Schedule of Benefits (Who Pays What)

Prior authorization may be required for some services. Please refer to the prior authorization list, which can be found on our website at denverhealthmedicalplan.org/medical-prior-authorization-list. For questions about prior authorization, call Health Plan Services at 303-602-2090 or toll-free at 1-855-823-8872 (TTY users call 711).

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

	Elevate Health Plans Network	Out-of-Network
Annual Deductible		
Individual	$6,950 per individual.	Not applicable.
Family	$13,900 per family. All individual deductible amounts will count toward the family deductible; an individual will not have to pay more than the individual deductible amount.	Not applicable.
Annual Out-of-Pocket Maximum		
Individual	$7,100 per individual.	Not applicable.
Family	$14,200 per family. The out-of-pocket maximum includes the annual deductible, coinsurance, and copays. It does not include monthly premium amounts. All individual out-of-pocket amounts will count toward the family out-of-pocket maximum; an individual will not have to pay more than the individual out-of-pocket maximum.	Not applicable.
Lifetime Maximum		
	No lifetime maximum.	Not applicable.
Covered Providers		
	See online provider directory for a complete list of current providers: https://www.denverhealthmedicalplan.org/find-doctor.	Not applicable.
Office Visits		
Primary Care Visit	50% coinsurance after deductible per visit.	Not covered.
Specialist Visit	50% coinsurance after deductible per visit.	Not covered.
Preventive Services		
Children & Adults	No copayment (100% covered). This applies to all preventive services with an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF). Includes annual well visit, well woman exams, well baby care, prenatal visits, preventive colonoscopy and mammogram. See USPSTF list on our website at: https://www.denverhealthmedicalplan.org/member-resource-quick-links.	Not covered.

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

1. Schedule of Benefits (Who Pays What)

Maternity		
Prenatal and Postnatal Care	Visits considered preventive are $0. PCP cost sharing may apply for additional services, after deductible.	Not covered.
Delivery	50% coinsurance after deductible per admission.	Not covered.
Prescription Drugs		
Denver Health Pharmacies *Prescriptions filled at Denver Health pharmacies must be written by a Denver Health physician.* *For drugs on our approved formulary list, call Health Plan Services at 303-602-2090 or visit our website at www.denverhealthmedicalplan.org/welcome-elevate-exchange.* *Drugs listed in the formulary as Medical Service Drugs (Tier 6) will have applicable out-of-pocket amounts according to the plan's medical benefit.*	Denver Health Pharmacy (30-day supply) Preventive (Tier 1): 0% coinsurance Generic (Tier 2): 50% coinsurance after deductible Preferred Brand (Tier 3): 50% coinsurance after deductible Non-Preferred Brand/Preferred Specialty (Tier 4): 50% coinsurance after deductible Specialty (Tier 5): 50% coinsurance after deductible Denver Health Pharmacy by Mail (90-day supply) Preventive (Tier 1): 0% coinsurance Generic (Tier 2): 50% coinsurance after deductible Preferred Brand (Tier 3): 50% coinsurance after deductible Non-Preferred Brand/Preferred Specialty (Tier 4): 50% coinsurance after deductible Specialty (Tier 5): N/A	Not covered.
National Network Pharmacies *Drugs listed in the formulary as Medical Service Drugs (Tier 6) will have applicable out-of-pocket amounts according to the plan's medical benefit.*	National Network Pharmacy (30-day supply) Preventive (Tier 1): 0% coinsurance Generic (Tier 2): 50% coinsurance after deductible Preferred Brand (Tier 3): 50% coinsurance after deductible Non-Preferred Brand/Preferred Specialty (Tier 4): 50% coinsurance after deductible Specialty (Tier 5): 50% coinsurance after deductible National Network Pharmacy (90-day supply) Preventive (Tier 1): 0% coinsurance Generic (Tier 2): 50% coinsurance after deductible Preferred Brand (Tier 3): 50% coinsurance after deductible Non-Preferred Brand/Preferred Specialty (Tier 4): 50% coinsurance after deductible Specialty (Tier 5): N/A	Not covered.
Hospital & Facility Services		
Inpatient Hospital	50% coinsurance after deductible per hospital stay.	Not covered.
Outpatient/Ambulatory Surgery	50% coinsurance after deductible per visit.	Not covered.
Emergency Room Services	50% coinsurance after deductible per visit.	50% coinsurance after deductible per visit.
Emergency Transportation	50% coinsurance after deductible per transport.	50% coinsurance after deductible per transport.

1. Schedule of Benefits (Who Pays What)

Urgent Care Center	50% coinsurance after deductible per visit.	50% coinsurance after deductible per visit.
Diagnostic Laboratory and Radiology		
Laboratory, X-Ray, and CT Scans	50% coinsurance after deductible.	Not covered.
MRI and PET Scans	50% coinsurance after deductible.	Not covered.
Other Diagnostic and Therapeutic Services		
Sleep Study	50% coinsurance after deductible per visit.	Not covered.
Radiation Therapy	50% coinsurance after deductible per visit.	Not covered.
Infusion Therapy (includes chemotherapy)	50% coinsurance after deductible per visit.	Not covered.
Injections	50% coinsurance after deductible per visit (Immunizations, allergy shots, and any other injections given by a nurse are $0 copay).	Not covered.
Renal Dialysis	50% coinsurance after deductible per visit.	Not covered.
Behavioral Health, Mental Health, Substance Use Disorder		
Mental Health Wellness Exam	No charge. One visit per year.	Not covered.
Outpatient	50% coinsurance after deductible No charge.	Not covered.
Inpatient	50% coinsurance after deductible per admission.	Not covered.
Therapies		
Rehabilitative: Physical, Occupational and Speech Therapy	50% coinsurance after deductible per visit. 30 visits of therapy per calendar year. Additional visits may be covered if medically necessary.	Not covered.
Habilitative: Physical, Occupational and Speech Therapy	50% coinsurance after deductible per visit. 30 visits of therapy per calendar year. Additional visits may be covered if medically necessary.	Not covered.
Inpatient Rehabilitation	50% coinsurance after deductible. 60 days per condition per year.	Not covered.
Pulmonary Rehabilitation	50% coinsurance after deductible per visit. 30 visit limit per calendar year.	Not covered.
Cardiac Rehabilitation	50% coinsurance after deductible per visit. 30 visit limit per calendar year.	Not covered.
Durable Medical Equipment		
	50% coinsurance after deductible.	Not covered.

1. Schedule of Benefits (Who Pays What)

Hearing Exams and Hearing Aids		
Hearing Exams	Routine hearing exams are covered are covered at 100% to age 19.	Not covered.
Hearing Aids	Children under the age of 18 are covered at 100%, no maximum benefit applies. Hearing screenings and fittings for hearing aids are covered under office visits and the applicable copayment applies. Cochlear implants are covered for children under age 18. The device is covered at 100%, applicable inpatient/outpatient surgery charges will apply.	Not covered.
Prosthetics		
	20% coinsurance after deductible; no maximum benefit.	Not covered.
Oxygen/Oxygen Equipment		
Oxygen	100% covered.	Not covered.
Equipment	50% coinsurance after deductible; no maximum benefit.	Not covered.
Organ Transplants		
	50% coinsurance after deductible per admission. Only covered at authorized facilities. Coverage is no less extensive than for other physical illnesses.	Not covered.
Home Health Care		
	50% coinsurance after deductible for prescribed, medically necessary skilled home health services.	Not covered.
Hospice Care		
	50% coinsurance after deductible.	Not covered.
Skilled Nursing Facility		
	50% coinsurance after deductible. Maximum benefit is 100 days per calendar year at an authorized facility.	Not covered.
Dental Care		
Adults 19 and over	Not covered.	Not covered.
Children 18 and under	Not covered.	Not covered.

1. Schedule of Benefits (Who Pays What)

Vision Care		
Adults 19 and over	Not covered.	Not covered.
Children 18 and under	Covered at 100%. One pair of eyeglasses (includes the frame and lenses) or contacts at $0 cost sharing every 24 months from an in-network provider. Limit of one routine eye exam per 12 months.	Not covered.
Chiropractic		
	50% coinsurance after deductible per visit. Maximum 20 visits per calendar year.	Not covered.
Acupuncture		
	50% coinsurance after deductible per visit, up to six (6) visits per year	Not covered.

ELEVATE HEALTH PLANS
Denver Health Medical Plan Inc.™

Peak HEALTH ALLIANCE

January 2025

The information contained in this Member Handbook explains the administration of the benefits of Denver Health Medical Plan (DHMP). Elevate Health Plans is a health insurance plan offered by Denver Health Medical Plan, Inc., a state-licensed health maintenance organization (HMO). This Member Handbook is also considered your Evidence of Coverage (EOC) document. Information regarding the administration of DHMP benefits can also be obtained through marketing materials, by contacting the Health Plan Services Department at 303-602-2090 or toll-free at 1-855-823-8872 and on our website at denverhealthmedicalplan.org. In the event of a conflict between the terms and conditions of this Member Handbook and any supplements to it and any other materials provided by DHMP, the terms and conditions of this Member Handbook and its supplements will control.

Coverage as described in this Member Handbook commences January 1, 2025 and ends December 31, 2025.

Contact Us

Health Plan Services 303-602-2090 • TTY 711 • Fax 303-602-2138
Monday through Friday • 8 a.m. - 5 p.m.

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

MedImpact Pharmacy 800-788-2949 • Fax 858-790-7100

- Pharmacy prior authorizations (medications that are not covered

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

- Medication cost
- Pharmacy claim rejections questions
- Medication safety

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

Online Member Portal

Visit our Denver Health Medical Plan, Inc. member portal, your go-to resource for managing your health insurance plan any time, any place. With it, you can access important information, member materials (including ID Cards), communicate with your health plan, check a claim status and more — all right from your desktop, tablet or smartphone.

Sign up today - visit denverhealthmedicalplan.org to get started!

Table of Contents

Eligibility

Elevate Health Plans is a health insurance plan offered by Denver Health Medical Plan, Inc. (DHMP). DHMP is a health maintenance organization (HMO) licensed to offer coverage in Grand, Summit, Lake, Dolores, San Juan, Montezuma, La Plata, and Archuleta counties in the state of Colorado.

Elevate Health Plans is offered both through Connect for Health Colorado and directly through DHMP. It is subject to all rules and regulations of Connect for Health Colorado. You can visit their website at www.connectforhealthco.com.

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

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

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

Who is Eligible to Join Elevate Health Plans?

- All residents of Grand, Summit, Lake, Dolores, San Juan, Montezuma, La Plata, and Archuleta counties are eligible to enroll in Elevate Health Plans.
- You are not eligible to enroll in Elevate Health Plans if you are enrolled in Child Health Plan Plus (CHP+).
- Elevate Health Plans members with APTC are ineligible to also be enrolled in Medicaid or Medicare.
- You may enroll in Elevate Health Plans without regard to physical or mental condition, race, creed, age, color, national origin or ancestry, handicap, marital status, sex, sexual preference or political/religious affiliation.

Eligible Dependents

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

- Your spouse as defined by applicable Colorado State Law (including common-law spouse or same sex domestic partner).
- A child married or unmarried until their 26th birthday as long as they are not eligible for health care benefits through their employer.
- An unmarried child of any age who is medically certified as disabled and dependent upon you.

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

For coverage under a Qualified Medical Child Support Order or other court order, you must provide a copy of the order.

Eligible dependents living outside of the network service area must use the DHMP network providers for their medical care, except for urgent care or emergency care.

Initial Enrollment

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

Open Enrollment

Open Enrollment is an annual period during which members may enroll in an Elevate Health Plans. Elevate Health Plans follow the Connect for Health Colorado open enrollment period:

Enrollment for plans effective January 1st, 2025 begins November 1st, 2024 and ends December 15th, 2024.

Special Enrollment

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

Of the cases below, you and/or your eligible dependent(s) must enroll within 60 days of when the event occurs:

- Involuntarily losing existing coverage for any reason other than fraud, misrepresentation or failure to pay a premium;
- Gaining a dependent or becoming a dependent through marriage, civil union, birth, adoption or placement for adoption, placement in foster care or by entering into a designated beneficiary agreement if the carrier offers coverage to designated beneficiaries;
- An individual's enrollment or non-enrollment in a health benefit plan that is unintentional, and is the result of an error,

misrepresentation or inaction of the carrier, producer of the Exchange;

- Demonstrating to the Commissioner that the health benefit plan in which the individual is enrolled has violated a material provision of its contract in relation to the individual;
- An Exchange enrollee becoming newly eligible or ineligible for the federal Advance Premium Tax Credit (APTC) or Cost Sharing Reductions (CSR) available through the Exchange;
- Gaining access to other coverage as a result of a permanent change in residence;
- A parent of legal guardian dis-enrolling a dependent or a dependent becoming ineligible for the Children's Basic Health Plan;
- An individual becoming ineligible under the Colorado Medical Assistance Act;
- An individual, who was not previously a citizen, a national or a lawfully present individual, gains such status; or
- An American Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another once per month.
- Effective January 1, 2024, a new SEP is available for individuals who receive certification from a healthcare provider, acting within their scope of practice, confirming pregnancy. This SEP applies to individuals without existing creditable coverage. Coverage under this SEP becomes effective from the first month in which pregnancy is certified, unless the individual chooses for the coverage to begin on the first day of the month after making a plan selection.

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

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

When Coverage Begins

- **Open Enrollment** – If you enroll in Elevate Health Plans during the annual Open Enrollment period, which ends on December 15th, your coverage will commence on January 1st of the following year.
- For enrollments occurring between December 16th and January 15th, coverage will begin on February 1st.

