DENVER HEALTH MEDICAL PLAN INC.

CHP+

MEMBER HANDBOOK
MANUAL PARA MIEMBROS

CO HCPF CHP+ Child Health Plan Plus

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

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BIG PRINT OR OTHER LANGUAGES

If you have questions about this handbook, we can help you for free. We can also give it to you in other formats like big print, audio or in other languages. Call 303-602-2100, toll free 1-800-700-8140, 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 303-602-2100, sin costo al

1-800-700-8140 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 Line:

- To make an appointment for a DHMP provider: 303-436-4949
- Stride Community Health Center: 303-762-6554 or stridechc.org

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

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

To refill your prescriptions at a Denver Health Pharmacy:

- Prescription Refill Service: 303-436-4488

To check the status of your authorization request:

- DHMP Pharmacy Department: 303-602-2070

Colorado's CHP+ Eligibility and Enrollment:

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

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

To get info on State Reviews:

- Office of Administrative Courts: 303-866-2000

Other phone numbers:

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

>> WELCOME TO DHMP!

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

We are happy you have chosen Denver Health Medical Plan, Inc. (DHMP) under Child Health Plan Plus (CHP+). CHP+ is a low-cost health plan program for Colorado children under age 19. Also available for pregnant women of any age. CHP+ is for children and pregnant women that cannot afford private health insurance.

DHMP is a health maintenance organization (HMO) that manages care for members of CHP+ through the Denver Health network. We are also your health plan. A **health plan** is a group of doctors, hospitals and other providers. They work together to get you the care you need. To have DHMP coverage, you must live in Denver, Jefferson, Adams or Arapahoe County. When you move and need to update your address, call your local county Department of Health & Human Services (DHHS) or Colorado Medical Assistance Program at 1-800-359-1991. At DHMP, our main concern is that you or your child gets the proper medical care. When you would like to get more details on the structure and operation of DHMP, call **Health Plan Services** at **303-602-2100**.

Watch our New Member Orientation video. The video has info about the services and benefits that are offered to you through your CHP+ plan. You will find the video at denverhealthmedicalplan.org/chp-plan-details.

Watch this video to learn about Denver Health appointment center. Learn how to connect with your doctor virtually and how to use MyChart.

This member handbook does not give detailed info about DHMP providers. Use the DHMP Provider Directory to get a list of care providers that work for DHMP and Stride Community Health Center: stridechc.org/locations. The Provider Directory shows info like names, locations, the languages the provider speaks and types of doctors. You can find the provider directory at denverhealthmedicalplan.org – look for 'Find a Provider' in the blue navigation bar. When you would like a hard copy, call Health Plan Services to request one at 303-602-2100. Your request will be provided in 5 business days.

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

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

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

This handbook, and all other member info, is available in other languages. It can be made into Braille, big print, or audio files. Call **Health Plan Services** at **303-602-2100** when you need this handbook or any other member info in a different language or form. There is no cost to you.

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

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

MyDHMP Member Portal

The MyDHMP member portal 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. See CHP+ Plan Details to learn more about the member portal.

Here are some benefits the portal can offer:

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

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 an appointment, request prescription refills and more, go to MyChart.Denverhealth.org**, the** Denver Health patient portal.

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

Your DHMP ID Card

Take your DHMP ID card with you when:

- You see your provider
- You pick up medicine at the Pharmacy
- You get any health services.

If you lose your ID card, call Health Plan Services to ask for a new one. The new card will come in the mail in a few weeks.

As a DHMP member, you should:

- Read this Member handbook.
- Call your Primary Care Provider, (PCP) whenever you or your child needs care.
- Keep appointments with your PCP and other providers.
- Give honest info about your health when asked by your PCP or the DHMP staff.
- Work willingly with your PCP.
- Use the DHMP network providers for services outside of the PCP's office.

As your health plan, we promise to:

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

ELEVATE CHILD HEALTH PLAN *PLUS*

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

CHP+ Child Health Plan Plus

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

MedImpact
RxBIN: 003585
RxPCN: ASPROD1
RxGrp: DHM03
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:	303-602-2100
Toll Free:	800-700-8140
TTY Users:	711
NurseLine:	303-739-1261

Pharmacy Providers

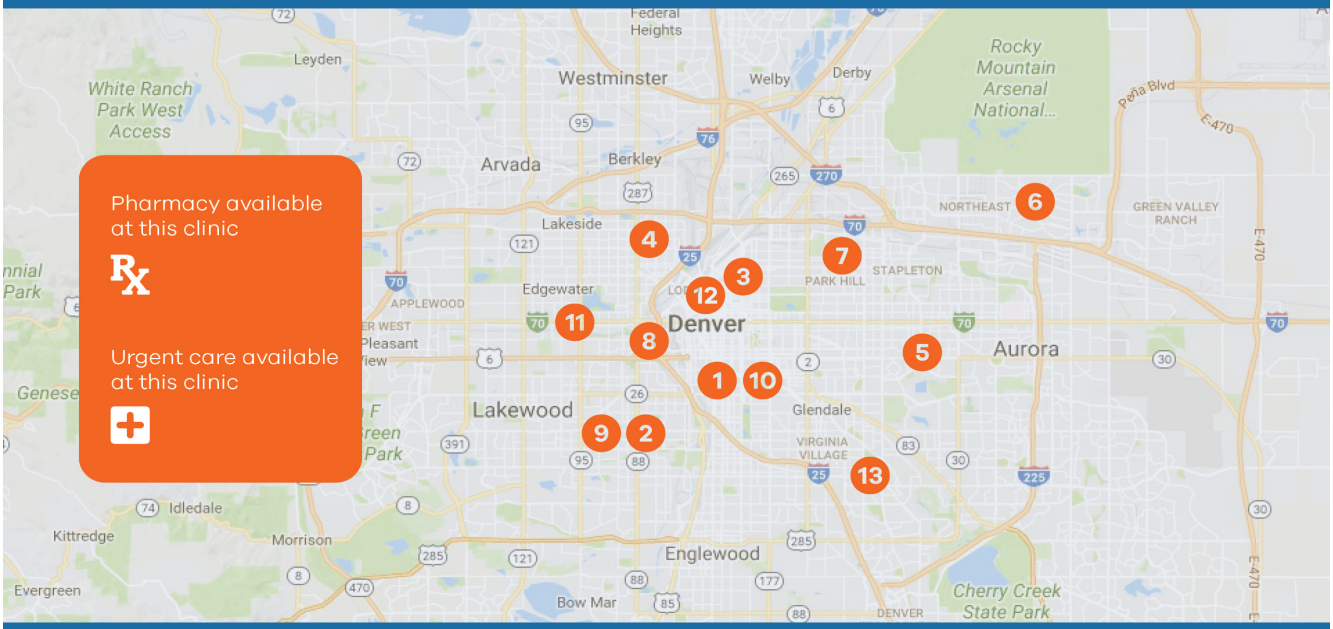
Rx Help Desk/Auths:	303-602-2070
MedImpact Help Desk:	800-788-2949

ELEVATE CHILD HEALTH PLAN *PLUS*
Denver Health Medical Plan Inc.

