, CO 80204-4507

You will not lose your Health First Colorado Enrollment benefits by filing a complaint. It is the law!

After You File a Complaint

After you file your complaint, DHMC will send you a letter in two working days to let you know that your complaint was received.

DHMC will look into the facts of your complaint and will decide how to handle it. The DHMC staff members who make decisions on your complaint will not be the same people who you are filing your complaint about. When you file a complaint because you feel you got poor health care or because DHMC denied your expedited appeal request, see the section called “What is an Appeal?” A DHMC staff member with appropriate medical training will look into your complaint.

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

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

When You Need Help Filing a Complaint

When you need help filing a complaint, call **Complaint and Appeals** at **303-602-2261**. We can help you with taking any of the steps to file a complaint. We can also help you fill out any forms linked to your complaint. TTY services and using a translator are choices when you need them.

When You are Still Not Happy With the Result of Your Complaint

When you are still not happy with how DHMP handles your complaint, you can bring your complaint to the Department of Health Care Policy & Financing. The Department of Health Care Policy & Financing's 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 DHMC Medicaid Choice Contract Manager
1570 Grant St.
Denver, CO 80203-1714

>> 12) APPEALS

What is a Notice of Adverse Benefit Determination Letter?

This is a letter that DHMC sends you when DHMC makes an Adverse Benefit Determination for any part of your DHMC care. An Adverse Benefit Determination is:

- When DHMC denies or limits a type or level of care you ask for
- When DHMC reduces, suspends, or stops authorizing care that you have been getting
- When DHMC denies full or a part of payment for your care
- When DHMC does not give you care in a timely manner
- When DHMC does not solve your appeal or complaint in the required timeframes
- The denial of your request to dispute your cost for health care

A Notice of Adverse Benefit Determination Letter includes:

- The Adverse Benefit Determination that DHMC plans to take
- The reason for the Adverse Benefit Determination
- Your right to appeal this Adverse Benefit Determination
- The date when you need to appeal by
- Your right to ask for a State fair hearing
- How to ask for a State fair hearing
- When you can ask to speed up the appeal process
- How to keep getting services while the appeal or State fair hearing is being decided
- When you might have to pay for those services you got while a final ruling is pending; and
- An explanation that you have the right to be given, upon request and for free, reasonable access to and copies of all documents, records, and other facts relevant to your adverse benefit determination.

Advance Notice of Adverse Benefit Determination

DHMC must let you know about an Adverse Benefit Determination before the action happens. When DHMC plans to stop paying for or reducing any services you have been getting, we have to send you a Notice of Adverse Benefit Determination letter ten calendar days before the date we stops paying for or reducing services.

DHMC can shorten the timeframe to five calendar days when:

- There is fraud

DHMP must give notice by the date of the adverse benefit determination when:

- 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 new address
- The member has moved out of state or outside the service area
- The member has become eligible for Medicaid benefits out of state
- The member's doctor orders a change in the level of care
- The notice involves an adverse determination about preadmission screening requirements
- You must be discharged or transferred to another facility quickly
- The adverse benefit determination is a denial of payment.

What is an Appeal?

An appeal is a request that you or your DPR can make to review an Adverse Benefit Determination taken by DHMC. When you think an Adverse Benefit Determination taken by DHMC 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 when you make them your DPR. When you are not happy after your appeal decisions, then you can ask for a State Fair Hearing after you have done all the proper steps in the DHMC appeal process. This hearing is explained under the State Fair Hearing section in this handbook.

How to File an Appeal

You have sixty calendar days to file an appeal after you get a notice of Adverse Benefit Determination letter. When you want DHMC to keep paying for your care during the appeal process, you must file your appeal sooner. See the section called **Continuation of Benefits During an Appeal or State Fair Hearing** for more facts.

To appeal an Adverse Benefit Determination you may:

- Call **DHMC Complaints and Appeals** at **303-602-2261**, TTY users should call 711.
- Fill out the Complaint and Appeal form in the back of this handbook and fax to **303-602-2078** or mail to **DHMC Complaint and Appeals, 777 Bannock St., MC 6000, Denver, CO 80204.**

Filing an Expedited Appeal

You can ask for an expedited appeal when your life or health is in danger. When you need DHMC to make a decision on your appeal right away, you can call **DHMC Complaint and Appeals** at **303-602-2261**. When DHMC approves your request for an expedited appeal, DHMC will make a decision on your appeal as quickly as your health condition requires, but no later than 72 hours from the receipt of your request.