Coverage for any dependents enrolled will start concurrently with the subscriber's coverage.

Effective Dates for Special Enrollment

- For life events such as marriage, civil union, or loss of creditable coverage, coverage begins no later than the first day of the month following the event.
- In instances of birth, adoption, placement for adoption, or placement in foster care, coverage begins on the date of the event.
- For individuals becoming pregnant without prior creditable coverage, and receiving certification from a healthcare provider, a Special Enrollment Period is triggered. Coverage begins on the first day of the month after plan selection, unless the individual chooses retroactive coverage starting from the month pregnancy was certified.
-

Other Qualifying Life Change Events (QLCEs):

- If coverage is purchased between the first and fifteenth day of any month, it becomes effective no later than the first day of the following month.
- If purchased between the sixteenth and the last day of the month, coverage begins no later than the first day of the second following month.

Confined Members –

- Members confined to a medical facility at the start of coverage, who were previously covered under a group health plan, will have all related costs covered by the previous carrier. Denver Health Medical Plan (DHMP) will not bear costs associated with this initial confinement.
- However, DHMP will cover any additional required services not related to the initial confinement as per the coverage details in Section 7 "Benefits/Coverage".
- If the member is confined to a medical facility and was not covered by any group health plan when DHMP coverage began, DHMP will cover all associated costs and services related to the confinement from the commencement of coverage.

When Coverage Ends

- You or a dependent no longer meets eligibility requirements;
- You no longer pay the monthly premium required for continuation of coverage; or
- You violate the terms of the plan.

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

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

End of Coverage When a Member is Confined to an Inpatient Facility - If a member is confined to a hospital or institution on the date coverage would normally end, and the confinement is a covered benefit under the plan, coverage will continue until the date of discharge, provided the member continues to obtain all medical care for covered benefits in compliance with the terms of the plan.

How to Access Your Services and Obtain Approval of Benefits

Welcome to Elevate Health Plans!

At Elevate Health Plans, our main concern is that you receive quality health care services. As a member of Elevate Health Plans, you must receive your health care services within the contracted network.

Your basic membership obligation is to consult with your primary care provider before seeking most health care services. Please see Section 1 “Schedule of Benefits” for a breakdown of cost sharing.

YOUR PRIMARY CARE PROVIDER

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

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

SELECTING A PRIMARY CARE PROVIDER

To find primary care providers that participate in the DHMP network, visit https://www.denverhealthmedicalplan.org/find-doctor. You may also contact Health Plan Services at 303-602-2090.

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

CHANGING YOUR PRIMARY CARE PROVIDER

If you decide to select a new primary care provider, there is no need to tell us. You can change your selection at any time. In addition, when a PCP leaves the DHMP network, a notification will be sent to all members who recently received care from this provider. Our website provides the most up-to-date information on providers that participate in the DHMP network. You may also call Health Plan Services at 303-602-2090 if you need more information.

SPECIALTY CARE

If you think you need to see a specialist or other provider, you should first contact your PCP. They will work with you to determine if you need to see a specialist, provide you with a referral (if necessary), and help to coordinate your care. A referral is not required for claim payment as long as the provider is included within the plan’s network.

Members may self-refer for the following services in network: OB/GYN, behavioral health, chiropractic, and children routine eye care. Applicable cost sharing will apply.

Your Health Network

To find a full list of Elevate Health Plans network providers, visit www.denverhealthmedicalplan.org/find-doctor for our web-based provider directory, or call Health Plan Services at 303-602-2090

If you need a service that is not offered by an in network provider or you cannot get an appointment in a timely manner, you can be referred to a provider outside of this network. However, you must have prior authorization for Elevate Health Plans to pay for the services. If prior authorization is not obtained, the costs associated with care received out of network may be your responsibility. You should contact your provider to submit a prior authorization request on your behalf. If your provider has any questions regarding this, they can call Health Plan Services at 303-602-2090.

AFTER HOURS CARE

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

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

EMERGENCY CARE

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

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

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

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

OUT-OF-NETWORK CARE

Care outside of the DHMP network may be covered if:

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

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

COMPLEX CASE MANAGEMENT

Complex Case Managers are available if you have complex medical issues, psychosocial or care coordination needs that require intensive support. We know that it can be hard to understand everything that needs to be done to manage your health, but we are here to assist you.

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

Our Case Managers are available to:

- Help coordinate care among your different doctors.
- Help find community resources to meet your needs.
- Advocate to ensure you get the care and services you need.
- Provide one-on-one health care information, guidance, and support.
- Provide education to support self-care skills.

Our goal is to assist you to:

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

Members or their caregivers may self-refer to gain access to these voluntary programs and services. Complex Case Management is provided at no cost to you and will not affect your plan benefits. To participate in any of these programs or to learn more, please call Health Plan Services at 303-602-2090. You can also obtain more information about our program eligibility and services at https://www.denverhealthmedicalplan.org/.

UTILIZATION MANAGEMENT/AUTHORIZATION PROCESS

Some medical services within your network must be reviewed and approved (prior authorized) by DHMP to ensure payment. It is the responsibility of your doctor or other provider to send a request to DHMP for prior authorization. The plan will notify you and your provider when the request has been approved or denied. Sometimes, requests are denied because the care is either not a covered benefit or is not medically necessary. If you disagree with the decision to deny, you can appeal the decision, see Section 13 “Appeals and Complaints”.

Preservice Care Determination Requests (Urgent and Non-Urgent)

We will review your request, if your provider says it is urgent, within 72 hours of receiving the request. A non-urgent request will be decided in 15 calendar days or less upon receipt. If we need additional information to make a decision, we may extend the time frame an additional 15 calendar days. We will tell you in writing if an extension is needed.

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

If you have questions about prior authorization or about an authorization that is already in place, please call Health Plan Services at 303-602-2090. You can also refer to the prior authorization list on our website at https://www.denverhealthmedicalplan.org/prior- authorization-list.

NURSELINE

DHMP members can call the Denver Health NurseLine 24 hours a day, seven days a week at 303-739-1261. The NurseLine

helps you quickly access trained triage nurses who can provide care advice. NurseLine nurses can advise you on the most appropriate place to get care for your condition, for example, if it makes the most sense to see a primary care provider or if your condition is best served with Urgent Care or Emergency Care.

INTERPRETATION AND TRANSLATION SERVICES

DHMP is committed to meeting our plan members' needs. DHMP contracts with an interpreter service: CERTIFIED LANGUAGES INTERNATIONAL, phone number 800-362-3241. If you need an interpreter during your provider visit or call, let your provider or Health Plan Services know. DHMP contracts with certified translation services at no cost to our plan members. If you need plan materials translated, contact Health Plan Services at 303-602-2090.

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

ACCESS PLAN

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

HEALTH AND WELLNESS

Health education is a no-cost benefit offered through DHMP. Our health education and well-being platform can help members take a more active role in their health care and control of illness. This helps boost motivation by encouraging and supporting members in making lifestyle changes to improve their health.

Health education can help you with:

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

Health education can help you control chronic diseases such as asthma, diabetes, COPD, congestive heart failure and depression.

WHEN YOU ARE OUT OF TOWN

When you are traveling within the U.S., you may go to any hospital emergency room or urgent care center that is convenient for you. Routine care received out-of-network is not covered. Services outside of the country are not covered. If you need emergency care, go to the nearest hospital or call 9-1-1. Following an emergency or urgent care visit out-of-network, one follow-up visit is covered if you cannot reasonably travel back to your service area. Travel expenses back to the DHMP network are not a covered benefit. If you plan to be outside the DHMP service area and need your prescription filled, we have many network pharmacies across the country that you may use. Please check with Health Plan Services at 303-602-2090 or toll-free at 1-855-823-8872. DHMP members are NOT covered anywhere outside of the U.S.

CHANGE OF ADDRESS

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

ADVANCE DIRECTIVES

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

Emergency and Non-Emergency Services Disclosure

Surprise Billing – Know your rights

Beginning January 1, 2020, Colorado state law protects you from "surprise billing". This is sometimes called "balance billing" and it may happen when you receive covered services, other than ambulance services, from an out-of-network provider in Colorado. This law does not apply to all health plans and may not apply to out-of-network providers located outside of Colorado. Check to see if you have a "CO-DOI" on your ID card; if not, this law may not apply to your health plan.

What is surprise/balance billing and when does it happen?

You are responsible for the cost-sharing amounts required by your health plan, including copayments, deductibles and/or coinsurance. If you are seen by a provider or use services in a hospital or other type of facility that are not in your health plan's network, you may have to pay additional costs associated with that care. These providers or services at hospitals and other facilities are sometimes referred to as "out-of-network".

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

Out-of-network hospitals, facilities or providers often bill you the difference between what Denver Health Medical Plan, Inc. (DHMP) decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called “surprise” or “balance billing.”

When you CANNOT be balance-billed:

Emergency Services

When you receive services for emergency medical care, usually the most you can be billed for emergency services is your plan’s in-network cost-sharing amounts, which are copayments, deductibles and/or coinsurance. You cannot be balanced-billed for any other amount. This includes both the emergency facility and any providers you may see for emergency care.

Non-emergency services at an In-Network or Out-of-Network Facility

The hospital or facility must tell you if you are at an out-of-network location or at an in-network location that is using out of network providers. It must also tell you what types of services may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. When this happens, the most you can be billed for covered services is your in-network cost-sharing amount (copayments, deductibles and/or coinsurance). These providers cannot balance bill you.

Additional Protections

- DHMP will pay out-of-network providers and facilities directly. Again, you are only responsible for paying your in-network cost-sharing for covered services.
- DHMP will count any amount you pay for emergency services or certain out-of-network services (described above) towards your in-network deductible and out-of- pocket limit.
- Your provider, hospital, or facility must refund any amount you overpay within 60 days of you reporting the overpayment to them.
- A provider, hospital or other type of facility cannot ask you to limit or give up these rights.

If you receive services from an out-of-network provider, hospital, or facility in any OTHER situation, you may still be balance billed, or you may be responsible for the entire bill.

If you voluntarily receive non-emergency services from an out-of-network provider or facility, you may also be balance billed.

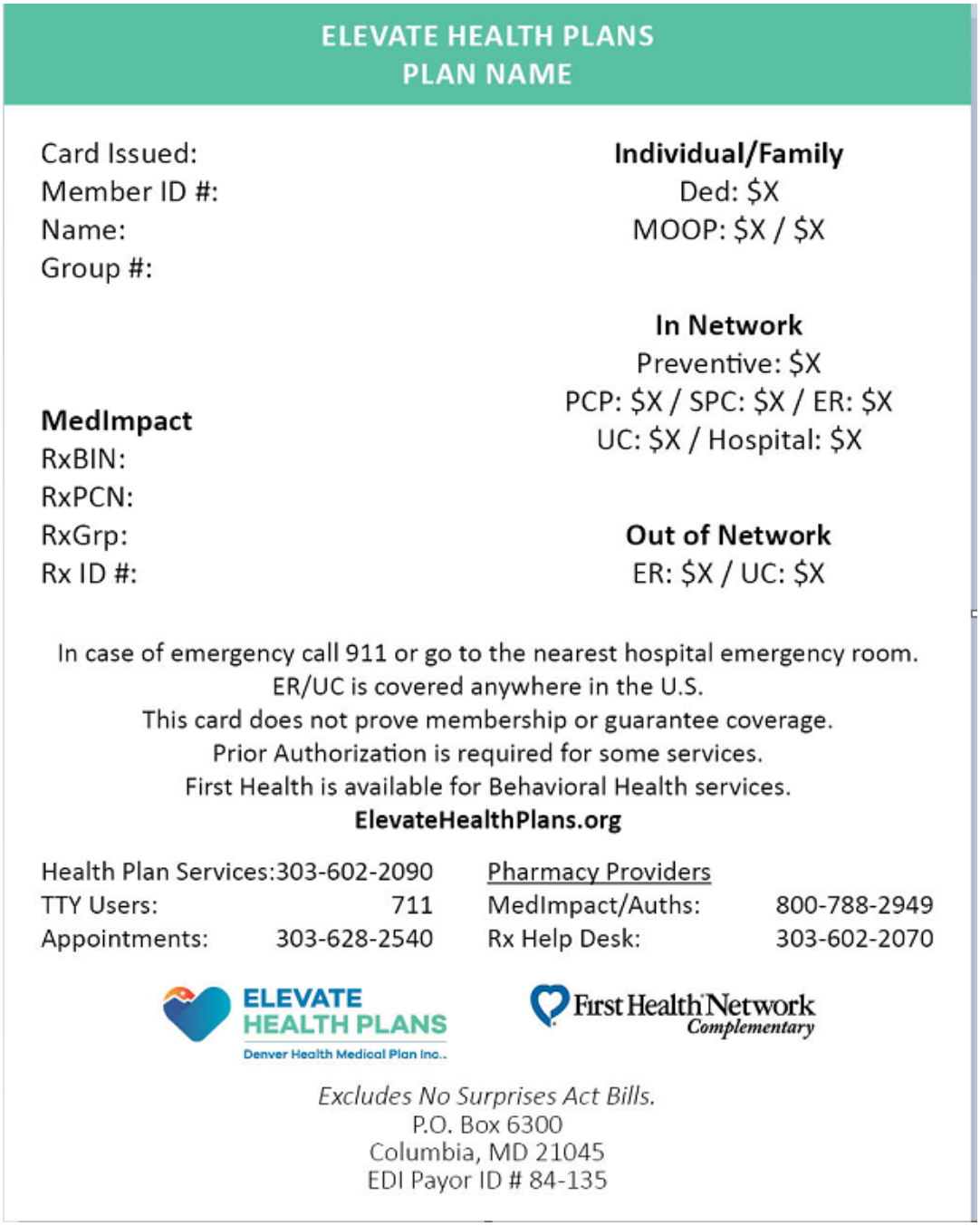
If you do receive a bill for amounts other than your copayments, deductible, and/or coinsurance, please contact us at the number on your ID card, or the Division of Insurance at 303-894-7490 or 1-800-930-3745.