Paper Claims: Denver Health Medical Plan, Inc.
P.O. Box 6300 | Columbia, MD 21045 | EDI Payor ID #84135

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 Bernard F. 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 Sam 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.

13 Denver Health Southeast Medical Center
6360 E Evans Ave.

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

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

>> 1) HOW YOUR PLAN WORKS

How to get info about providers

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

What is a PCP?

Your **primary care provider (PCP)** is a doctor or Nurse Practitioner (NP) who helps you get and stay healthy. Your PCP works with nurses, physician assistants (PA's) and social workers in the clinic or office. Your PCP is your main contact for all your care. Your PCP can answer your health questions and help you get the care you need.

Why is your PCP important?

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

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

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

Prenatal Care Program members may choose an OB/GYN as their primary care provider. Your PCP helps you get the care you need. They provide a wide range of care services like:

- Checkups
- Sick visits
- Shots
- Initial diagnosis and care
- Health supervision
- Management of chronic conditions
- Referrals to specialist when you need one
- Ensuring continuity of care

Choosing or changing your DHMP PCP

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

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

You can change your 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.

Getting an approval or referral to see a specialist

You need a referral from your PCP to see some types of specialists. A **specialist** is a provider who works in one area of medicine, like a surgeon. A referral is a request made by your PCP (Primary Care Physician) to DHMP (Denver Health Medical Plan). A referral seeks approval for your visit to a specialist. The Utilization Management department will carefully assess the referral and make a determination to either approve or deny it.

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

You do not need a pre-approval:

- For a routine eye exam with a DHMP eye provider.
- To see a Denver Health OB/GYN, a provider who treats only women for reproductive reasons, for yearly exams.
- For family planning services or family planning providers.
- For emergency or urgent care, in or outside of DHMP.
- Outpatient mental health services – you may self-refer for these services to an in-network provider. Covered services include:
    - Individual counseling
    - Family counseling
    - Group counseling
    - Case management services
- For emergency services for mental health or drug use. You are responsible for ensuring that DHMP has been notified of emergency admission.

Call Health Plan Services to get more info on pre-approvals.

When your benefits, provider or services change

DHMP will tell you in writing when there is ever a significant change to any of these:

- Your disenrollment rights
- Provider info
- Your rights and protections
- Complaint, appeal, and State Review processes
- Benefits available to you through DHMP

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

- Benefits available to you that are not through DHMP
- How to get your benefits, including pre-approval requirements and family planning benefits
- Emergency, urgent and post-stabilization care services
- Pre-approvals for specialty care
- Cost sharing

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

Enrolling and Disenrolling

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

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

Presumptive Eligibility

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

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

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

You, or DHMP, can request to disenroll from DHMP at any time for these reasons:

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

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

- You are no longer a permanent resident in the DHMP service area.
- You have been living outside of the DHMP service area for 90 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 besides CHP+.
- You are in a Medicare plan or other health plan that is not a DHMP plan.
- Child welfare eligibility status.
- Upon the member's death.
- You knowingly give DHMP incorrect or incomplete info about yourself, and this info affects your enrollment status.
- Any other reason given by DHMP that HCPF agrees with.

Your provider can request to disenroll you from DHMP for any of these reasons:

- You keep missing appointments 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 DHMP. They are listed as your Member Responsibilities in this handbook
- You are abusive to your providers, other DHMP staff, or other DHMP members.

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

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

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

Open Enrollment

The 90 days before the end of your eligibility period is called your Open Enrollment period. You can switch from DHMP to a different health plan for any reason during this time.
A reminder letter is sent out when you are in your Open Enrollment period. During this time, you can choose to stay in DHMP or choose a different health plan.

When Are You Not Able to be a DHMP Member?

You are not able to get services through DHMP when:

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

Other Health plan:

Being eligible for CHP+ depends on you not having any other health plan. Indigent Care and the Health Care Program for Children with Special Needs, HCP do not count as a health plan. When you are covered by any other valid health plan, you will no longer be eligible for CHP+.

When you get any other health plan, you must tell DHMP. You can find forms online on the CHP+ Plan details web page. You can ask for a form to be sent to you by calling **Health Plan Services**. When a DHMP member is found to have another health plan, their DHMP coverage might be ended. The exceptions to have double coverage are Medicare and dental health plans.

Renewals: What You Need to Know

The Renewal Process:

Check to see if you still qualify for Child Health Plan Plus (CHP+).

Some members will be automatically renewed. This is based on existing information. Others will need to complete the renewal process.

If You Are Auto-Renewed:

You will receive a letter several weeks before your renewal deadline. The letter will confirm that your health coverage has been renewed.

After renewal, you may also get a letter to verify if your income information is correct. You must respond to this letter to continue your coverage.

If You Are Not Auto-Renewed:

You must complete the renewal process. It determines if you still qualify for Health First Colorado or CHP+.

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

A renewal packet will be sent to you by mail. Also, it is available online at CO.gov/PEAK about 60-70 days before your renewal deadline.

You will receive notifications about your renewal through mail or if you opted for electronic notifications, via email, text message, and push notifications on the Health First Colorado app.

You need to complete, sign, and return the renewal packet to your local county human services department by the deadline. This can be done by mail, in person, online at CO.gov/PEAK, or through the Health First Colorado app.

How Will I Know When My Renewal Is Due?

Health First Colorado will notify you several weeks before your renewal due date with a renewal packet sent by mail or to your email. Check your PEAK mailbox for details.

If you use the Health First Colorado app and have opted in for push notifications, you will receive a notification when it's time to take action.

Ways to Complete and Return the Renewal Packet:

- Online: Fill out the renewal form at CO.gov/PEAK or through the Health First Colorado app.
- In Person: Submit the packet at your local county human services office.
- By Mail or Fax: Send the signed renewal packet to your county human services department.

To find a provider, follow these steps:

- Go to the Denver Health Medical Plan website.
- Navigate to the Elevate Child Health Plan Plus (CHP+) Members section.
- Click on the FIND A PROVIDER link located on the top right of the page.
- Once you're in the provider search section, select your plan.
    - To search for an optometry provider, choose "Optometry" under the specialty options.

Medical Bills:

DHMP pays for all your covered benefits. You should never get a bill from a provider when the service is a DHMP covered benefit. You may have to pay for a service when it is not covered. You may have to pay when you get the service from a non-participating provider. A **non-participating provider** is a provider, facility or supplier that does not give care services and products to health plan members. You should not get a bill from a provider outside of DHMP providers network if you got a pre-approval first. See Getting an Approval to see a Specialist for more info. Call Health Plan Services if you get a bill from a provider.