When DHMC denies your request for an expedited appeal, DHMC will call you to let you know your request was denied. DHMC will also send you a letter in 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 complaint when you are not happy with DHMC's decision.

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

After You File an Appeal

After you file an appeal, DHMC will send you a letter in two working days. The letter will let you know your appeal was received. If you file an expedited appeal, DHMC may not send a letter.

DHMC will look into the details of your appeal. We will decide to accept your appeal or deny your appeal. DHMC will use different complaint and appeal department members to review this action. When you appeal

an Adverse Benefit Determination that uses the reason lack of medical necessity, a DHMC staff member will review with a health professional to make a decision on your appeal. DHMC will provide the case file to you or your representative, including medical records, other documents, and records, and any new or additional documents considered, relied on, or generated by DHMC in connection with the appeal. These facts will be provided free of charge and sufficiently in advance of the appeal resolution time frame, upon request.

At any time during the appeal process, you or your DPR may give DHMC i any evidence or other facts to help your case. This can be in person or in writing. Note that when your appeal is expedited, you have a shorter amount of time to give DHMC these fact. 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 facts that DHMC is using to decide on your appeal.

For standard appeals, DHMC will decide and send you written notice of the decision no later than ten working days from the receipt of your standard appeal. For expedited appeals, DHMC will decide and send you written notice of the decision no later than 72 hours from the receipt of your expedited appeal. DHMC will also try to notify you of the decision over the phone for expedited appeals.

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

- Your right to ask for a State fair hearing and how to ask for one
- Your right to ask DHMC to continue your services while the State fair hearing is pending and how to make that request

Extending Appeal Timeframes

You or DHMC can extend the time limit for a decision on your appeal. When you ask for more days or when DHMC believes that more facts are needed to make a decision on your appeal, DHMC may add fourteen more calendar days. DHMC will only extend this time limit when it is in your best interest. DHMC will send you a written notice when more time is needed. This notice will include our reason for needing more time. This written notice will also explain that you have the right to file a complaint when you do not agree with DHMC's decision to extend the time limit. During the extended time limit, DHMC will make a decision. DHMC will send you written notice of the decision by the end of the extension time limit.

Getting Help Filing an Appeal

To get help filing your appeal, you can:

- Call **DHMC Complaints and Appeals** at **303-602-2261**; TTY call 711.
- Call the **Health First Colorado Ombudsman** at **303-830-3560** or **1-877-435-7123**.

You will not lose your Health First Colorado benefits when you appeal an Adverse Benefit Determination. It is the law!

State Fair Hearing

When you are not happy with an action that DHMC takes, you MUST go through the appeal rules explained above. At any time in 120 calendar days after you get a Notice of Appeal Determination Letter, you or your DPR have the choice to ask for an Administrative Law Judge to review an action taken by DHMC. Your provider can also ask for a review when you make them your DPR. This review is called a State Fair Hearing. You may ask for a State Fair Hearing when:

- Health care you seek is denied or the ruling to approve health care is not acted upon in a timely way
- You believe the action taken is wrong.

To ask for a State Fair Hearing, you, your DPR, or your provider must send a letter to the Office of Administrative Courts. The letter should have:

- Your name, address, and Medicaid ID number (a letter and 6 numbers)
- The action, denial, or failure to act quickly on which the appeal is based.
- The reason for appealing the action, denial, or failure to act quickly.

At the hearing, you can represent yourself or use a provider, legal guide, a relative, a friend, or other person. You or your representative will have a chance to show evidence to the Administrative Law Judge to support your case. You or your representative may also ask for records that are about your appeal.

When you would like someone else to represent you, you must fill out the State Fair Hearing 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 120 calendar days from the notice of appeal resolution to request a State Fair Hearing

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

When you need help asking for a State fair hearing, DHMC will help you. Call **DHMC Complaints 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 fair hearing is final.