Ambulance Information: You may be balance billed for emergency ambulance services you receive if the ambulance service provider is a publicly funded fire agency, but state law against balance billing does apply to private companies that are not publicly funded fire agencies. Non-emergency ambulance services, such as ambulance transport between hospitals, are not subject to the state law against balance billing, so if you receive such services and they are not a service covered by DHMP, you may receive a balance bill.

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

YOUR ELEVATE HEALTH PLANS IDENTIFICATION CARD

Keep your DHMP identification card with you at all times. Before receiving medical or prescription services, you must show your DHMP identification card. If you fail to do so, or misrepresent your membership status, claims payment may be denied. If you lose your identification card and need a new one, call Health Plan Services at 303-602-2090, Monday through Friday, 8 a.m. — 5 p.m. You can also access a copy of your ID card on the Member Portal. The ID card lists the most common cost sharing. You can find definitions for cost sharing below.



Benefits/Coverage (What is Covered?)

MEMBER NEWSLETTER

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

YOUR BENEFITS

It is important that you understand the benefits and cost sharing that apply to you. When in doubt, call the DHMP Health Plan Services department at 303-602-2090. This is the best source for information about your health care plan benefits.

OFFICE VISITS

Primary care and specialty services are covered. The plan does not require referral to a specialist. Phone consultations are not subject to cost sharing. For information about preventive care services, please refer to the Preventive Care section of this book.

Primary Care Visit:

In network:	50% coinsurance after deductible.
Out-of-network:	Not covered.

Specialty Visit:

In-network:	50% coinsurance after deductible.
Out-of-network:	Not covered.

ACUPUNCTURE

In-network:	50% coinsurance after deductible per visit.
Out-of-network:	Not covered.

Benefit Maximum: 6 visits per plan year.

ALLERGY TESTING AND TREATMENT

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

Medically necessary allergy testing is covered.

Allergy Testing:

In-network:	100% covered.
Out-of-network:	Covered with prior authorization only.

Allergy Treatment:

In-network:	50% coinsurance after deductible per visit.
Out-of-network:	Covered with prior authorization only..

AUTISM SPECTRUM DISORDER

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

Treatment for autism spectrum disorders shall include the following:

- Evaluation and assessment services.
- Habilitative or rehabilitative care, including, but not limited to, occupational therapy, physical therapy or speech therapy, or any combination of those therapies. Visit limits for physical therapy, occupational therapy, and speech therapy do not apply to therapies that are Medically Necessary to treat autism spectrum disorder..
- Behavior training and behavior management and applied behavior analysis, including but not limited to consultations, direct care, supervision, treatment, or any combination thereof, for autism spectrum disorders provided by autism service providers.

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

7. Benefits/Coverage (What is Covered)

BARIATRIC SURGERY

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

In-network:	50% coinsurance after deductible.
Out-of-network:	Not covered.

CHIROPRACTIC

Coverage includes evaluation, lab services and x-rays required for chiropractic services and treatment of musculoskeletal disorders.

See Section 8 “Limitations and Exclusions”.

In-network:	50% coinsurance after deductible per visit.
Out-of-network:	Not covered.

Benefit Maximum: 20 visits per plan year.

7. Benefits/Coverage (What is Covered)

CLINICAL TRIALS AND STUDIES

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

- The member's in-network primary care provider recommends participation, determining that participation has potential therapeutic benefit to the member;
- The clinical trial or study is approved under the September 19, 2000, Medicare national coverage decision regarding clinical trials, as amended;
- The patient care is provided by a certified, registered, or licensed health care provider practicing within the scope of his or her practice and the facility and personnel providing the treatment have the experience and training to provide the treatment in a competent manner;
- Member has signed a statement of consent for participation in the clinical trial or study and understands all applicable cost sharing will apply;
- Health care services excluded from coverage under the member's health plan will not be covered. DHMP will not cover any service, drug or device that is paid for by another entity involved in the clinical trial/ study;
- The member suffers from a condition that is disabling, progressive or life-threatening;
- Extraneous expenses related to participation in the clinical trial or study or an item or service that is provided solely to satisfy a need for data collection or analysis are not covered.

See Section 15 "Definitions" for more information.

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

CONTRACEPTIVE COVERAGE

We cover all eighteen (18) forms of emergency and preventative contraception approved by the FDA at no-cost to the consumer and included in the Health Resources and Services Administration (HRSA)Women's Preventive Services Guidelines. These include, tubal ligation, various intrauterine devices (IUDs), implants, shots, oral contraceptives (sometimes known as "the pill"), patches, vaginal rings, diaphragms, sponges, cervical caps, female condoms, spermicide, and emergency contraceptives (sometimes known as "Plan B"). The no-cost coverage also includes contraceptive counseling, initiation of contraceptive use, and follow-up care (e.g., office visits, management, evaluation, associated laboratory testing, as well as changes to and removal or discontinuation of the contraceptive method).

We cover twelve (12) months of a prescription contraceptive at one time. While we may utilize certain medical management techniques to prioritize coverage of one medication or item in the same category, it does not use the following techniques, as they create unreasonable delay: Denial of coverage for all or particular brand name contraceptives, fail-first or step therapy requirements, and age limitations on coverage.

If you require a different type of contraception, We will cover, without cost to the enrollee, any necessary contraceptive service or item, and the Company will defer to your provider's determination. We have an exceptions process to request a different type of contraception that is easily accessible, transparent, sufficiently expedient, and not unduly burdensome on You or your provider. More information about the exceptions process can be found here: https://www.denverhealthmedicalplan.org/elevate-exchangeco-option-pharmacy-prior-authorization-criteria.

COVID-19

Testing and treatment for COVID-19 is covered without prior authorization.

DIABETIC EDUCATION AND SUPPLIES

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

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

DIETARY AND NUTRITIONAL COUNSELING

Coverage for health coach counseling is covered for multiple situations, including the following:

- New onset diabetes.
- Weight reduction counseling by a dietitian.
- Eating disorders

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

DURABLE MEDICAL EQUIPMENT

General

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

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

See Section 8 “Limitations and Exclusions”.

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

In-network:	50% coinsurance after deductible.
Out-of-network:	Not covered.

Dressings/Splints/Casting/Strapping

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

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

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

Prosthetic Devices

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

Prosthetic devices require prior authorization. Coverage includes the following prosthetic devices:

- Internally implanted devices for functional purposes, such as pacemakers and hip joints.
- Prosthetic devices for members who have had a mastectomy. Both internal and external prosthesis are covered in-network. DHMP will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.
- Prosthetic devices, such as obturators and speech and feeding appliances, required for treatment of cleft lip and cleft palate in newborn members when prescribed by a network provider and obtained from sources designated by the plan.
- Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a plan physician, as medically necessary and provided in accord with this EOC (including repairs and replacements).
- Artificial eyes.

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

No benefit maximum. See Section 8 “Limitations and Exclusions”.

Orthotic Devices

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

Orthotic devices may require prior authorization.

In-network:	50% coinsurance after deductible.
Out-of-network:	Not covered.

No benefit maximum. See Section 8 for “Limitations and Exclusions.

EARLY INTERVENTION SERVICES

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

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

No cost sharing applies to early intervention services.

Benefit Maximum: A total of 45 speech, occupational or physical therapy visits for all early intervention services per plan year.

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

EMERGENCY SERVICES

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

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

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

Services for the treatment of an emergency are covered. See definition of “Emergency” in Section 15 “Definitions”. If you are admitted to the hospital directly from the Emergency Department, you will not have to pay Emergency Department cost sharing but will be responsible for the inpatient cost sharing. See “Inpatient Hospital” section for more details.

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

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

In-network: 50% coinsurance after deductible per visit.
Out-of-network: 50% coinsurance after deductible per visit.

Ambulance Service

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

In-network: 50% coinsurance after deductible per transport.
Out-of-network: 50% coinsurance after deductible per transport.

Urgent Care Services

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

In-network: 50% coinsurance after deductible per visit.
Out-of-network: 50% coinsurance after deductible per visit.

EYE EXAMINATIONS AND OPHTHALMOLOGY

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

Pediatric Vision Benefit:

In-network: 100% covered for children 18 and under.
Out-of-network: Not covered.

One pair of eyeglasses, includes frame and lenses, or contacts every 24 months. One routine eye exam per 12 months.

FAMILY PLANNING SERVICES

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

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

- Family planning counseling.
- Information on birth control.
- Diaphragms (and fitting).
- Insertion and removal of intrauterine devices.
- Sterilization procedures such as tubal ligations and vasectomies
- Formulary contraceptives (oral) up to 12-month supply (see Pharmacy section). Currently the Food and Drug Administration (FDA) has approved 18 different methods of contraception. All FDA approved methods of contraception are covered under this policy without cost sharing as required by federal and state law.

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

Abortion Services

Abortion services are covered if obtained from an in-network provider and no cost sharing will apply once the deductible has been met.

In-network: 0% coinsurance after deductible.
Out-of-network: Not covered.

Formulary Exceptions: A member or prescriber may ask for a formulary exception (coverage of a non-formulary drug). A pharmacist will review the request to determine if the following rules have been met:

- The request for coverage is for an indication (health condition) supported by the medical literature.
- The plan requires the therapeutic trial of at least two different formulary medication alternatives to the non-formulary medication being requested. The provider or member would have to show they failed the trial of these alternatives. Otherwise, they would need to show that the formulary alternatives would be contraindicated for use. In cases where only one formulary alternative exists, an adequate therapeutic trial with this one formulary alternative is

required before coverage of the non-formulary medication will be considered.

- Trial of formulary alternatives must be for a reasonable period of time. This is defined as one month of therapy or more, except in cases where the prescriber gives clinical reasons why alternatives are contraindicated or not effective, tolerable, or safe.

The Pharmacy Prior Authorization Request (PAR)/Exception Request form can be found on the DHMP member webpage at the following location:
https://www.denverhealthmedicalplan.org/pharmacy-prior-authorization-par-exception-request-form

Infertility Services

Covered infertility services including diagnostic testing, treatment of involuntary infertility and artificial insemination, except for donor semen, donor eggs, and services related to their procurement and storage, appropriate medical advice and instruction, in accordance with accepted medical practice.

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

See section 8 for Limitations and Exclusions.

GENDER DYSPHORIA AND GENDER-AFFIRMING CARE

Medically necessary treatments and procedures are covered, including pre- and post-operative care. Prior authorization and a finding of medical necessity are required for all surgical services. DHMP will not deny, exclude, or otherwise limit gender-affirming care coverage for medically necessary services, in accordance with generally accepted professional standards of care, based upon sexual orientation or gender identity.

Covered services include all medically-necessary physical and behavioral health services, including but not limited to office visits, counseling, preventive health, hormone therapies, prescription drugs, laboratory services, and surgical procedures, including pre- and post-operative care. You pay the applicable Copayment, Coinsurance, and/or Deductible for the applicable type of service shown in the “Schedule of Benefits (Who Pays What)” section. For example, see “Inpatient Hospital" in the “Schedule of Benefits (Who Pays What)” for the Copayment, Coinsurance, and/or Deductible that apply to inpatient hospital services and care. This includes all services listed below:

- Hormone therapy (any drug requested for gender affirming care will be approved via a prior authorization request through either the medical or pharmacy benefit) including associated laboratory services
- Laser or electrolysis hair removal (at surgical and nonsurgical sites),
- Breast/chest surgery (male to female)
- Augmentation Mammoplasty
- Implants/Lipofillings
- Breast/chest augmentation, reduction, construction
- Penectomy
- Orchiectomy
- Vaginoplasty
- Dilator (Medical Equipment)
- Clitoroplasty
- Vulvoplasty
- Labiaplasty
- Prostatectomy
- Vagina/Perineum reconstrcution
- Facial Feminization Surgery
- Blepharoplasty (eye and lid modification)
- Face/forehead and/or neck tightening
- Facial bone remodeling for facial feminization
- Genioplasty (chin width reduction)
- Rhytidectomy (cheek, chin, and neck)
- Cheek, chin, and nose implants
- Lip lift/augmentation

7. Benefits/Coverage (What is Covered)

- Mandibular angle augmentation/creation/reduction (jaw)
- Orbital recontouring
- Thyroid Cartilage Reduction/Reduction thyrochondroplasty
- Gluteal Augmentation (Implants/Lipofilling)
- Hair Reconstruction
- Rhinoplasty (nose reshaping)
- Subcutaneous Mastectomy (for Creation of Male Chest)
- Simple/Total Mastectomy
- Partial Mastectomy
- Modified Radical Mastectomy
- Radical Mastectomy
- Breast reduction (reduction mammoplasty)
- Hysterectomy
- Ovariectomy/Oophorectomy
- Salpingectomy
- Liposuction
- Metoidioplasty
- Phalloplasty
- Vaginectomy
- Vulvectomy
- Scrotoplasty
- Urethroplasty
- Trachelectomy
- Penis/perineum reconstruction
- Implantation of Erection and/or Testicular Prosthesis
- Voice Surgery
- Pectoral Implants
- Calf Implants
- Nipple reconstruction following mastectomy
- Voice Therapy Lessons

The above lists are not comprehensive or exhaustive lists of surgical procedures or therapies available to a transgender person, rather only provides examples of the detail expected by the Division of Insurance to be described in the plan's Certificate of Coverage, Evidence of Coverage, and Summary of Benefits Coverage documents. Please note that Colorado Insurance Regulation 4-6-62 Concerning Insurance Unfair Practices Act Prohibitions on Discrimination Based Upon Sexual Orientation or Gender Identity prohibits discrimination in private health insurance plans based on sexual orientation or gender identity.