Protect Yourself and CHP+ from Fraud

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

Examples of Member Fraud

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

Examples of Provider Fraud

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

You can help fight fraud too!

When you get 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 info.

When 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 go to some providers or specialists without pre-approval from DHMP and your PCP
- When you get 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 deciding when a service or provider is covered by DHMP, call Health Plan Services.

Physician Incentive Plans

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

DHMP does not compensate, reward, or incent, financially or otherwise, associates for inappropriate restrictions of care. We do not promote or otherwise provide an incentive to employees or provider reviewers for withholding benefit for approval for medically necessary services to which you are entitled. Utilization review and benefit coverage decisions are based on proper care and service. We do not design, calculate, award, or permit financial or other incentives based on;

- the frequency of denials of authorization for coverage
- reductions, or limitations on hospital lengths of stay
- medical services or charges
- telephone calls or other contacts with care providers or members

When Another Party Causes Your Injuries or Illness

Your injuries or illness for which you get care may be caused by another party. The party who caused your injury or illness, liable party, could be;

- another driver
- your employer
- a store
- a restaurant
- someone else

When another party causes your injury or illness, you agree that:

- DHMP may collect the cost of your care benefits directly from the liable party or the liable party's health plan company.
- In 30 days of becoming ill or suffering an injury caused by a liable party, you must inform DHMP that your injury or illness was caused by a liable party and: You have 30 days to let DHMP know that you injury or illness was caused by a liable party. The 30 days start the day you become ill or suffer the injury and:
    - You must give DHMP the name of the liable party and the liable party's health plan company.
    - You must give DHMP the name of any attorney or law firm you hired to seek damages from the liable party.
- You must direct your attorney to notify the liable party's health plan company that:
    - DHMP has paid, and/or is in the process of paying, your medical bills.
    - The liable party's health plan company must contact DHMP to discuss reimbursing DHMP.
    - The liable party's health plan company must pay back DHMP before you get paid. Payment to you first means you or your attorney or may be liable for the care costs.
        - When you do not have an attorney, you must notify the liable party's health plan company of the above three things.
- You will not and you will not permit your attorney to make an agreement with the liable party's health plan company that does not provide for full payment to DHMP.

- You will not and you will not permit your lawyer to collect money from the liable party's health plan company until DHMP is paid in full. You must do so even when the money to be paid is referred to as damages for pain and suffering, lost wages, or other damages.
- When the liable party's health plan company pays you or your attorney before reimbursing DHMP, you or your attorney must reimburse DHMP up to the total cost of your care. DHMP is not required to and will not pay your attorney any attorney's fees or costs for collecting the money.
- DHMP has a lien on any money owed to you by the liable party's health plan company, or that has already been paid to you or your attorney.
- DHMP may notify other parties of the lien.
- DHMP, in accordance with applicable law, may give the liable party's health plan company and your attorney your DHMP records necessary for collection.
- You must sign whatever documents are needed to allow DHMP to provide your records to the liable party's health plan company, your attorney and to help DHMP in collecting the money owed.
- You or you must direct your attorney to cooperate with DHMP in collecting the money owed by providing info requested about your potential or actual health care bill against the liable party.
- You or you must direct your attorney to notify DHMP of any dealings with, or lawsuits against, the liable party and the liable party's health plan company.
- You and/or your attorney must not do anything to harm the DHMP
- You must not hinder the ability to collect reimbursement from the liable party's health plan company.
- You must reimburse DHMP any money it is unable to collect from the liable party's health plan company as a result of you or your lawyer's, lack of help or interference with DHMP's efforts to collect reimbursement.
- You must pay any attorney's fees and costs DHMP pays to collect reimbursement from you.
- DHMP will not and is not required to pay any medical bills that should have been paid by a liable party or a liable party's health plan company.
- You must follow the rules and directions of the liable party's health plan company when necessary to have your medical bills paid. DHMP will not and is not required to pay any medical bills the liable party's health plan company did not pay because you did not follow their directions or rules.
- When you or your attorney interfere with or do not help DHMP in collecting reimbursement, DHMP may request you be disenrolled from DHMP for cause and enrolled in the state run CHP+ program.

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

<u>Using a Designated Personal Representative (DPR):</u>

You can choose someone to be in charge of your medical care. This is a Designated Personal Representative (DPR). You can make a friend, family member, a provider, or any other person your DPR. A DPR looks after your interests when you cannot make care decisions for yourself. You must tell DHMP in writing if you choose a DPR. The DPR's name, address and a phone number, and both member's and DPR's signature must be

included in the letter so DHMP knows who to call when needed. You can call Health Plan Services to ask for a copy.

Privacy

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

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

Text Messages and Automated Communications

By providing a mobile telephone number to Denver Health Medical Plan (DHMP), you consent to receive text messages from DHMP, and its service providers acting on DHMP's behalf, at that number. These messages may be delivered via SMS or other comparable text-based messaging platforms, may be sent using an automated telephone dialing system, and may include messages related to quality improvement activities, member experience, or satisfaction surveys.

Consent to receive text messages is not a condition of enrollment, eligibility, or receipt of benefits. Message frequency may vary. Standard message and data rates may apply.

You may opt out of receiving text messages at any time by replying STOP to any text message you receive. After opting out, you will no longer receive text messages from that service, except as permitted by law. You may also contact DHMP using the contact information on the back of your ID card to manage your communication preferences.

DHMP will only send text messages to mobile numbers that you have provided to us, or through other applicable application portals, and will use text messaging in accordance with applicable federal and state law and our privacy practices.

Advanced Directives

Advance directives are written instructions to those caring for you. It tells 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 if you become so ill or hurt that you cannot speak for yourself. Your PCP or health plan can tell you more and give you an advance directives form.

Being on the Member Advisory Committee

The DHMP Member Advisory Committee is a group of DHMP staff, members and other community health workers. They meet regularly to talk about the DHMP Plan. When you join the DHMP Member Advisory Committee, you help us change DHMP for the better. Do you want to help make your health plan better? Do you have some ideas about how DHMP should change? Or do you just want to share your experiences with DHMP staff? We want to hear everything you have to say. Call **Health Plan Services** at

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

303-602-2100 if you wish to be part of the DHMP Member Advisory Council or leave us a review. We value your feedback.

DHMP Member Newsletter

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

Requesting the Quality Assessment and Improvement Plan

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

>> 2) YOUR RIGHTS AND RESPONSIBILITIES

Your Rights

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

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

- To be treated with respect and with consideration to your dignity and privacy.
- To get info about all of the care options and alternatives for your health condition in a way that makes sense to you.
- To participate in decisions regarding your care, including the right to say no.
- To get a second opinion. This means having another provider review your case at no cost to you. DHMP will arrange a second opinion with an out-of-network provider if a DHMP provider is not available.
- To make an Advance Directive.
- To get detailed info about Advance Directives from your provider and to be told up front when your provider cannot follow your Advance Directives because of their beliefs.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. This means that DHMP providers and staff cannot hold you against your will to punish you, get you to do something they want, or get back at you for something you have done.
- To get services from providers in the DHMP appointment standards timeframes in this handbook.
- To see providers who make you comfortable and who meet your cultural needs.