Continuation of Benefits During an Appeal or State Fair Hearing

In some cases, DHMC will keep paying for care while you wait for the ruling of an appeal or State fair hearing. DHMC will keep paying for your care while you wait for a ruling when:

- You file your appeal in ten calendar days from the date on your notice of Adverse Benefit Determination letter or by the effective date of DHMC's action.
- Your appeal involves ending, pausing, or getting less of an authorized course of care
- The care you are getting is from an authorized provider; and
- Your original authorization timeframe on your care is not expired.

- You ask to continue your benefits in 10 calendar days of DHMP sending the notice of adverse benefit determination on or before the intended effective date of the date DHMP's proposed adverse benefit determination.

Again, you must still call **DHMC Complaints and Appeals** at **303-602-2261** and tell them that you want DHMC to keep covering your care. Your care will keep going until

- You decide to cancel your appeal
- Ten calendar days after the ruling of your appeal unless, in those 10 days, you ask for a State fair hearing with continuation of services until the State fair hearing ruling is reached
- The State fair hearing office rules that DHMC does not have to pay for your care; or
- The time limit on your original service authorization is up.

When DHMC or the State fair hearing office decides to approve your appeal or the State fair hearing reverses the decision to deny your care and you were getting a continuation of services while your appeal or State fair hearing was pending, DHMC will pay for that care. When DHMC or the State fair hearing office comes to a ruling that they do not agree with your appeal, you do not have to pay for that care. When DHMC or the State fair hearing office decides to approve your appeal or the State fair hearing reverses the decision to deny your care, and you were not getting a continuation of services while your appeal or State fair hearing was pending, DHMC will authorize or provide that care as quickly as your health condition needs but no later than 72 hours from the date of reversing the adverse benefit determination.

Health First Colorado Ombudsman

The Ombudsman is set apart from all of the Health First Colorado health care plans. When you have a problem or concern, the Ombudsman will work with you. They will work with your doctor or health plan to find an answer that works for everyone.

When you are Health First Colorado member (this includes DHMC)and have a problem with a Denver Health Provider or with your Mental Health Provider:

- First talk with your doctor or with **DHMC Health Plan Services** by calling **303-602-2116**. Often this will help.
- You can also call the **Ombudsman for Health First Colorado Managed Care**:

  Metro area 303-830-3560

  Out of metro area 1-877-435-7123

Call the Ombudsman Program when:

- You cannot get a visit or have to wait too long for a visit.
- You cannot see a specialist.
- You are not happy with care for you or a family member.
- Your health plan denied a service.
- You need help filing a complaint, complaint, or appeal.
- You are not sure whom to call.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families™

Recommendations for Preventive Pediatric Health Care
Bright Futures/American Academy of Pediatrics

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest variations from normal.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of infants, Children, and Adolescents.* 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017)

	INFANCY								EARLY CHILDHOOD						
AGE[1]	**Prenatal**[2]	**Newborn**[3]	**3-5 d**[4]	**By 1 mo**	**2 mo**	**4 mo**	**6 mo**	**9 mo**	**12 mo**	**15 mo**	**18 mo**	**24 mo**	**30 mo**	**3 y**	**4 y**
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS															
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●			
Weight for Length		●	●	●	●	●	●	●	●	●	●				
Body Mass Index[5]												●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●
SENSORY SCREENING															
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●
Hearing		●[8]	●[9] →			★	★	★	★	★	★	★	★	★	●
DEVELOPMENTAL/BEHAVIORAL HEALTH															
Developmental Screening[11]								●			●		●		
Autism Spectrum Disorder Screening[12]											●	●			
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●
Psychosocial/Behavioral Assessment[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[14]															
Depression Screening[15]															
Maternal Depression Screening[16]				●	●	●	●								
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]															
Newborn Blood		●[19]	●[20] →												
Newborn Bilirubin[21]		●													
Critical Congenital Heart Defect[22]		●													
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★
Tuberculosis[27]				★			★		★			★		★	★
Dyslipidemia[28]												★			★
Sexually Transmitted Infections[29]															
HIV[30]															
Cervical Dysplasia[31]															
ORAL HEALTH[32]							●[33]	●[33]	★		★	★	★	★	★
Fluoride Varnish[34]							←				●				
Fluoride Supplementation[35]							★	★	★		★	★	★	★	★
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