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

See Section 8 for Limitations and Exclusions.

HEARING EXAMS AND HEARING AIDS

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

Hearing Exams (up to age 19):

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

Hearing Aids (up to age 18):

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

Benefit Maximum: Not covered more frequently than every five years, however a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. This requirement shall apply to each hearing aid if the minor child has two hearing aids.

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

HOME HEALTH CARE

Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.

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

Newborn and Postpartum

Mothers and newborn children who, at their request and with physician approval, are discharged from the hospital prior to 48 hours after a vaginal delivery or prior to 96 hours after a cesarean-section are entitled to one home visit by a registered nurse. Additional visits for medical necessity may be authorized by DHMP.

Physical, Occupational and Speech Therapy

Physical, occupational and speech therapy, as well as audiology services, in the home are covered as home health care services when prescribed by your primary care provider or specialist and may require prior authorization.

Periodic assessment and continued authorization may be required to extend therapy beyond the time specified by the initial authorization.

Generally, home physical therapy, occupational therapy and speech therapy and audiology services will be authorized only until maximum medical improvement is reached, or the patient is able to participate in outpatient rehabilitation.

However, early intervention services for eligible dependent from birth up until the third birthday are covered, even if the purpose of the therapy is to maintain functional capacity. See “Early Intervention Services” section for more detail about the therapies authorized.

Skilled Nursing Services

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

Other Services

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

In-network: 50% coinsurance after deductible.
Out-of-network: Not covered.
Benefit Maximum: 28 hours per week

HOSPICE CARE

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

Hospice benefits are allowed only for individuals who are terminally ill and have a life expectancy of six months or less. Any member qualifying for hospice care is allowed two 3-month hospice benefit periods. Should the member continue to live beyond the prognosis for life expectancy and exhaust his/her two 3-month hospice benefit periods, hospice benefits will continue at the same rate for one additional benefit period.

After the exhaustion of three benefit periods, Utilization Management will work with the primary care physician and the hospice’s medical director to determine the appropriateness of continuing hospice care. Services and charges incurred in connection with an unrelated illness or injury are processed in accordance with the provisions of this handbook. Palliative care is offered to our members. The network is limited; please call Health Plan Services at 303-602-2090 for further information.

7. Benefits/Coverage (What is Covered)

7. Benefits/Coverage (What is Covered)

After the exhaustion of three benefit periods, Utilization Management will work with the primary care physician and the hospice's medical director to determine the appropriateness of continuing hospice care. Services and charges incurred in connection with an unrelated illness or injury are processed in accordance with the provisions of this handbook. Palliative care is offered to our members. The network is limited; please call Health Plan Services at 303-602-2090 for further information.

Home Hospice Care

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

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

Hospice Facility

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

In-network:	50% coinsurance after deductible.
Out-of-network:	Not covered.

IMMUNIZATIONS

There is no cost sharing for preventive immunizations including COVID-19 vaccinations. DHMP covers all immunizations recommended by the CDC. A schedule of these immunizations can be found on our website at https://www.denverhealthmedicalplan.org/, as well as the CDC website at https://cdc.gov/vaccines/schedules/index.html. DHMP will cover these vaccines based on the age and risk indicators listed by the CDC.

Travel immunizations are not a covered benefit. However, some travel vaccinations may be included on the CDC recommendation list. All immunizations on the CDC list are covered at 100%. Formulary prophylactic drugs for travel will be covered if prescribed by your primary care provider. Travel vaccines administered in a Travel Clinic are not covered unless the vaccines are on the CDC recommended immunization list. Vaccines with "travel" as the only indicator will not be covered. Clinic visits for administration of covered immunizations do not require cost sharing. However, if the visit is a combination of the injection and a primary care provider or specialist visit, the required cost sharing will apply.

7. Benefits/Coverage (What is Covered)

INFUSION SERVICES

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

In-network: 50% coinsurance after deductible per visit.
Out-of-network: Not covered.

INJECTION ADMINISTRATION

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

In-network: 50% coinsurance after deductible per visit.
Out-of-network: Not covered.

INPATIENT HOSPITAL

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

- Hospital services, including surgery, anesthesia, laboratory, pathology, radiology, radiation therapy, respiratory therapy, physical therapy, occupational therapy, and speech therapy are covered. Oxygen, other gases, drugs, medications, and biologicals (including blood and plasma) as prescribed are also covered. See Section 8 “Limitations and Exclusions” for non-covered services.
- General inpatient nursing care is covered. Private duty nursing services and sitters are covered when medically necessary and may require prior authorization.
- Accommodations necessary for the delivery of medically necessary covered services are covered, including bed (semi-private room, private when available, private room when medically necessary), meals and services of a dietitian, use of operating and specialized treatment rooms, and use of intensive care facilities.

In-network: 50% coinsurance after deductible per admission.
Out-of-network: Not covered except for emergency admissions.

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

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

LABORATORY AND PATHOLOGY SERVICES

All medically necessary laboratory testing and pathology services ordered by your primary care provider or specialist, or resulting from emergency or urgent care, are covered. COVID-19 testing is covered with no cost share.

Certain genetic tests are covered and may require prior authorization.

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

In-network: 50% coinsurance after deductible.
Out-of-network: Not covered.

MATERNITY CARE

Prenatal Care

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

7. Benefits/Coverage (What is Covered)

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

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

In-network:	100% covered.
Out-of-network:	Not covered except for emergencies.

Delivery (Vaginal or Cesarean)

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

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

In-network:	50% coinsurance after deductible per admission.
Out-of-network:	Not covered except for emergency admissions.

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

Limitations: Home deliveries are not covered.

Postpartum

Breastfeeding support and equipment are covered benefits for DHMP mothers of newborns. A fully covered breast pump can be ordered through our preferred vendor. Please call 303-602-2090 for more information.

*Coverage is limited to the standard equipment provided by a DME provider contracted with DHMP.

MEDICAL FOOD

Medical food is covered for metabolic formulas to treat enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids shall include, but not be limited to, the following diagnosed conditions:

- Phenylketonuria
- maternal phenylketonuria
- maple syrup urine disease
- Tyrosinemia
- Homocystinuria
- Histidinemia
- urea cycle disorders;
- hyperlysinemia
- glutaric acidemias
- methylmalonic acidemia
- propionic acidemia

Covered care and treatment of such conditions shall include, to the extent medically necessary, medical foods for home use for which a physician who is a participating provider has issued a written, oral, or electronic prescription. Enteral (by tube) or parenteral (by intravenous infusion) nutrition is covered if the member has non-function or disease of the structures that normally permit food to enter the small intestine or impairment of small bowel that impairs digestion and absorption of an oral diet.

See “Limitation and Exclusions” for more details.

MENTAL HEALTH AND BEHAVIORAL HEALTH SERVICES

Inpatient Psychiatric/Mental/Behavioral Health Services

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

Prior authorization is required for non-emergency admissions. Notification to the plan should be made as soon as

reasonably possible, preferably within one business day of an emergency admission.

In-network: 50% coinsurance after deductible per admission.
Out-of-network: Not covered except for emergencies.

Partial Hospitalization/Day Treatment

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

Virtual residency therapy is a covered benefit when medically necessary and multiple other therapies and interventions have not been successful. See Section 15 "Definitions" for more information. Virtual residency therapy is considered outpatient care and the outpatient cost sharing applies for each day of service. Cost sharing may apply to additional services performed at these visits.

Prior authorization may be required.

In-network: 50% coinsurance per visit.
Out-of-network: Not covered.

Outpatient Psychiatric/Mental/Behavioral Health Services

Individual and group psychotherapy sessions are covered. You may obtain mental health services from any mental health professional in the DHMP network, no referral is necessary. Cost sharing may apply to additional services performed at these visits.

Outpatient Office Visit:

In-network: 50% coinsurance after deductible per visit.
Out-of-network: Not covered.

Outpatient Services:

In-network: 50% coinsurance after deductible.
Out-of-network: Not covered.

Medication-Assisted Treatment (MAT)

Medication-Assisted Treatment (MAT), a combination of behavioral therapies and medications approved by the FDA to treat substance use disorders (SUD) is a covered benefit. This coverage includes services provided by Opioid Treatment Programs (OTPs) for methadone administration and maintenance for the treatment of opioid use disorder (OUD).

Marital Counseling, Stress Counseling and Family Therapy

Marital and couples counseling, family therapy and counseling for stress-related conditions are covered. You may obtain these services from any mental health professional in the DHMP network without a referral from your primary care provider. Cost sharing may apply to additional services performed at these visits.

Outpatient Office Visit:

In-network: 50% coinsurance after deductible per visit.
Out-of-network: Not covered.

Outpatient Services:

In-network: 50% coinsurance after deductible.
Out-of-network: Not covered.

Biologically Based Mental Illnesses and Mental Disorders

DHMP will provide coverage for the treatment of biologically based mental illnesses and mental disorders that is no less extensive than for any other physical illness. No benefit maximum. Cost sharing may apply to additional services performed at these visits.

Inpatient:

In-network: 50% coinsurance after deductible per admission.
Out-of-network: Not covered except for emergencies.

Prior authorization required for inpatient services.

Outpatient Office Visit:

7. Benefits/Coverage (What is Covered)

In-network: 50% coinsurance after deductible per visit.

Out-of-network: Not covered.

Outpatient Services:

In-network: 50% coinsurance after deductible.

Out-of-network: Not covered.

Mental Health Wellness Exam:

In-network: No charge, one visit per year.

Out-of-network: Not covered.

Limitations: One visit per year. Cost sharing may apply to additional services performed at these visits.

Note: Applicable court ordered behavioral health, mental health and substance use disorder services are covered. Applicable cost sharing will apply.

The use of Body Mass Index (BMI) or Ideal Body Weight (IBW) or any other standard requiring an achieved weight will not be utilized to determine medical necessity or level of care appropriateness of the treatment of eating disorders, including but not limited to bulimia nervosa, atypical anorexia nervosa, binge-eating disorder, avoidant restrictive food intake disorder, and other specified feeding and eating disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

BMI or IBW will not be a determining factor when assessing medical necessity or level of care appropriateness for treatment of anorexia nervosa, restricting subtype, or binge-eating/purging subtype as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders,

NEWBORN CARE

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

After the first 31 days of life, the plan covers all medically necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities as long as the member is eligible (see Therapies for more information).

The plan covers all medically necessary care and treatment for cleft lip or cleft palate or both, including oral and facial surgery, surgical management and follow-up care by plastic surgeons and oral surgeons; prosthetic treatment such as obturators, habilitative speech therapy, speech appliances, feeding appliances, medically necessary orthodontic and prosthodontic treatment; otolaryngology treatment and audiological assessments and treatment. Care under this provision for cleft lip or cleft palate or both will continue as long as the member is eligible. All care must be obtained through DHMP network providers and may require prior authorization.

Circumcision

Circumcision for newborns is covered when performed in a hospital setting prior to discharge after birth. This procedure must be conducted by a qualified healthcare provider. Coverage includes all associated medical services necessary for the circumcision procedure.

Once the member has been discharged from the hospital, circumcision is covered only when there is a demonstrated medical necessity, such as repeated infections or other medical conditions that necessitate this procedure as determined by a healthcare provider. Members may incur out-of-pocket costs, such as deductibles, copayments, or coinsurance, depending on their specific benefit plan and the healthcare services required for the procedure outside of the hospital setting.

OBSERVATIONAL HOSPITAL STAY

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

In-network: 50% coinsurance after deductible per visit.

Out-of-network: Not covered.

7. Benefits/Coverage (What is Covered)

OFFICE VISITS

Primary care and specialty services are covered. The plan does not require referral to a specialist. Phone consultations are not subject to cost sharing. For information about preventive care services, please refer to the Preventive Care section of this book.

Primary Care Visit:

In-network:	50% coinsurance after deductible per visit.
Out-of-network:	Not covered.

Specialty Visit:

In-network:	50% coinsurance after deductible per visit.
Out-of-network:	Not covered.

OSTOMY SUPPLIES

Colostomy, ileostomy and urostomy supplies are covered.

In-network:	50% coinsurance after deductible.
Out-of-network:	Not covered.

OXYGEN/OXYGEN EQUIPMENT

Equipment for the administration of oxygen is covered. Oxygen is covered and no cost sharing is required.

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

Oxygen:

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

Oxygen Equipment:

In-network:	50% coinsurance after deductible.
Out-of-network:	Not covered.

PHARMACY BENEFITS

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

Members will not be responsible to pay more than $100 for a 30-day supply of insulin, or $300 for a 90-day supply of insulin. Members shall not be charged any additional copayments, deductibles, or coinsurance for an additional fill of those same prescriptions in that 90-day period if the fill is to ensure the covered person has sufficient insulin available until the next 90-day period begins.

Where You Can Fill Your Prescription

- Denver Health Pharmacies: DHMP has conveniently located Denver Health pharmacies in many of the Denver Health clinics. While you have the choice to fill your prescription at any national network pharmacy, filling your prescriptions at Denver Health pharmacies will give you the lowest cost sharing and allows your provider to see your prescription filling information. This helps your provider to give you the most complete care at each visit.
    - To fill a prescription at a Denver Health pharmacy your prescription must be written by a Denver Health provider.
- National Network Pharmacies: DHMP offers thousands of pharmacies nationwide for you to fill your prescriptions. To locate a network pharmacy, access the “Pharmacy Search” tool by logging in to the member portal from your plan’s pharmacy page at https://www.denverhealthmedicalplan.org/pharmacy or you can call Health Plan Services at 303-602-2090.