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

- To use any hospital or other facility for emergency and urgent care services. Emergency and urgent care services do not require pre-approval or referral.
- To get care services outside of the Denver Health Network if you are not able to get them in the Denver Health Network. DHMP must approve non-emergency and non-urgent care services first.
- To request and receive a copy of your medical records, and request that they be changed or corrected.
- To file a Complaint, appeal or ask for a State Review.
- To join the DHMP Member Advisory Committee.
- To get complete benefit info from DHMP. This info includes covered services, how to get all types of care like emergency care, detailed info about providers and your disenrollment rights.
- To use your rights above, without fear of being treated poorly by DHMP.
- To be provided with care services in accordance with requirements for access, coverage and coordination of medically necessary services.
- To freely exercise your rights. Using those rights will not affect the way DHMP, its network providers, or the State Medicaid agency treats you.
- You cannot be balance billed.
    - If you get care that is covered by your health plan, even from an out-of-network provider approved by the plan, you should not receive a bill for the remaining balance after your plan pays.
    - If a provider tries to bill you, call health plan services right away.

Your Responsibilities

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

As a DHMP member, you are also responsible for:

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

>> 3) HOW TO GET CARE

Emergency Care

An **emergency** is when 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 service you get from an emergency room provider 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 care services when you go to the hospital for an emergency health problem. An emergency is when you believe that by not getting care right away it could result in:

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

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

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

Call Health Plan Services as soon as possible when you or your child is admitted to the hospital for an emergency situation.

When you need care after hours you can call the **Denver Health NurseLine** at **303-739-1261**. The nurse can help you decide if you need to see a provider, go to the emergency room or give you health advice when you are not sure what to do.

Urgent Care

Sometimes you need urgent care**. 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 NurseLine** at **303-739-1261**. This line can connect you to a DHMP nurse 24 hours a day, 7 days a week. The DHMP nurse can help you decide when you should go to the emergency room or urgent care center.
- Virtual Urgent Care is now available for all Denver Health MyChart users. It's easy and convenient to get the urgent care you need from the comfort of your home, using your smartphone, tablet or computer. contact Denver Health Hospital Authority. 303-436-6000 for further help and details.

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

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

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

Post-Stabilization Care

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

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

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

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

- A DHMP provider who also works at the non-Denver Health hospital takes responsibility for your care;
- The provider at the non-Denver Health hospital tells DHMP you are healthy enough to be transferred, so you are transferred to Denver Health hospital and a DHMP provider takes care of you;
- DHMP and the provider at the non-Denver Health hospital reach an agreement on how to handle your 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, DHMP will work to safely bring you to Denver Health hospital. Your care will still be covered by DHMP when you get transferred to Denver Health hospital. If you refuse this transfer, you will have to pay for the rest of the care you get at the non-Denver Health hospital. You will not be charged any more than what DHMP would charge for services provided by DHMP.

Preventive Care and Routine Care

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

Making an Appointment

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

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

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

Pharmacy

If 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, like you have other health insurance, call us and we can help you verify who is primary and who is secondary. Your PCP may order you a prescription drug. **Prescription drugs** are medicines or drugs your doctor orders for you. They treat or prevent a condition or illness. In order for DHMP to pay for your prescription, you must bring your DHMP ID card with you when you go to the pharmacy. When your Denver Health provider writes you a prescription, you can fill it at any of the Denver Health Pharmacies listed below:

Denver Health Refill Request and Central Pharmacy Call Line: 303-436-4488

Webb Center for Primary Care Pharmacy
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 Pharmacy
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 denverhealth.org/services/pharmacy.

You may also take your prescriptions to any other pharmacy that accepts DHMP health plan. Some pharmacies outside of Denver Health take DHMP health plan, like King Soopers, Safeway, Rite-Aid, Walmart and Walgreens. You can go online to denverhealthmedicalplan.org and log into the MyDHMP member portal to find a pharmacy near you.

You may call the phone number on your bottle to order a refill. When you use Denver Health Pharmacies you may order a refill by calling the **Refill Request Line** at **303-436-4488** or by using the MyChart smart phone app. You should always order your refills at least five working days before you run out of your prescription. 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.

When you have questions or need help with your prescriptions outside of the normal business hours, 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 DHMP medical records.

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

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

These include drugs for:

- Cosmetic use. 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. Viagra, Cialis, Levitra etc.
- 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 (CDC) only for travel outside of the United States. Covered vaccines are listed in the formulary.

Pharmacy by Mail

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

Medications that are covered are $0. You do not need to keep a credit card on file when you only want to have covered medications 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.

Outpatient Pharmacy can mail out controlled medications and deliver specialty medications. To refill Pharmacy by Mail prescriptions, call the Refill Request Line at 303-436-4488.

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

- Click the Formulary/Drug List link to see the list of covered drugs. 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 (PAR)/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 member ID to log in to:
    - Search the formulary 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 **303-602-2100** or **1-800-700-8140**. TTY users should call 711.

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

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

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

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

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

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

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

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

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

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

>> 5) WOMEN'S CARE

Family Planning

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

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

Seeing an OB/GYN (Obstetrics and Gynecology):

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

Pregnancy Care

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

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

How to Sign Your Newborn Up for DHMP

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

Adult Members in the Prenatal Care Program

Newborn children of women who are approved for the CHP+ Prenatal Care Program are automatically covered under CHP+ for 12 months from the date of birth. Contact CHP+ Eligibility and Enrollment at 800-359-1991 to enroll your baby. After you have your baby, you could be eligible for CHP+ coverage still. Mothers in the CHP+ Prenatal program may get up to 12 months of coverage after their baby is born. Call CHP+ Enrollment at 800-359-1991 to report your pregnancy and when you have your baby.

>> 6) CHILDREN'S CARE

Early Intervention Services (EIS):

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

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

For more info about EIS, contact **1-888-777-4041** or visit eicolorado.org.

Recommended Child Check-ups with Your PCP

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

DHMP recommends the following check-ups and screenings:

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

Childhood and Adolescent Immunizations

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

Schedule for Immunizations:

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

Pediatric and Adolescent Immunizations

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

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

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

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

See the Schedule for Immunizations table in this handbook for more info on shots.

>> 7) SPECIAL CARE PROGRAMS

DHMP 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. Things like high blood pressure or asthma.
- Health problems that require you to use special devices like wheelchairs or oxygen tanks.
- Health problems that seriously limit your emotional, physical, or learning activities.