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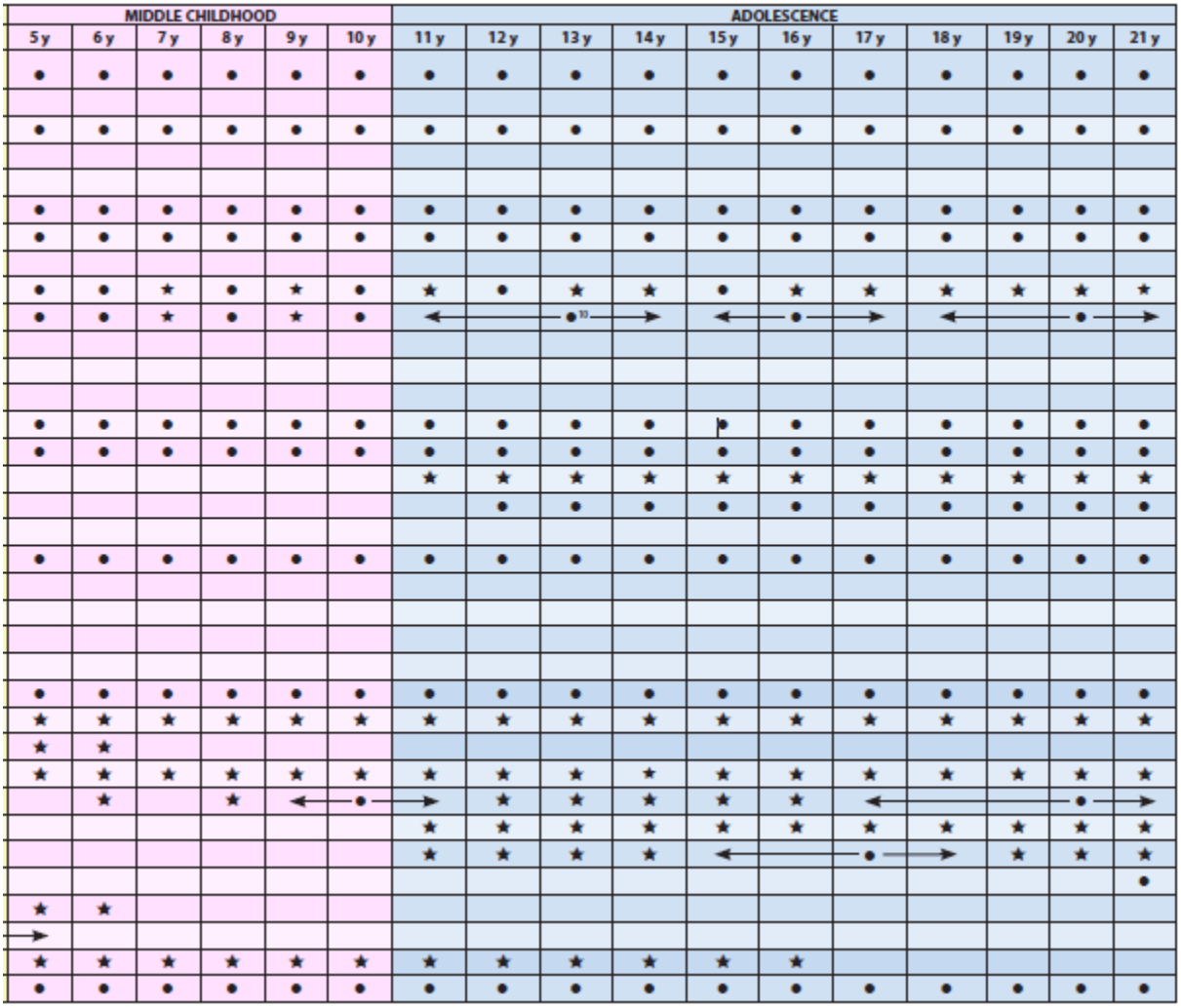
Recommendations for Preventive Pediatric Health Care
Bright Futures/American Academy of Pediatrics (Cont'd)

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.



For more facts on the Periodicity Schedule, visit https://www.aap.org/en-us/professional-resources/practice-transformation/managing-patients/Pages/Periodicity-Schedule.aspx