7. Benefits/Coverage (What is Covered)

Refilling Your Prescription

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

- Eye drops can be filled after you have used 70% of your prescription. If your provider writes a prescription for you to get two bottles at a time for use at child or adult day care or school, this is covered by your plan.
- For contraceptive (birth control) prescriptions, the first prescription fill quantity may be up to a maximum of a three-month supply. The second prescription fill quantity may be up to a 12-month supply or to the end of your plan year, whichever is shorter.

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

Mail Order Pharmacy

Save time by signing up to have your prescriptions delivered to your home by mail. DHMP members have two choices for Mail Order Pharmacy. If you see a Denver Health provider, Denver Health Pharmacy by Mail is available for a 90-day supply. If you see a provider outside of Denver Health, MedImpact Direct (MID) Mail, serviced by Birdi pharmacy, offers a 90-day mail order option.

Registration forms and frequently asked question (FAQ) documents are available for both mail order options at https://www.denverhealthmedicalplan.org/pharmacy.

Denver Health Pharmacy by Mail:
Phone: 303-436-4488
Monday – Friday, 8 a.m. – 5 p.m.

- Denver Health Pharmacy by Mail will give you the lowest copay.
- To have your prescription filled at a Denver Health pharmacy, your prescription must be written by a Denver Health provider.
- Use one of these three easy options to sign up for Denver Health's Pharmacy by Mail:
  - Through the MyChart App on your smartphone
  - Call the Automated Refill Line at 303-389-1390
  - Call the Pharmacy directly at 303-436-4488

MedImpact Direct (MID) Mail, serviced by Birdi pharmacy :
P.O. Box 51580
Phoenix, AZ 85076-1580
Phone: 855-873-8739
medimpactdirect.com

90-Day Supply at Retail

Your pharmacy benefit allows you to get a 90-day supply of medication at any Choice 90 participating retail pharmacy. To find out if your drug and/or pharmacy are eligible for this benefit, access the "Drug Price Search" tool by logging in to the member portal from your plan's pharmacy page at https://www.denverhealthmedicalplan.org/pharmacy then select "Online Formulary and Pharmacy Directory" under the Online Tools link, or call Health Plan Services at 303-602-2090.

Your Formulary

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

- Your formulary covers many drugs including oral anti-cancer drugs.
- Off-label use of cancer drugs is covered when appropriate.
- Formulary palliative drugs, in quantities that are within the formulary limits, prescribed for pain control and symptom management of a terminal illness are a covered benefit. You must obtain these drugs from a plan pharmacy. Certain drugs are limited to a maximum of a 30-day supply.

7. Benefits/Coverage (What is Covered)

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

Note: When DHMP is modifying or applying a modification to the current prescription drug formulary during the current plan year, a notification will be sent out 60 days prior to the effective date of the change, to both covered persons enrolled and prescribing providers informing them of the changes per Colorado Insurance Regulation 4-2-93 Section 6.

Your Right to Request an Exception (Prior Authorization)

The prior authorization process is available to you and your provider to ask the plan to cover your drug if it is not on the formulary or if you would like the plan to cover a quantity greater than what the plan's formulary allows. To start a prior authorization please contact our Pharmacy Benefit Manager (PBM) MedImpact 800-788-2949 .

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

If you are not satisfied with the decision made by the plan you have the right to request an appeal or an external review. Please see Section 13 entitled "Appeals and Complaints" for additional information.

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

You can view the current formulary, restrictions, and Pharmaceutical Management Procedures at https://www.denverhealthmedicalplan.org/pharmacy or call Health Plan Services at 303-602-2090 to ask for a printed copy.

Step Therapy

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

A carrier cannot require a covered person with stage four advanced metastatic cancer to undergo step therapy for a covered medication that has been approved by the U.S. Food and Drug Administration (FDA) or other recognized body for the treatment of stage four advanced metastatic cancer.

A carrier shall not require a covered person to undergo step therapy or to receive prior authorization:

- before a pharmacist may prescribe or dispense an FDA Approved HIV infection prevention drug listed on the formulary, or
- before a provider may, acting within the provider's scope of practice, prescribe or dispense any drug approved by the FDA and used for the treatment or prevention of HIV that is included on the carrier's prescription drug formulary.

For the treatment of serious mental illness (SMI), when step therapy is mandated, a covered individual is required to try only one (1) alternative prescription drug before receiving coverage for the medication prescribed by their healthcare provider. SMI, as defined by the American Psychiatric Association in the latest Diagnostic and Statistical Manual of Mental Disorders, includes the following:

- Bipolar disorders (hypomanic, manic, depressive, and mixed);
- Depression in childhood and adolescence;
- Major depressive disorders (single episode or recurrent);
- Obsessive-compulsive disorders;
- Paranoid and other psychotic disorders;
- Schizoaffective disorders (bipolar or depressive); and
- Schizophrenia.

Drug samples are not considered a trial and failure of a required prescription drug when trying to meet a step therapy requirement. When you are trying to meet a step therapy requirement your plan may require documentation from you or your provider to support your request.

Substance Use Disorder (SUD)

7. Benefits/Coverage (What is Covered)

Prior authorization or step therapy is not required or applied to any FDA-approved prescription drug listed on our formulary for the treatment of SUD, defined as alcohol use disorder, opioid use disorder, opioid reversal agents, and nicotine dependence. At least one FDA approved medication for the treatment of each defined SUD is available on the lowest tier of the formulary.

Specialty Drugs

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

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

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

- To find out if your drug is a specialty drug, please call Pharmacy Help desk at 800-788-2949.

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

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

Generic and Brand Name Drugs

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

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

7. Benefits/Coverage (What is Covered)

Drug Exclusions (See General Exclusions and Limitations for Additional Limitations)

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

- Cosmetic use (anti-wrinkle, hair removal, and hair growth products)
- Dietary supplements
- Blood or blood plasma (except anti-hemophilic factor VIII and IX when approved with a prior authorization)
- Infertility
- Over-the-counter drugs (unless listed in the formulary)
- Pigmenting/de-pigmenting
- Therapeutic devices or appliances (unless listed in the formulary)
- Investigational or experimental treatments

Drug Plan Information

Please visit https://www.denverhealthmedicalplan.org/pharmacy, click the appropriate plan name and you will find:

- A list of pharmaceuticals, including restrictions and preferences
- Information on how to use the pharmaceutical management procedures
- An explanation on limits or quotas
- Information on how practitioners must provide information to support an exception request
- The process for generic substitution, therapeutic interchange, and step-therapy protocols
- You may also call and request a printed copy of this information by calling Health Plan Services at 303-602-2090.

7. Benefits/Coverage (What is Covered)

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

Drugs listed in the formulary as Medical Service Drugs (Tier 6) will have applicable out-of-pocket amounts according to the plan's medical benefit.

	Preventive (Tier 1)	Generic (Tier 2)	Preferred Brand (Tier 3)	Non-Preferred Brand/Preferred Specialty (Tier 4)	Specialty (Tier 5)
DH Pharmacy (30-day supply)	0% coinsurance	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible
DH Pharmacy or DH Pharmacy by Mail (90-day supply)	0% coinsurance	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	N/A
National Network Pharmacy (30-day supply)	0% coinsurance	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible
National Network Pharmacy or MedImpact Direct (MID) Mail Order (90-day supply)	0% coinsurance	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	N/A

PREVENTIVE CARE SERVICES

DHMP has developed clinical and preventive care guidelines and health management programs to assist members with common health conditions including diabetes management, asthma and pregnancy care. For information, please call Health Plan Services at 303-602-2090 or visit our website at: https://www.denverhealthmedicalplan.org/. Preventive care services are designed to keep you healthy or to prevent illness, and are not intended to treat an existing illness, injury or condition. Please refer to the following chart for cost sharing that may apply to preventive care services received by a network provider. Please refer to the following link for USPSTF recommended screenings: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations

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

COVERAGE FOR HIV PRE-EXPOSURE PROPHYLAXIS COVERAGE

7. Benefits/Coverage (What is Covered)

Coverage is provided for HIV pre-exposure prophylaxis (PrEP), including baseline and monitoring services consistent with USPSTF recommendations, for federal Food and Drug Administration (FDA)-approved medications without copayment, coinsurance, or other cost-sharing.

FDA approved HIV PrEP medications listed on our formulary are not subject to step therapy or prior authorization requirements. Non-formulary FDA approved HIV PrEP medications are not subject to step-therapy or prior authorization when prescribed or dispensed by a pharmacist. Requests from a non-pharmacist for FDA-approved non-formulary HIV PrEP medications shall be processed on an urgent basis within 24 hours of receipt.

Preventive drugs are $0 at all pharmacies.

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

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

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

7. Benefits/Coverage (What is Covered)

CANCER SCREENINGS

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

- Pap Tests: DHMP provides coverage under the preventive care benefits for a routine annual pap test and the related office visit.
- Mammogram Screenings: DHMP provides coverage under the preventive care benefits for routine screening of diagnostic mammogram regardless of age.
- Prostate Cancer Screenings: DHMP provides coverage under the preventive care benefits for routine prostate cancer screening for men.
- Colorectal Cancer Screenings: Several types of colorectal cancer screening methods exist. DHMP provides coverage for routine colorectal cancer screenings, such as fecal occult blood tests, barium enema sigmoidoscopies, and colonoscopies. Covered persons are eligible for colorectal cancer screening coverage at no cost in accordance with A or B recommendations of the USPSTF. Colorectal cancer screening coverage is provided at no cost to covered persons who are at high risk for colorectal cancer, including covered persons who have a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by the provider.

RADIOLOGY/X-RAY

DIAGNOSTIC AND THERAPEUTIC SERVICES

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

In-network: 50% coinsurance after deductible per test.
Out-of-network: Not covered.

Radiation Therapy:

In-network: 50% coinsurance after deductible per therapy.
Out-of-network: Not covered.

CT Scans:

In-network: 50% coinsurance after deductible per test.
Out-of-network: Not covered.

MRI:

In-network: 50% coinsurance after deductible per test.
Out-of-network: Not covered.

PET Scans:

In-network: 50% coinsurance after deductible per test.
Out-of-network: Not covered.

Prior authorization may be required for CT, MRI and PET Scans.

RENAL DIALYSIS

Renal dialysis is covered if provided at an authorized facility.

In-network: 50% coinsurance after deductible.
Out-of-network: Not covered.

SEXUALLY TRANSMITTED INFECTIONS

The plan provides coverage for the treatment of an existing sexually transmitted infection; defined as the medically necessary care for the management of chlamydia, syphilis, gonorrhea, HIV, and relevant types of hepatitis, as well as any other sexually transmitted infections, regardless of mode of transmission.

In-network: (100% covered)

Out-of-network: Not covered.

SKILLED NURSING FACILITY/ EXTENDED CARE SERVICES

Extended care services at authorized skilled nursing facilities are covered. Covered services include skilled nursing care,

bed and board, physical therapy, occupational therapy, speech therapy, respiratory therapy, medical social services, prescribed drugs, medications, medical supplies and equipment and other services ordinarily furnished by the skilled nursing facility. Prior authorization is required.

In-network: 50% coinsurance after deductible.
Out-of-network: Not covered.

Benefit Maximum: 100 days per plan year.

SLEEP STUDIES

Covered if provided at a network facility or in home by a network provider.

In-network: 50% coinsurance after deductible per visit.
Out-of-network: Not covered.

SUBSTANCE USE DISORDER SERVICES

Drug and Alcohol Use - Detoxification

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

In-network: 50% coinsurance after deductible per admission.
Out-of-network: Not covered except for emergencies.

Inpatient Substance Use Disorder Rehabilitation

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

In-network: 50% coinsurance after deductible per admission.
Out-of-network: Not covered.

Exclusions: Maintenance or aftercare following a rehabilitation program.

Outpatient Substance Use Disorder Services

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

Outpatient Office Visit:

In-network: 50% coinsurance after deductible
Out-of-network: Not covered.

Outpatient Services:

In-network: 50% coinsurance after deductible per visit

Out-of-network: Not covered.

Medication-Assisted Treatment (MAT)

Medication-Assisted Treatment (MAT), a combination of behavioral therapies and medications approved by the FDA to treat substance use disorders (SUD) is a covered benefit. This coverage includes services provided by Opioid Treatment Programs (OTPs) for methadone administration and maintenance for the treatment of opioid use disorder (OUD).

Note: Applicable court ordered behavioral health, mental health and substance use disorder services are covered. Applicable cost sharing will apply.

SURGERY SERVICES

Inpatient Surgery

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

In-network: 50% coinsurance after deductible per admission, except for transplants.
Out-of-network: Not covered.

Outpatient Surgery

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

7. Benefits/Coverage (What is Covered)

In-network:	50% coinsurance after deductible per visit.
Out-of-network:	Not covered.

7. Benefits/Coverage (What is Covered)

Oral/Dental Surgery

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

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

- The child has a physical, mental or medically compromising condition; or
- The child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or
- The child is an extremely uncooperative, unmanageable, anxious or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred; or
- The child has sustained extensive orofacial and dental trauma.

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

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

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

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

Breast Surgery

The plan provides coverage for medically necessary mastectomies, lumpectomies and the physical complications of mastectomies, including lymphedemas. Breast reconstruction of the affected and non-affected side, by a network provider, as well as internal prosthetic devices are covered if prior authorized by DHMP.

Medically necessary breast reduction is covered when prior authorized by DHMP. External prosthetic devices following medically necessary mastectomy or lumpectomies are covered according to criteria for durable medical equipment (DME).