Call the Care Management team at 303-602-2184 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 Care Needs

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

When you are in your 2nd or 3rd trimester of your pregnancy and you are a new DHMP member, you may keep seeing your current OB/GYN through your completion of care up to delivery, even when your OB/GYN is outside of the DHMP network. When you have an out of network provider, they will need to submit a pre-approval for services and should contact Health Plan Service for more info. You will have 90 days from enrollment date to request to disenroll and join another Managed Care Organization plan if you wish to do so.

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

medical equipment (DME) — 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. **Home health care** — Skilled nursing services, certified nurse aide (CNA) services physical therapy, occupational therapy, and speech/language pathology services given in your home by a licensed and certified home health agency.

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

When you have a special health condition that requires you to see a specialist, you will need a pre-approval for a certain number of visits to see the specialist or use this doctor as your PCP.

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

Care Management Services

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

- Our **Blood Pressure Program** focuses on improving blood pressure control through education, support, monitoring, and appointment coordination.
- Our **Diabetes Program** is designed to help the health of members with diabetes through education and support, better engagement with 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 CHP+ 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 (DHHA) 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.
- 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 Condition 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 can call at 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 care, but who may not fall into other programs in Care Management. Services include:

- Applications/membership support
- Community resource support
- Disease management
- Education
- Health needs assessment
- Medication management
- Care provider coordination
- Help with getting rides to provider visits
- Appointment 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 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 place.

Utilization Management gets referral requests from your doctor. We make sure the referral is a covered benefit. We make sure the care is medically necessary. You must have a pre-approval when you get care outside of the Denver Health Network. Some care inside the Denver Health Network needs a pre-approval.

Here are some things that require pre-approval: home health care, durable medical equipment (DME), and all care not done at a Denver Health facility. See the section, Your DHMP Benefits in this handbook to find a list of services that require pre-approval. Your provider will work with Utilization Management to get a pre-approval when it is needed.

When you have questions about care, pre-approval, or a decision we made, you can call Health Plan Services. You can also file an appeal when you do not agree with a referral decision that Utilization Management makes about your referral. See the What is an Appeal? Section in this handbook for more info.

You can call Health Plan Services when you want to know what info DHMP uses when making decisions or how we make sure that you are getting quality care.

Medically Necessary

In this handbook, you may see the terms 'medically necessary' or needed for care. This term will be used when discussing the benefits that will be covered under this plan. When a service is not medically necessary, such as cosmetic surgery, DHMP will not cover the cost. **Medically necessary services** include any covered program, product or service that is delivered in the most appropriate setting required by your 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:

- 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 to not include:
    - Care that is 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

Clinical Practice Guidelines

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

To view more info on Clinical Practice Guidelines you may find it at: denverhealthmedicalplan.org/quality-improvement-program. You can also request to get a copy of any of these guidelines for free by calling Health Plan Services

>> 8) YOUR DHMP BENEFITS

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

PART A TYPE OF COVERAGE

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

PART B SUMMARY OF BENEFITS

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

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

WHAT CARE AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. List of exclusions available immediately upon request or in the Member Handbook. Review them to see if a service or care you need may be excluded from the policy.
COPAYS. This is a fixed amount you pay when you get a covered care service.	No copay for all covered services

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

	× Restoring teeth, mouth or jaws from biting or chewing × Restorations that are not medically necessary × Inpatient or outpatient dental services, except the situation described above × Upper or lower jaw augmentation or reduction × Artificial implanted devices and bone graft for denture wear × Temporomandibular (TMJ) joint therapy or surgery unless it has a medical basis
Doula Benefit	DHMP members can now get doula benefits. A doula is a trained helper. They give physical, emotional, and information support to a pregnant person. They do this before, during, and after childbirth. They help families have the best birth experience.
Early Intervention Services	No copay. 100% covered Early Intervention Services, or EIS, are services that give support to children who have special developmental needs. See the Early Intervention Services section in this handbook for more info. The following are some services offered unlimited through EIS for children ages 0-3: ✓ Physical Therapy ✓ Speech Therapy ✓ Occupational Therapy Otherwise, up to 30 visits per calendar year per diagnosis
Emergency, Urgent and After-Hours Care Services	No copay. 100% covered. No pre-approval needed in-network or out-of-network. See the Emergency and Urgent Care sections in this handbook for more info about these services.
Family Planning/reproductive Health	No copay. 100% covered. No pre-approval or referral for any provider regardless of whether they are in-network or not. This could be a PCP or OB/GYN. ✓ Injection of Depo-Provera for birth control purposes ✓ Fitting of a diaphragm or cervical cap ✓ Surgical implantation and removal of an implantable contraceptive device ✓ Fitting, inserting or removing Intrauterine Device (IUD) ✓ Tests to diagnose a possible genetic illness/disease ✓ STI (Sexually Transmitted Infections) and HIV testing and care ***Not-Covered Services*** × Surgical sterilization. For example, tubal ligation or vasectomy and related services × Reversal of sterilization procedures × Over-the-counter contraceptive products such as condoms and spermicide × Preconception, paternity, or court-ordered genetic counseling and testing. For example, tests to determine the sex or physical characteristics of an unborn child.
Food and Nutrition Services	No copay. 100% covered. An in-network licensed therapist has to provide the nutrition services. All services must be pre-approved.

	✓ Enteral therapy and Parenteral Nutrition (TPN) – these services are usually provided through a home health agency ✓ Medical foods for home use for inherited enzymatic disorders involved in the metabolism of amino, organic and fatty acids ✓ Diabetic nutrition counseling ✓ Nutritional services in hospice care – nutritional assessment, counseling and feeding as determined medically necessary ✓ Formulas for metabolic disorders ✓ Nutritional assessment and therapy when medically necessary ✓ Feeding appliances and feeding evaluations that are necessary where normal food intake is not possible ✓ Obesity/overweight nutritional assessment ✓ Human breast milk when required for survival of infant Any equipment related to Nutrition Services will be subject to the DME limit. See Medical Equipment and Supplies section in this table. ***Not-Covered Services*** × Tube feeding, enteral feeding or any type of food or meals that are not medically necessary or for the reasons provided above × Weight loss, exercise or gym programs × Baby formula, except for metabolic disorders × Feeding clinics
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 and associated risks and benefits have been discussed ✓ The Member has given informed consent for the service ✓ Subject to the exceptions in C.R.S. § 13-22-103, if 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

	✓ If under 18 years of age, demonstrates the emotional and cognitive maturity required to understand the potential impacts of the care Other Gender-Affirming Hormone Therapy requirements include: ✓ Prior to beginning gender-affirming hormone therapy, a licensed 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 ✓ Understands 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

	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 ✓ Subject to the exceptions in C.R.S. § 13-22-103, if 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, 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, • Understands the potential effect of the gender-affirming surgery on fertility
Health Education	No copay. 100% covered. Health education provided by your child's PCP is covered. This may include info on achieving and keeping physical and mental health and avoiding illness and injury. Your child's doctor may ask age-appropriate questions during your child's health visit. This will help the PCP decide on topics to talk about during your child's health education discussion. Maternal Care education is also provided in our Women's Clinic.
Hearing Care Services	No copay. 100% covered. ✓ Age-appropriate hearing screenings for preventive care ✓ Newborn hearing screening and follow-up for failed screen ✓ Hearing aids, when medically necessary
Home Health Care	No copay. 100% covered. Pre-approval required. This benefit applies to home health and home infusion therapy (IV therapy) and includes all services, supplies and/or therapies that are medically needed for care due to illness or injury. Prior hospitalization is not required.