Reconstructive Surgery

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

Transplants

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

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

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

In-network:	50% coinsurance after deductible per admission.
Out-of-network:	Not covered.

TELEHEALTH

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

7. Benefits/Coverage (What is Covered)

THERAPIES

Habilitative Services

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

In-network: 50% coinsurance after deductible per visit.
Out-of-network: Not covered.

Benefit Maximum: 30 visits per plan year per therapy to learn skills for the first time or maintain current skills. Additional visits require prior authorization.

Rehabilitative Services

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

In-network: 50% coinsurance after deductible per visit.
Out-of-network: Not covered.

Benefit Maximum: 30 visits per plan year per therapy to learn skills for the first time or maintain current skills. Additional visits may be covered if medically necessary – prior authorization will be required.

Visit limits for physical therapy, occupational therapy, and speech therapy do not apply to therapies that are Medically Necessary to treat autism spectrum disorder (See Autism Spectrum Disorder).

Inpatient Rehabilitation

Treatment in a multidisciplinary rehabilitation program provided in a designated rehabilitation facility.

In-network: 50% coinsurance after deductible.
Out-of-network: Not covered.

Benefit Maximum: 60 days per condition per year.

Cardiac Rehabilitation

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

In-network: 50% coinsurance after deductible per visit.
Out-of-network: Not covered.

Benefit Maximum: 30 visits per plan year.

Pulmonary Rehabilitation

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

In-network: 50% coinsurance after deductible per visit.
Out-of-network: Not covered.

Benefit Maximum: 30 visits per plan year.

TOBACCO CESSATION

Talk to your primary care provider about tobacco cessation. The Colorado Quitline has tools and resources to help including counseling and nicotine replacement such as patches or gum. You can contact the Colorado Quitline at 1-800-QUIT-NOW. Formulary tobacco cessation drugs including Chantix, the generic form of Zyban, nicotine patches, gum and lozenges are all available and are 100% covered.

WELL-BEING PROGRAM

DHMP provides an online wellbeing program at no cost to members. A health resource library with articles, decision tools, and workshops are available on many health care and prevention topics. Workshops, health assessments and trackers are available to check and to monitor your activity, nutrition and health measures.

Limitations and Exclusions (What is Not Covered)

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

OUT-OF-NETWORK PROVIDERS

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

- Provided under prior written referral by a participating primary care provider and prior authorized by the Utilization Management Department or;
- Provided in an emergency or urgent circumstance, and notification is made to the Utilization Management Department as soon as reasonably possible, preferably within one business day.

GENERAL EXCLUSIONS

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

- **Adaptive Equipment/Corrective Appliances:** Adaptation to telephone for the deaf; replacement of artificial eyes if lost, stolen or damaged; reading aids, vision enhancement devices; wheelchair ramps; home remodeling or installation of bathroom equipment; prosthetic devices (except for artificial limbs and breast prostheses).
- **Ambulance Services:** Ambulance service for non-emergency care or transportation except as requested by DHMP with prior authorization.
- **Artificial Hair**: Artificial hairpieces, hair transplants or implants.
- **Care Not Medically Necessary:** Medical care, procedures, equipment, supplies and/or pharmaceuticals that are not consistent with generally accepted principles of professional medical practice, as determined by whether or not: the service is the most appropriate available supply or level of service for the insured in question, considering potential benefits and harms to the individual; is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; for services and interventions not in widespread use, is based on scientific evidence.
- **Chiropractic Care:** Hypnotherapy, behavior training, sleep therapy, weight loss programs, services not related to the treatment of the musculoskeletal system, vocational rehabilitation services, thermography, air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices and appliances or transportation costs. This includes local ambulance charges, prescription drugs, vitamins, minerals, food supplements or other similar products, education programs, non-medical self-care or self-help training, all diagnostic testing related to these excluded services, MRI and/or other types of diagnostic radiology, physical or massage therapy that is not a part of the chiropractic treatment, durable medical equipment (DME) and supplies for use in the home.
- **Comfort and Convenience Items:** Personal comfort or convenience items or services obtained or rendered in or out of a hospital or other facility, such as television, telephone, guest meals, articles for personal hygiene and any other similar incidental services and supplies.
- **Cosmetic and Reconstructive Surgery**: Elective cosmetic and reconstructive surgeries or procedures that are only performed to improve or preserve physical appearance. Exclusion does not apply to medically necessary gender affirming care.
- **Criminal Exclusions:** A medical treatment for accidental bodily injury or sickness resulting from or occurring during the member's commission of a crime, except for a crime defined 18 and under 18-102(5) C.R.S.
- **Dental Services:** Dental ancillary services; occlusal splints; overbite or underbite; osteotomies; TMJ (except as a result of trauma or fracture); hard or soft tissue surgery; maxillary, mandibular or other orthogenic conditions unless certified by a participating primary care practitioner (primary care provider) as medically necessary as a result of trauma. The following services for TMJ may be covered if a network physician determines they are medically necessary: diagnostic x-rays, lab testing, physical therapy, and surgery.
- **Disability/Insurance Physicals:** Coverage for physicals to determine or evaluate a member's health for enrollment in another insurance is excluded from coverage.
- **Drugs/Medications:** Non-formulary drugs and/ or drugs that require prior authorization if prior authorization is not received.
- **Durable Medical Equipment:** Humidifiers, air conditioners, exercise equipment, whirlpools, health spa or club are excluded whether or not prescribed by a physician.

8. Limitations and Exclusions (What is Not Covered)

- **Employment Exams:** Physical examinations for purposes of employment or employment-required annual examinations (e.g., D.O.T. exams) are excluded from coverage.
- **Enzyme Infusions:** Therapies for chronic metabolic disorders.
- **Excluded drugs and drug classes for the prescription drug benefit:** Some drugs are not covered at all. These include drugs for the following: cosmetic use (anti-wrinkle, hair removal, and hair growth products), dietary supplements, blood or blood plasma (anti-hemophilic factor VIII and IX are covered), infertility, over-the-counter drugs (unless listed in the formulary), pigmenting/de-pigmenting, therapeutic devices or appliances (unless listed in the formulary), prescription vitamins (unless listed in the formulary), investigational or experimental treatments.
- **Experimental Procedures and Drugs:** Medical care, procedures, equipment, supplies, and/or pharmaceutics determined by DHMP to be experimental, investigational or not generally accepted in the medical community are not covered. This means any medical procedure, equipment, treatment or course of treatment or drugs or medicines that are considered to be unsafe, experimental, or investigational. This is determined by formal or informal studies, opinions and references to or by the American Medical Association, the Food and Drug Administration, the Department of Health and Human Services, the National Institutes of Health, the Council of Medical Specialty Societies, experts in the field and any other association or federal program or agency that has the authority to approve medical testing, treatment, or pharmaceutical drug efficacy and appropriateness.
- **Extended Care:** Sanitarium, custodial or respite care (except as provided under Hospice Services), maintenance care, chronic care and private duty nursing.
- **Eyewear:** Glasses, contacts, all eyewear except as noted in specific plan benefits.
- **Governmental Facilities:** Services or items for which payment is made by or available from the federal or any state government or agency or subdivision of these entities; services or items for which a DHMP member has no legal obligation to pay.
- **Infertility Services:** Reversal of voluntarily induced infertility (sterilization), procedures considered to be experimental, invitro fertilization, the Gamete Intrafallopian Transfer (GIFT) procedure, surrogate parents, drug therapy for infertility, the costs for services related to each of these excluded procedures, the costs related to sperm collection, preparation and/or storage for members not actually seeking active treatment for infertility utilizing this assisted reproductive technology, the costs related to sperm collection from non-DHMP members.
- **Learning and Behavior Problems:** Special education, counseling, therapy or care for learning disabilities or behavioral problems, whether or not associated with a manifest mental disorder, retardation or other disturbance.
- **Long-term, Non-structured Treatment Centers**
- **Massage Therapy:** This form of therapy aims to enhance overall wellness, alleviate pain, improve circulation, reduce stress, encourage relaxation, and assist in the general health and recovery from injuries.
- **Maternity Care:** Home deliveries; scheduled, non-medically necessary Cesarean sections.
- **Medical Food:** Food products for cystic fibrosis or lactose or soy intolerance or other food allergies. Standardized or specialized infant formula for conditions other than inborn errors of metabolism or inherited metabolic diseases, including, but not limited to: food allergies; multiple protein intolerances; lactose intolerances; gluten-free formula for gluten-sensitive enteropathy/celiac disease; milk allergies; sensitivities to intact protein; protein or fat maldigestion; intolerances to soy formulas or protein hydrolysates; prematurity; or low birth-weight.
    - Food thickeners
    - Dietary and food supplements
    - Lactose-free products; products to aid in lactose digestion
    - Gluten-free food products
    - Weight-loss foods and formula
    - Normal grocery items
    - Low carbohydrate diets
    - Baby food
    - Grocery items that can be blenderized and used with enteral feeding system
    - Nutritional supplement puddings
    - High protein powders and mixes
    - Non formulary oral vitamins and minerals
- **Neurostimulators**: Replacements or repairs, including batteries.
- **Obesity:** Maximum on surgical treatment of morbid obesity of once per lifetime. Commercial weight loss programs or exercise programs are not covered benefits.

8. Limitations and Exclusions (What is Not Covered)

- **Optometric Vision Therapy/Treatment:** Individualized treatment regimen prescribed in order to provide medically necessary treatment for diagnosed visual dysfunctions, prevent the development of visual problems or enhance visual performance to meet defined needs of the patient. Optometric vision therapy includes visual conditions such as strabismus, amblyopia, accommodative dysfunctions, ocular motor dysfunctions, visual motor disorders and visual perceptual (visual information processing) disorders.
- **Orthotics:** Corrective shoes and orthotic devices for podiatric use and arch supports. Dental devices and appliances except those medically necessary treatment of cleft lip or cleft palate for newborn members is covered when prescribed by a network provider. Experimental and research braces. More than one orthotic device for the same part of the body, except for replacements, spare devices or alternate use devices. Replacement of lost orthotic devices. Repairs, adjustments or replacements necessitated by misuse.
- **Other Providers:** Services provided by massage therapists, faith healers, palm readers, physiologists, naturopaths, reflexologists, rolfers, iridologists or other alternative health practitioners.
- **Over-the-Counter Drugs:** Over-the-counter drugs (except as required by law), nutritional supplements or diets and over-the-counter medical supplies (except insulin and diabetic testing supplies) are not covered. This includes vitamins, minerals or special diets, even if prescribed by a physician (except medical food for children with inherited enzymatic disorders) with the exception of formulary prescription items such as electrolytes, certain vitamins and minerals listed in the Denver Health Medical Plan formulary.
- **Paternity Testing**
- **Pet Therapy**
- **Plastic Surgery:** Plastic surgery for cosmetic purposes (this exclusion does not apply to medically necessary gender affirming care); removal of tattoos and scars; chemical peels or skin abrasion for acne.
- **Prosthetic Devices:** Dental prostheses, except for medically necessary prosthodontic treatment for treatment of cleft lip and cleft palate in newborn members, as described above. Internally implanted devices, equipment and prosthetics related to treatment of sexual dysfunction. More than one prosthetic device for the same part of the body, except for replacements; spare devices or alternate use devices. Replacement of lost prosthetic devices. Repairs, adjustments or replacements necessitated by misuse.
- **Psychological Testing Required by a Third Party:** Psychological testing required by a third party; educational or occupational testing or counseling; vocational or religious counseling; developmental disorders such as reading, arithmetic, language or articulation disorders; IQ testing.
- **Refractive Surgery:** Vision correction surgery such as Lasik, except as noted in specific plan benefits.
- **Transplants:** Organ transplants not listed in Section 7 “Benefits/Coverage”; donor-related expenses for DHMP members who are donating to an individual who is not a DHMP member.
- **Vocational Rehabilitation:** Vocational rehabilitation, services related to screening exam or immunizations given primarily for insurance, licensing, employment, weight reduction programs or for any other non-preventive purpose.
- **Work-Related Injury or Illness:** Charges for services and supplies (including Return to Work exams) resulting from a work-related illness or injury, including expenses resulting from occupational illnesses or accidents covered under workers’ compensation, employers’ liability, municipal, state or federal law or occupational disease laws except for members who are not required to maintain or be covered by workers’ compensation insurance as defined by Colorado workers’ compensation laws.

Member Payment Responsibility

ABOUT YOUR MEDICAL BENEFITS

All services covered by DHMP must satisfy certain basic requirements. The services you seek must be medically necessary, you must use DHMP network providers, the services cannot exceed benefit maximums and the services must be appropriate for the illness or injury.

These requirements are commonly included in health benefit plans but are often not well understood or are simply overlooked. By communicating with your primary care provider and allowing your primary care provider to manage your care, these requirements will be met and will help to ensure that you receive medically necessary covered services.

AN "ALLOWED" AMOUNT

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

A "BILLED" AMOUNT

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

BENEFIT MAXIMUMS

Benefit maximums are the limits set by DHMP on the number of visits per calendar year, services per lifetime or a max dollar amount paid by the plan within a specified time period.

COPAYMENTS

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

COINSURANCE

The charge, typically stated as a percentage of eligible expenses, that you are required to pay for certain covered health services after applicable deductibles are met. This amount will apply to your out-of-pocket maximum.

DEDUCTIBLES

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

OUT-OF-POCKET COSTS

What you pay for medical expenses that aren't paid back by your health insurance plan. Your out-of-pocket costs include any costs you personally pay for covered medical or pharmacy services.

OUT-OF-POCKET MAXIMUM

This is the maximum amount you are responsible for in a given plan year. Deductibles, coinsurance and copays apply to the out-of-pocket maximum. This does not include your monthly premiums.

PREMIUM PAYMENT

Monthly premiums are due the 25th of the month prior to coverage (for example, February's premium payment would be due on January 25th). To make a credit card payment over the phone, please call Health Plan Services at 303-602-2090. You may also make a credit card payment online at https://www.denverhealthmedicalplan.org/pay-my-premium.

To make a payment by check or a money order, please submit payment to:

Elevate Health Plans
P.O. Box 5363
Denver, CO 80214

9. Member Payment Responsibility

GRACE PERIOD

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

For persons who are not receiving a federal subsidy, the policyholder is entitled to a 31-day grace period for the payment of any premium due other than the first month's premium. Coverage continues during the first 31-day grace period only. If payment is not made, then the member will be terminated as of the last day of the month that was paid in full.

The grace periods noted above are only available to members who have made their initial premium payment for their first month of coverage.

Claims Procedure (How to File a Claim)

HOW TO FILE A CLAIM

For Medical Service

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

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

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

Denver Health Medical Plan, Inc.
P.O. Box 6300
Columbia, MD 21045

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

Authorized claims that were part of a Utilization Management review, will be paid within 30 days of receipt. Applicable cost sharing will apply.

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

Payments made in accordance with an assignment are made in good faith and release DHMP from further obligation for payments due.

For Pharmacy Service

Present your DHMP identification card at any network pharmacy when you have your prescriptions filled. You are responsible for paying the pharmacy cost sharing. If you are out of the network area and cannot locate a network pharmacy, please call the Health Plan Services Department at 303-602-2090 for information on how to get your prescription filled.

Claims Investigation

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

Denver Health Medical Plan
Attn: Grievance Coordinator
777 Bannock St., Mail Code 6000
Denver, CO 80204

If you are appealing a claim that was denied due to lack of medical necessity or prior authorization, denial of prior authorization, or experimental status, please see Section 13 "Appeals and Complaints".

Physical examinations and autopsy

The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in cases of death where it is not forbidden by law.

10. Claims Procedure (How to File a Claim)

Claims Timeframes

- Claims will be paid in a timely manner:
- Electronic claims within 30 days.
- Paper claims within 45 days.
- All claims within 90 days.

Claims Fraud

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, and denial of insurance. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or payment from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
DHMP follows all OIG regulations for Fraud, Waste, or Abuse for your protection. DHMP is required to document and track any settlements or malpractice lawsuits that involve our members. If you are in this situation or think you are in this situation, please notify DHMP.

WHEN ANOTHER PARTY CAUSES YOUR INJURIES OR ILLNESS

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

- DHMP may collect paid benefits directly from the liable party, the liable party's insurance company, and from any other person, business, or insurance company obligated to provide benefits or payments to you including your own insurance company if you have other coverage.
- You will tell DHMP, within 30 days of your becoming injured or ill:
  - If another party caused your injury or illness.
  - The names of the liable party and that party's insurance company.
  - The name of your own insurance company if you have other coverage for your injury or illness.
  - The name of any lawyer that you hired to help you collect your claim from a liable party.
- You or your lawyer will notify the liable party's insurance company, and your own insurance company, that DHMP is paying your medical bills.
- The insurance company must contact DHMP to discuss payment.
- The insurance company must pay DHMP before it pays you or your lawyer.
- Neither you nor your lawyer will collect any money from an insurance company until after DHMP is paid in full. This applies even if the insurance money to be paid is referred to as damages for pain and suffering, lost wages or other damages.
- If an insurance company pays you or your lawyer and not DHMP, you or your lawyer will reimburse DHMP up to the amount of benefits paid out. DHMP will not pay your lawyer any attorney's fees or costs for collecting the insurance money.
- DHMP will have an automatic subrogation lien, and direct right of reimbursement, against any insurance money that is owed to you by an insurance company, or that has been paid to your lawyer. DHMP may notify other parties of its lien and direct right of reimbursement.
- DHMP may give an insurance company and your lawyer any DHMP records necessary for collection. If asked, you agree to sign a release allowing DHMP records to be provided to an insurance company and your lawyer. If asked, you agree to sign any other papers that will help DHMP collect money due.
- You and your lawyer will give DHMP any information requested about your claim against the liable party.
- You and your lawyer will notify DHMP of any dealings with, or lawsuits against, the liable party.
- You and your lawyer will not do anything to hurt the ability of DHMP to collect paid benefits from the liable party or an insurance company.
- You will owe DHMP any money that the plan is unable to collect because of your, or your lawyer's, lack of help or interference. You agree to pay to DHMP any attorney's fees and costs that the plan must pay in order to collect this money from you.
- DHMP will not pay any medical bills that should have been paid by another party or insurance company.

If you have questions, please call our Health Plan Services Department at 303-602-2090.

10. Claims Procedure (How to File a Claim)

DISCLOSURE OF HEALTH AND BILLING INFORMATION TO THIRD PARTIES

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

VENUE

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

General Policy Provisions

PRIVACY/HIPAA INFORMATION

Confidential Information

DHMP is committed to protecting your privacy. All patient information is kept confidential. In addition, we will not discuss any of your Protected Health Information (PHI) with anyone other than yourself without approval. If you'd like for us to discuss your information with another family member, you will need to fill out the Designation of Personal Representative (DPR) form, see Attachment B in your handbook. Your handbook can be accessed on our website at https://www.denverhealthmedicalplan.org/, or you may call Health Plan Services at 303-602-2090 and request a hard copy be mailed to you.

Complete privacy information is also available on our website at https://www.denverhealthmedicalplan.org/, or you may call Health Plan Services at 303-602-2090 and request it be mailed to you.

Original Effective Date: April 14, 2003.

Revised Effective Date: September 23, 2013.

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

PLEASE REVIEW IT CAREFULLY.

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

This notice explains how we use information about you and when we can share that information with others.

It also informs you of your rights with respect to your health information and how you can exercise those rights.

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

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

Our Uses and Disclosures

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

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

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

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

11. General Policy Provisions

State and Federal Laws Pertaining to Personal Health Information

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

- If you are injured or unconscious, we may share PHI with your family or friends to ensure you get the care you need and talk about how the care will be paid for.
- To a personal representative designated by you or by law.
- To state and federal agencies that regulate us, such as the US Department of Health and Human Services, Colorado Division of Insurance, Colorado Department of Public Health and Environment and the Colorado Department of Health Care Policy and Financing.
- For public health activities. This may include reporting disease outbreaks or helping with product recalls.
- To public health agencies if we believe there is a serious health or safety threat.
- With a health oversight agency for certain oversight activities, such as: audits, inspections, licensure and disciplinary actions.
- To a court or administrative agency, for example, pursuant to a court order or search warrant.
- For law enforcement purposes or with a law enforcement official.
- To a government authority regarding child use, neglect, or domestic violence.
- To respond to organ and tissue donation requests and work with a funeral director or medical examiner.
- For special government functions, such as for national safety.
- For job-related injuries because of state worker's compensation laws.

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

Other uses and Disclosures of Health Information:

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

We will also not use or disclose your health information for the following purposes without your specific, ***written authorization:***

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

Your Rights Regarding Personal Health Information

The following are your rights with respect to your health information. If you would like to exercise the following rights, please contact the Privacy Officer by telephone at 303-602-7025, via email at privacy@dhha.org, or by US mail or walk-in at:

Denver Health
Attn: Privacy Officer
777 Bannock Street, Mail Code 1919
Denver, CO 80204.

11. General Policy Provisions

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

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

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

- ***You have the right to ask to receive confidential communications*** of information. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not. Any such request must be made in writing to the Privacy Officer.

- ***You have the right to inspect and obtain a copy*** of information that we maintain about you. You have the right to obtain such information in an electronic format and you may direct us to send a copy directly to your designee, provided we receive a clear and specific written request to do so.

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

- Contained in psychotherapy notes (which may, but are not likely to, come into our possession);
- Compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding; and
- Subject to certain federal laws governing biological products and clinical laboratories.

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

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

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

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

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

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

11. General Policy Provisions

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

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

Questions or Complaints

If you have any questions about this notice, how we use or share information or if you believe your privacy rights have been violated, please contact the Privacy Officer at 303-602-7025, via email at privacy@dhha.org, or by US mail or walk-in at:

Denver Health
Attn: Privacy Officer
777 Bannock St, Mail Code 1919
Denver, CO 80204.

You can file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights, 200 Independence Avenue S.W., Washington, D.C. 20201 or by calling 877-696-6775.

We will not take any action against you for filing a complaint

MEMBER RIGHTS AND RESPONSIBILITIES

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

DEFINITIONS:

Effectuated - An enrollment status where a qualitied Exchange individual has paid their first month's payment in full.

Member - A member is entitled to appeal and grievance rights, authorization requests, claims processing. Exchange individuals must be effectuated in order to be considered a DHMP member.

Member's Rights:

Members have the right to:

- Have access to practitioners and staff who are committed to providing quality health care to all members without regard for race, religion, color, creed, national origin, age, sex, sexual preference, political party, disability or participation in a publicly financed program.
- Receive medical/behavioral health care that is based on objective scientific evidence and human relationships. A partnership based on trust, respect and cooperation among the provider, the staff and the member will result in better health care.
- Be treated with courtesy, respect and recognition of your dignity and right to privacy.
- Receive equal and fair treatment, without regard to race, religion, color, creed, national origin, age, sex, sexual preference, political party, disability or participation in a publicly financed program.
- Choose or change your primary care provider within the network of providers, to contact your primary care provider whenever a health problem is of concern to you and arrange for a second opinion if desired.
- Expect that your medical records and anything that you say to your provider will be treated confidentially and will not be released without your consent, except as required or allowed by law.
- Get copies of your medical records or limit access to these records, according to state and federal law;
- Ask for a second opinion, at no cost to you;
- Know the names and titles of the doctors, nurses and other persons who provide care or services for the member.
- A candid discussion with your provider about appropriate or medically necessary treatment options for your condition regardless of cost or benefit coverage.
- A right to participate with providers in making decisions about your health care.
- Request or refuse treatment to the extent of the law and to know what the outcomes may be.

11. General Policy Provisions

- Receive quality care and be informed of the DHMP Quality Improvement program.
- Receive information about DHMP, its services, its practitioners and providers and members' rights and responsibilities, as well as prompt notification of termination or other changes in benefits, services or the DHMP network. This includes how to get services during regular hours, emergency care, after-hours care, out-of-area care, exclusions and limits on covered service.
  - Learn more about your primary care provider and his/her qualifications, such as medical school attended or residency, go to https://www.denverhealthmedicalplan.org/find-doctor for our web based provider directory or call Health Plan Services at 303-602-2090.
- Express your opinion about DHMP or its providers to legislative bodies or the media without fear of losing health benefits.
- Receive an explanation of all consent forms or other papers DHMP or its providers ask you to sign; refuse to sign these forms until you understand them; refuse treatment and to understand the consequences of doing so; refuse to participate in research projects; cross out any part of a consent form that you do not want applied to your care or to change your mind before undergoing a procedure for which you have already given consent.
- Instruct your providers about your wishes related to advance directives (such issues as durable power of attorney, living will or organ donation).
- Receive care at any time, 24 hours a day, seven days a week, for emergency conditions and care within 48 hours for urgent conditions.
- Have interpreter services if you need them when getting your health care.
- Change enrollment during the times when rules and regulations allow you to make this choice.
- Have referral options that are not restricted to less than all providers in the network that are qualified to provide covered specialty services; applicable cost sharing will apply.
- Expect that referrals approved by the plan cannot be changed after prior authorization or retrospectively denied except for fraud, abuse or change in eligibility status at the time of service.
- Make recommendations regarding DHMP's Members' Rights and Responsibilities' policies.
- Voice a complaint about or appeal a decision concerning the DHMP organization or the care provided and receive a reply according to the grievance/appeal process.
- Receive a standing referral, from a personal provider to see a DHMP network specialty treatment center, for an illness or injury that requires ongoing care.

Member's Rights for Pregnancy and Special Needs:

- To receive family planning services from any licensed physician or clinic in the DHMP network.
- To go to any participating OB/GYN in the DHMP network without getting a referral from your primary care provider.
- To see your current non-network provider for prenatal care, until after delivery of the baby if you become a member of DHMP during your second or third trimester. This is dependent upon the non-network provider agreeing to accept DHMP's arrangements.
- To continue to see your non-network doctor(s) or provider(s), when medically necessary, for up to 60 days after becoming a DHMP member. (Dependent upon the non-network provider accepting DHMP's arrangements for this transition.)

Member's Responsibilities:

- To treat providers and their staff with courtesy, dignity and respect.
- To pay all premiums and applicable cost sharing (i.e. deductible, coinsurance, copays).
- To make and keep appointments, to be on time, call if you will be late or must cancel an appointment and to have your DHMP identification card available at the time of service and pay for any charges for non-covered benefits.
- To report your symptoms and problems to your primary care provider and to ask questions and take part in your health care.
- To learn about any procedure or treatment and to think about it before it is done.
- To think about the outcomes of refusing treatment that your primary care provider suggests.
- To follow plans and instructions for care that you have agreed upon with your provider.
- To provide, to the extent possible, correct and necessary information and records that DHMP and its providers need in order to provide care.

- To understand your health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- To state your complaints and concerns in a civil and appropriate way.
- To learn and know about plan benefits (which services are covered and non-covered) and to contact a DHMP Health Plan Services representative with any questions.
- To inform providers or a representative from DHMP when not pleased with care or service.

DHMP Records

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

Member Medical Records

DHMP maintains and preserves the confidentiality of any and all medical records of members in accordance with all applicable State and Federal laws, including HIPAA.