	All services have to be ordered by your PCP or another provider from the DHMP network. DHMP must approve all services and may review care plans for home health at any time. Services include, but are not limited to: ✓ Nursing services ✓ Physical, Occupational, Respiratory, and Speech and other therapies ✓ Medical supplies, including respiratory supplies. Durable medical equipment for rental or purchase, oxygen, appliance, prostheses, and orthopedic appliances. ✓ Intravenous (IV) medications and other prescription medications that are not ordinarily available through a retail pharmacy ✓ Nutritional services for certain disorders. See Food and Nutrition Services section. ***Not-Covered Services*** × Custodial care × Care that is provided by a nurse that normally lives in the member's home or that is an immediate family member of the patient × Services or supplies for personal comfort or convenience × Food services, meals or formulas not medically needed for approved disorders × Religious or spiritual counseling
Hospice Care- Care that focuses on comfort and support for people in the end stage of life	No copay. 100% covered. Pre-approval required. This includes all services, supplies and/or therapies that are medically needed for care. ✓ Provider visits ✓ Skilled nursing and licensed nursing. 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. ✓ Physical, Occupational, Respiratory, and Speech and other therapies ✓ Nutritional services for certain disorders. See Food and Nutrition Services section. ✓ Respite care provided for up to five continuous days for every 60 days of hospice care To be eligible for home or inpatient hospice benefits, the member must have a life expectancy of six months or less, as certified by the attending physician. DHMP initially approves hospice care for three months. Once this period has been exhausted, DHMP will work with your PCP and the hospice provider to determine if continuing hospice care is appropriate. DHMP may review care plans for home health at any time. ***Not-Covered Services*** × Food services, meals or formulas not medically needed for approved disorders × Services or supplies for personal comfort or convenience × Private duty nursing × Religious or spiritual counseling × Grief counseling for family members outside of hospice care

Human Organ and Tissue Transplant Services	No copay. 100% covered. Limited coverage. Coverage is available for transplant services that are medically necessary and that are not experimental procedures. All transplants must be performed at approved transplant facilities. Services are covered based on standards established by the medical community and DHMP; and are only provided with a referral from your PCP. A member is eligible for the covered services contained in this section if the following guidelines are met: • All transplant services must be performed at a hospital chosen and approved by DHMP • DHMP and the approved hospital have to determine that the member is a candidate for these services • All transplants must be pre-approved; DHMP will make the decision to approve the service or not • When transplant services are needed because of an emergency, the services can be performed without pre-approval. DHMP must be notified in one business day after admission ***Covered Transplants. When pre-authorized by DHMP*** ✓ Heart ✓ Lung, single or double. For end stage pulmonary disease only ✓ Heart-Lung ✓ Kidney ✓ Kidney-Pancreas ✓ Liver ✓ Bone marrow for a member with Hodgkin's disease, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II or III breast cancer or Wiskott-Aldrich syndrome ✓ Peripheral bone stem cell for the same procedures listed under bone marrow ✓ Cornea ***Covered Services. Hospital, Medical, Surgical, Other.*** ✓ Room and board for semi-private room, unless a private room is medically necessary ✓ Services, supplies, medications, therapies needed; this includes operating services. Only one complete surgical procedure is covered at a time; many surgical procedures cannot be performed at once. ✓ Anesthesia ✓ Care provided in a special care unit ✓ Inpatient and/or outpatient services ✓ Medical care, monitoring or consultation by more than one physician, if medically necessary ✓ Home, office and other outpatient medical care visits for check-up and care of the member ✓ Evaluation, surgical removal, transport of the donor organ or tissue ✓ Transport costs to and from the hospital for the person getting the transplant and for one adult. See Travel and Lodging below.

	Donor Covered Services • Donor means a person who donates, or gives, a human organ or human tissue for transplantation. When a donor provides this to a member, the following will be true: • When the recipient is a DHMP member or when both the recipient and the donor are DHMP members, both the donor and the recipient will be covered for all of the covered services listed in this section • The donor benefits are limited to those that are not available to the donor from any other source • When the donor is a DHMP member and the recipient is not a DHMP member, benefits will not be provided for the donor or recipient expenses ***Travel and Lodging*** If the member must temporarily move to receive a covered transplant, coverage is available for travel to the city where the transplant will be performed. This benefit will also cover reasonable lodging expenses for the member and one adult. These expenses are limited to a lifetime maximum $10,000 per transplant. Lodging cannot be over $100 per day. Travel costs for the donor do not apply towards the member's lifetime traveling expense limit, but it does apply to the overall maximum lifetime benefit for transplants. ***Maximum Lifetime Benefit*** Coverage for all covered organ transplants and all transplant-related services (including travel, lodging and donor expenses and procurement) is limited to a maximum lifetime benefit for major organ transplants of $1,000,000 per member. Amounts applied to the maximum lifetime benefit include all covered charges for transplant-related services, care and supplies received during the transplant benefit period – the benefit period is up to five days before or in one year after the transplant. Exception: Pre-transplant evaluations may be received more than five days before the transplant and may be considered transplant-related services. The pre-transplant evaluation does not cover travel expenses and does count towards the maximum lifetime benefit. When a member receives a covered transplant under DHMP and later requires another transplant of the same type, the covered charges for the new transplant are applied to the remaining maximum lifetime benefit available to the member. Payments for the transplant benefit are not applied to other specific benefit maximums. Expenses for covered transplant-related services that are over the maximum lifetime benefit for organ transplants are not payable under this or any other benefit in this handbook. ***Not-Covered Services*** × Services performed at a hospital that was not approved by DHMP × Services performed if the hospital that DHMP has approved determines that the member is not a suitable transplant candidate. × Services for donor searching or tissue matching, or any expenses related to this. × Experimental or investigational transplants, or any services related to this.

	× Transplants of organs/tissues other than the ones listed in this section as covered. × Services and supplies related to artificial and/or mechanical hearts or ventricular and/or atrial help devices
Inpatient Facility Services. Hospital and Surgical Services.	No copy. 100% covered. Pre-approval required. Inpatient services are services that you get when you stay in a hospital for one day or more. Inpatient services are covered when they are pre-approved or if you need them due to an emergency. This includes all services and/or supplies that are medically needed for care of your condition and include, but are not limited to: ✓ Semi-private room, board, and general nursing services; includes room in a special care unit approved by DHMP ✓ Physician, clinician and surgical services ✓ Any medical supplies, medication and/or care medically necessary; this includes charges for anesthesia ✓ Rehabilitation medically needed to bring back or better lost functions after illness or injury; 30-day limit per calendar year and have to be received in six months of the date of illness or injury ✓ Consultation for second opinion ✓ Chemotherapy and radiation services ✓ Reconstructive surgery is only covered when medically necessary or when after a mastectomy (removal of one or both breasts) ***Not-Covered Services*** × Private room expenses, unless one is medically necessary. × Admissions related to non-covered services or procedures × Nursing home services × Procedures to correct further illness or injury resulting from a member not following ordered medical care × Facility room and board charges for the day of discharge
Lab, X-rays and Other Imaging Services	No copy. 100% covered. Lab, X-ray and other imaging services are covered when they are needed to diagnose or monitor a symptom, disease or condition. No approval required if performed at Denver Health facility. If care is out of network, approval is required. These services include, but are not limited to: ✓ X-ray and other radiology services ✓ Lab and pathology services ✓ Ultrasound for non-pregnancy-related conditions. See Maternity and Newborn Care in this table for info about pregnancy ultrasounds ✓ Allergy tests direct skin and patch allergy tests and RAST tests, charges for allergy serum ✓ Hearing and vision tests required for diagnosis and/or care of an injury or illness ***Not-Covered Services*** × Lab, X-ray or any other imaging service related to a service that is not covered.

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

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

	You can self-refer for these outpatient behavioral health services: individual, family, or group counseling and case management to providers in our contracted network. Any care with a provider outside of our contracted network requires preapproval. ✓ Outpatient mental health services, which are services you get outside of a hospital or residential facility. Covered outpatient care does not require pre-approval when the provider is in-network with DHMP. Covered services include but are not limited to: Individual, family, group counseling and case management services. ✓ Biologically based mental illness care is covered and is no less extensive than the coverage provided for any other physical illness ✓ Coverage is also for non-biologically based conditions identified as a mental disorder ✓ All Inpatient admissions for mental health conditions at Denver Health Hospital are covered without pre-approval. Any inpatient stay not occurring at Denver Health Hospital requires pre-approval and review. Inpatient is valid for semi-private room, group psychotherapy, medication management, ancillary services and provider visits. ✓ Residential care (you will be staying 24 hours a day) needs pre-approval by DHMP. You must need 24-hour supervision to qualify for this level of care. ✓ Outpatient substance abuse care and services is considered a mental health condition for the purpose of this benefit and is covered ✓ Substance abuse detoxication services ***Not-Covered Services*** × Private room expenses × Biofeedback × Psychoanalysis or psychotherapy that a member may use towards getting a degree or furthering their education × Applied Behavioral Analysis (ABA) therapy × Hypnotherapy × Religious, marital, and social counseling × Residential care services for anorexia nervosa or bulimia nervosa × Therapies or programs not medically necessary × Cost of damage to facilities caused by member × Court or police-ordered care that would otherwise not be covered. × Services not authorized by DHMP × Autism related care
Physician Routine Medical Office Visits	No copay. 100% covered for providers in network. Office visits are covered for both PCP and specialists. You should see your PCP for all services, unless you have a separate OB/GYN, are getting vision services or have a referral to a specialist. Referrals are needed for visits with most specialists. Benefits include: ✓ Medical care, consultations and second opinions. Second opinions require a referral from your PCP; DHMP may request a second opinion in certain cases.

	✓ Office-based surgical services, include anesthesia and supplies. Subject to pre-approval guidelines. ✓ Kidney dialysis is considered a benefit as a medical office visit ***Not-Covered Services*** × Expenses for obtaining medical reports or transfer of files × Care of hair loss except when caused by alopecia areata × Routine foot care. Except for members with diabetes. × Care for sexual dysfunction × Infertility services × Genetic Counseling
Outpatient/Ambulatory Facility Services	No copay. 100% covered. Pre-approval required if not done at Denver Health. Outpatient services are services that you receive and get to leave that same day. You can get these services at facilities like an acute hospital outpatient department, ambulatory surgery center, radiology center, dialysis center and outpatient clinics. The benefit includes all services and/or supplies that are medically needed for care of your condition and include, but are not limited to: ✓ Physician, clinician and surgical services ✓ Any medical supplies, medication and/or care medically necessary; this includes charges for anesthesia ✓ Chemotherapy and radiation services ✓ Consultations for second opinions ***Not-Covered Services*** × See Inpatient Facility Services not-covered services in this table and General Exclusions section
Outpatient Therapy Services	No copay. 100% covered. Outpatient rehabilitation therapies include: ✓ Physical therapy ✓ Speech therapy ✓ Occupation therapy ✓ Cardiac rehabilitation programs ✓ **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. Maximum benefit is 30 visits per calendar year per diagnosis. When medically necessary, additional services can be provided with a pre-approval. There is no limit for these therapies for children from birth up to the child's third birthday. There is no limit for speech therapies to treat cleft lip or cleft palate. Services must be received six months from the date the injury or illness occurred. ***Not-Covered Services*** × Maintenance therapy or care provided after you have reached your rehabilitative potential as determined by DHMP

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

	<table><tr><td>9 months</td><td></td><td></td><td>18 years</td></tr></table> See the Recommended Child Check-ups section in this handbook for more info about preventive care for your child. ***Family Planning Services*** The following services are covered for family planning: ✓ Birth control, including injection of Depo-Provera ✓ Fitting for a diaphragm or cervical cap ✓ Surgical implantation or removal of NORPLANT device ✓ Tests to diagnose possible genetic illness ✓ STD/HIV testing and care ***Not-Covered Services*** × Immunizations for international travel × Surgical sterilization or any related services × Court-ordered testing or counseling
Skilled Nursing Facility Care	No copay. 100% covered. Pre-approval required. These are therapies and protective supervision for patients who have uncontrolled, unstable, or chronic conditions. Coverage for medically necessary skilled nursing facility provided only if there is a reasonable expectation of measurable improvement in the member's health status. ✓ 100 days of skilled nursing facility services per calendar year or until maximum medical improvement is reached ***Not-Covered Services*** × Custodial or maintenance care × Skilled nursing care once member has reached maximum medical improvement and no more improvement is expected
Vision Services	Limited Coverage. Covered vision services include ✓ Age-appropriate vision screening and routine eye exam or vision screenings to diagnose a medical condition ✓ One (1) routine eye exam per member, per calendar year ✓ One (1) pair of eyeglasses (frames and lenses) per member, per calendar year ✓ Contact lenses when medically necessary ✓ Replacement of eyeglasses or contact lenses when lost, damaged, or when there is a change in prescription (limited to one replacement per year) ✓ Specialty vision services with a pre-approval from the member's PCP. Eye exams must be received from a DHMP participating provider. Eyewear can be purchased from any vision provider who can bill DHMP. To find a provider, follow these steps: Go to the Denver Health Medical Plan website. Navigate to the Elevate Child Health Plan Plus (CHP+) Members section. Click on the FIND A PROVIDER link located on the top right of the page. Once you're in the provider search section, select your plan.

	To search for an optometry provider, choose "Optometry" under the specialty options. ***Not-Covered Services*** × Vision therapy × Specialty services without a pre-approval × Services related to any procedure designed to correct vision. Lasik.
General Exclusions	The following list of exclusions is not a complete list of all services, supplies, conditions, or situations that are not covered services. Other specific limitations, conditions and exclusions may also apply. **REMEMBER** • You may be billed for services that are not covered. Even when you receive a referral from your PCP, services will not be covered when the service is an exclusion or not a covered benefit. • When the service is not covered, then all services performed in conjunction with that service are not covered. • CHP+ HMO is the final authority for determining when services and supplies are medically necessary for the purpose of payment. ***Not-Covered Services*** × Acupuncture × Alternative or complementary medicines. Holistic medicine, homeopathy, hypnosis, reike therapy, and aromatherapy are examples of alternative medicine. × Adoption or surrogate expenses × Artificial conception × Applied Behavioral Analysis (ABA Therapy) × Before effective date. No coverage for services received before the member's effective date of coverage. × Biofeedback × Chelating agents, unless it is used for heavy metal poisoning. × Chiropractic services × Chronic Pain × Clinical research × Convalescent care, unless the care is normally received for a specific condition × Convenience, luxury, deluxe services, or equipment. This includes services that are used for member's comfort or convenience and are not medically necessary. × Cosmetic services. Face lifts, botox and breast augmentation are examples of cosmetic procedures. × Court-ordered services rendered under parole or probation, unless those series would otherwise be covered under the benefits section of the handbook. × Custodial care. This includes helping the member in daily living activities or in meeting personal rather than medical needs, meal preparation and help with bathing are examples of custodial care. × Dental services. See Dental Care section on this table. × Discharge against medical advice at a hospital or other facility services if you leave a hospital or other facility against the medical advice of your provider.

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

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

Additional benefits offered by Denver Health Medical Plan

Medical Care

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

Eye Care

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

Pharmacy

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

>> 9) EXTRA SERVICES

Denver Health NurseLine

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

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

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

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

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

Dental

Routine dental is a covered benefit through DentaQuest. For questions on this benefit, contact DentaQuest directly at 1-888-307-6561.

>> 10) QUALITY

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

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

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

>> 11) COMPLAINTS

What is a Complaint?

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

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

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

What to do when you have a Complaint

When you have a Complaint, you or your Designated Personal Representative (DPR) can call Complaint & Appeals at 303-602-2261. You or your DPR can also write to Complaint and Appeals. Be sure to include your name, CHP+ identification (ID) number, address and phone number in your letter when you write to DHMP Complaint and Appeals.

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

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

After You File a Complaint

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

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

DHMP 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 DHMP's decision on your Complaint and the date DHMP made that decision.

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

When You Need Help Filing a Complaint

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

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

If you are still unhappy with how DHMP handles your Complaint, you can bring your Complaint to the Department of Health Care Policy & Financing. You can call them at **1-800-221-3943** for free. Or you can write them at:

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

When You Need to File a Complaint About Access to Behavioral Care:

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

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

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

>> 12) APPEALS

What is a Notice of Adverse Benefit Determination Letter?

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

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

A Notice of Adverse Benefit Determination Letter Includes:

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

Advance Notice of Adverse Benefit Determination:

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

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

What is an Appeal?

An appeal is a request that you or your DPR can make to review an Adverse Benefit Determination taken by DHMP. When you think an Adverse Benefit Determination taken by DHMP is not right, you or your DPR can call or write us to appeal the Adverse Benefit Determination. A provider may file an appeal for you when you make them your DPR. If you are still unhappy after your appeal decision, then you can ask for a State Review after you have completed all the proper steps in the DHMP appeal process. This hearing is explained under the State Review section in this handbook.

How to File an Appeal

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

To appeal an Adverse Benefit Determination you may:

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

Filing a Quick Appeal

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

When DHMP denies your request for a quick appeal, DHMP will call you as soon as possible to let you know your request was denied. DHMP 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 unhappy with DHMP's decision.

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

After You File an Appeal

After you file an appeal, DHMP will send you a letter in two working days to let you know your appeal was received.

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

At any time during the appeal process, you or your DPR may provide DHMP, in person or in writing, any evidence or other info to help your case. Note that when your appeal is quick, you have a shorter amount of time to give DHMP this info. 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 info that DHMP is using to decide on your appeal. The info will be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.

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

The written notice will tell you the outcome of DHMP'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 info on:

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

Extending Appeal Timeframes

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

Getting Help Filing an Appeal

To get help filing your appeal, you can:

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

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

State Review

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

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

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

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

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

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

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

When you need help requesting a State Review, DHMP will help you. Just call **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 Review is final.

Notice of Non-Discrimination

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

The Company

- Provides free aids and services to people with disabilities to communicate effectively with us, such as
    - Qualified sign language interpreters
    - Written info in other formats. Big print, audio, accessible electronic formats, other formats.
- Provides free language services to people whose primary language is not English, such as
    - Qualified interpreters
    - Info written in other languages

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

When you believe that the Company failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, health status, or need for care services, you can file a Complaint with the Company's Complaint and Appeal Department at Mailing address 777 Bannock St, Denver, CO 80204. MC 6000., Denver, CO 80204, telephone 303-602-2261. You can file a Complaint by mail or telephone. When you need help filing a Complaint, the Complaint and Appeal Specialist is available to help you.

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

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

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

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

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

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

주의: 한국어를사용하시는경우, 언어지원서비스를무료로이용하실수있습니다.

1-800-700-8140 (TTY: 711) 번으로전화해주십시오.

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

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

لحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم
(رقم هاتف الصم والبكم :711). 1-800-700-8140

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

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

ध्यानदिनुहोस्: तपाईंलेनेपालीबोल्नुहुन्छभनेतपाईंकोनिम्तिभाषासह
यतासेवाहरूनिःशुल्करूपमाउपलब्धछ।फोनगर्नुहोस् 1-800-700-8140 (टिटिवाइ: 711)

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

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

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

1-800-700-8140 هجوت: سراف نابزهبرگ ایوف تگگینکمی ست،دینابزتالهیگاتررو صبیابرنایفامش
گ بسامتی (TTY: 711)

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

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

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

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