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

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

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

NOTICE OF PRIVACY PRACTICES

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

The DHMP Notice of Privacy Practices is available on the DHMP website at https://www.denverhealthmedicalplan.org/. A new notice will be provided if there is any material change in our practices. You may, at any time, obtain a copy of the notice by contacting Health Plan Services at 303-602-2090.

ADMINISTRATION OF COVERED BENEFITS

Under federal law, individuals responsible for the operation of DHMP must perform their duties in a careful and conscientious manner and with the interest of all members taken into consideration. DHMP and/or its agents will professionally and consistently strive to administer the plan in accordance with this handbook, to the specific definitions of terms used (see Section 15 "Definitions") and applicable state and federal laws. DHMP will assist you in obtaining the benefits for which you are eligible. No one, including your employer, a union or any other person, may fire you or discriminate against you to prevent you from obtaining any benefit under this plan or exercising your rights under law.

No covered person will be denied coverage for medical/surgical or behavioral health, mental health, or substance use disorder care as a result of self-harm, suicide attempt or completion.

AGREEMENT TO THE TERMS IN HANDBOOK

By selecting DHMP, paying the premium and accepting the benefits offered, all members and their legal representatives expressly agree to all terms, conditions and provisions of the plan outlined in this member handbook. As a member, you are required to receive covered services through the DHMP network unless otherwise directed by your primary care provider and authorized by DHMP.

11. General Policy Provisions

AFFIRMATIVE STATEMENT ABOUT INCENTIVES

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

DHMP affirms the following regarding Utilization Management (UM) practices:

- UM decision-making is based only on appropriateness of care and services and the existence of coverage;
- Practitioners or other individuals are not rewarded for issuing denials of coverage or service of care;
- UM decision makers do not receive financial incentives to encourage decisions that result in underutilization.

Please feel free to contact Health Plan Services at 303-602-2090 should you have questions regarding this practice.

RELATIONSHIP BETWEEN DHMP AND NETWORK PROVIDERS

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

STATEMENT OF APPROPRIATE CARE

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

- DHMP does not reward staff or providers for issuing denials.
- DHMP does not offer incentives to encourage under-utilization.
- DHMP participates in a national pharmacy benefit management program that makes drug rebate programs available to participating health plans.

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

CONFORMITY WITH STATE LAW

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

QUALITY IMPROVEMENT PROGRAM

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

- Monitors and measures the level and quality of service and care.
- Monitors compliance with certain preventive health measures.
- Identifies opportunities to improve patient care and service.
- Addresses identified disparities through appropriate intervention and education.

Please visit https://www.denverhealthmedicalplan.org/ or call Health Plan Services at 303-602-2090 to learn more about our Quality Improvement Program such as program goals, progress toward goals, processes, outcomes and specific measurements.

PEDIATRIC DENTAL SERVICES

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

STATEMENT OF RIGHTS UNDER THE WOMEN'S CANCER RIGHTS ACT OF 1998

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

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These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under DHMP. See Section 1 “Schedule of Benefits” for details.

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

REINSTATEMENT

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

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

NEW TECHNOLOGIES

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

CONTRACT

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

COMPLIANCE STATEMENT

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

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FRAUD, WASTE, AND ABUSE PREVENTION PROGRAM

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

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

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

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

REPORTING CONCERNS

Please tell us if you have a concern that involves fraud, waste and use or any type of compliance concern. You can call our toll-free anonymous Compliance Hotline (Values Line) or send us a letter via fax or mail. When making a report, please provide as much detail as possible. Names, dates and a description of the issues in question are helpful. For example, you may wish to describe why you think an activity is a cause for concern. If possible, please include your name and telephone number -- that way, we can contact you if we have any questions during our investigation. When making an anonymous report to the Compliance Hotline (Values Line), you will be provided with a call identification number and a call back date. This will allow you to provide additional information (if needed) and receive status updates on the investigation.

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Compliance Contact Information

Compliance Hotline: 1-800-273-8452 (available seven days a week, 24 hours a day). Reports can be made anonymously.

Fax Number: 303-602-2025

Mailing Address or In-Person:
Denver Health Enterprise Compliance Services
Attn: Compliance Manager
601 Broadway, MC 7776
Denver, CO 80204

Termination/Non-Renewal/Continuation

TERMINATION OF COVERAGE BY ENROLEE

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

TERMINATION OF COVERAGE BY ELEVATE Health Plans

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

NON-PAYMENT OF PREMIUMS

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

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

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

The grace periods noted above are only available to members who have made their initial premium payment for their first month of coverage.

TIME LIMIT ON CERTAIN DEFENSES FOR TERMINATION

Two years after the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two-year period. The policy cannot be retroactively terminated except for fraud or intentional misrepresentation. For any termination other than for fraud or intentional misrepresentation, the carrier shall provide notice thirty days in advance of the cancellation of the policy.

The foregoing policy provision does not affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor limit the application of section 10-16-203 in the event of misstatement with respect to age or occupation or other insurance.

A policy that the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age fifty, or in the case of a policy issued after age forty-four, for at least five years after its date of issue, may contain, in lieu of the foregoing, the following provision, from which the clause in parentheses may be omitted at the insurer's option, under the caption "Incontestable":

- After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it becomes incontestable as to the statements contained in the application.

RECISSION

We may terminate your membership retroactively in the event of fraud or material misrepresentation of a material fact. We will send you written notice at least 30 days prior to the termination.

Within 180 days after you receive our adverse benefit determination that your membership will be terminated retroactively, you must tell us, verbally or in writing, that you want to appeal our termination of your membership retroactively.

12. Termination/Non-Renewal/Continuation

FALSE OR MISLEADING INFORMATION

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

MISUSE OF IDENTIFICATION CARD

Your Elevate Health Plans identification card is solely for identification purposes. Possession of the card does not ensure eligibility and/or rights to services or benefits. The holder of the card must be a member for whom all premiums under the Plan have been paid. If a member allows the use of his/her Elevate Health Plans identification card by any other person, Elevate Health Plans may terminate the member's coverage upon 30 days written notification prior to termination that includes reason for termination.

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

NOTICES, REFUNDS, AND PAYMENTS

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

Appeals and Complaints

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

DEFINITIONS

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

Adverse benefit determination:

- A denial of your request for a pre-service or post-service benefit when the benefit has been reviewed and, based upon the information provided, does not meet DHMP's requirement for medically necessity, or it is not appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care, or is experimental or investigational
- A denial for a service that is not a covered benefit for which you are able to present evidence from a medical professional that there is a reasonable medical basis that the exclusion does not apply to the denied service. This is known as a benefit exclusion.
- Termination of your coverage by the plan retroactively, except as the result of non-payment of premiums (also known as rescission or cancellation).
- Denial of your (or, if applicable, your dependent's) application for individual plan coverage.

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

Appointing a Representative to Act on Your Behalf

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

How to File a Complaint or Appeal

You can file a complaint by telephone, fax, in person, in writing, or electronically through the member portal. Additionally, you may complete a Member Complaint and Appeal Form that is located at the end of this handbook. You may call the Grievance and Appeal Department at the telephone number given below to have the Member Complaint and Appeal Form sent to you. DHMP allows 180 calendar days from the event occurrence for you to file a grievance.

Please see below information for the method in which to contact the plan. Please note that appeal requests may be submitted verbally or in writing. The appeal request must contain the following elements: (1) your name and Member I.D. Number; (2) your medical condition or relevant symptoms; (3) the specific service that you are requesting; (4) all of the reasons why you disagree with our adverse benefit determination; and (5) all supporting documents, such as medical records, you wish for us to consider in support of your position.

Denver Health Medical Plan
Attn: Grievance and Appeal Department
777 Bannock Street, Mail Code 6000
Denver, Colorado 80204

Telephone: (303) 602-2261
Fax: (303) 602-2078
** Please note this is a secure and confidential fax**

13. Appeals and Complaints

Initial Coverage Determination Process

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

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

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

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

Tell us, in writing, that you want to make a request for us to provide or pay for a service you have not yet received. You must send your request to the Utilization Management Department by fax at 303-602-2128 or by mail at:

Denver Health Medical Plan
777 Bannock Street, Mail Code 6000
Denver, CO 80204

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

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

If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the Information we have within 15 days following the end of the 45-day period.

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

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

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

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

13. Appeals and Complaints

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

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

We will review your claim, and if we have all the information we need we will make a decision within a reasonable period of time. If you submitted your claim 24 hours or more before your care is ending, we will make our decision before your authorized care actually ends. If your authorized care ended before you submitted your claim, we will make our decision but no later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 calendar days if circumstances beyond our control delay our decision, if we send you notice before the initial 15 calendar day decision period ends and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information before the initial decision period ends and we will give you until your care is ending or, if your care has ended, 45 calendar days to send us the information. We will make our decision as soon as possible if your care has not ended or within 15 calendar days after we first receive any information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within the stated timeframe after we send our request, we will make a decision based on the information we have within the appropriate timeframe, not to exceed 15 calendar days following the end of the timeframe we gave you for sending the additional information.

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

APPEAL PROCESS

- Within 180 days after you receive our adverse benefit determination notice, you must tell us, verbally or in writing that you want to appeal our denial of your initial coverage determination. Please include the following: (1) your name and Member I.D. Number, (2) your medical condition or relevant symptoms, (3) the specific service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit determination and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may either mail or fax your written appeals to the Grievance and Appeal Department.
- For first level appeal reviews, DHMP will conduct a written appeal review. You have the right to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your request for benefits. You may not be present for the written appeal review.
- For standard appeal requests that do not involve emergency or urgent care needs, we will make a decision and notify you in writing within 30 calendar days of receipt of your appeal for a pre-service appeal or within 60 calendar days of receipt of your appeal for a post-service appeal.
- For emergency and urgent care appeal requests, you will be notified of the decision, in writing, as expeditiously as your medical condition requires, but no later than seventy-two (72) hours from the date the appeal request was filed. You may also begin an external review at the same time as the internal appeals process if the matter involves an urgent care situation, or if you are in an ongoing course of treatment.
- If you do not agree with the outcome of the first level appeal decision, you may request another review, in writing, called a second-level review, within sixty (60) calendar days of the first level review decision.
- DHMP will provide you, upon request, sufficient information relating to the review to help you to make an informed judgement about whether to submit the adverse determination to a review. Your decision to go forward with or not go forward with a review will have no effect on your rights to any other benefits under your health insurance plan, the process for selecting the decision maker or the impartiality of the decision maker.
- A committee will conduct this review. All committee members will not have been involved in any prior decision of your issue, nor will they be subordinates of previous decision makers. You have the right to participate in the review in

person or by telephone conference, but are not required to. You will be notified in writing in advance as to when the committee meeting will occur, and if you wish to participate you or your appointed representative can present your position to the committee.

- You have the right to receive, upon request, a copy of the materials that DHMP intends to present at the review committee at least five (5) calendar days prior to the date of the review meeting. Any new material developed after the five (5) day deadline shall be provided by DHMP, when practicable. You have the right to ask questions of the review committee.
- The review committee will hold a meeting to review the appeal request. For standard appeal requests that do not involve emergency or urgent care needs, you will be notified of the review committee's decision, in writing, within seven (7) calendar days after the review committee meeting.

Urgent Appeal

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

EXTERNAL REVIEW

Following receipt of an adverse benefit determination, you may have a right to request an external review. You have the right to request an independent external review of our decision if our decision involves an adverse benefit determination involving a denial of a claim, in whole or in part, that is (1) a denial of a preauthorization for a service; (2) a denial of a request for services on the ground that the service is not medically necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; and/or (3) a denial of a request for services on the ground that the service is experimental or investigational.

You may request an external review for denial of a request for an alternate standard or a waiver of a standard that would otherwise be applicable to an individual under a wellness and prevention program that offers incentives or rewards for satisfaction of a standard related to a health risk factor (this is not subject to the internal appeal process). These review requests are not eligible for the expedited external review process.

You may request an external review when we deny your appeal because you request medical care that is excluded under your benefit plan and you present evidence from a licensed Colorado professional that there is a reasonable medical basis that the exclusion does not apply.

If our final adverse decision does not involve an adverse benefit determination or denial as described in the scenarios above, then your request is not eligible for external review.

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

Requests for an external review must be submitted in writing. To request external review, you must:

1. Submit a completed Independent External Review of Carrier's Final Adverse Determination form which will be included with the internal appeal decision letter and explanation of your appeal rights within 4 months of the date of receipt of the internal appeal decision.
2. Include in your written request a statement authorizing us to release your claim file with your health information including your medical records. If we do not receive your external review request form and/or authorization form to release your health information, then we will not be able to act on your request. We must receive all of this information prior to the end of the applicable timeframe for your request of external review.

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

13. Appeals and Complaints

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

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

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

You will not be able to present your appeal in person to the independent external review organization. You may, however, send any additional information that is significantly different from information provided or considered during the internal claims and appeal procedure. If you send new information, we may consider it and reverse our decision regarding your appeal.

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

If DHMP fails to comply with any requirement set forth in C.R.S. §10-16-113, §10-16-113.5, Regulation 4-2-17, or Regulation 4-2-21, it will deem the internal process exhausted and you can request an independent external review.

Appeal for Retroactive Termination of Membership (Rescission)

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

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

Information on Policy and Rate Changes

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

Amendment or Termination of this Plan

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

Renewability

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

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

Definitions

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

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

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

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

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

- **FEDERALLY FUNDED TRIALS** - The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  i. The National Institutes of Health.
  ii. The Centers for Disease Control and Prevention.
  iii. The Agency for Health Care Research and Quality.
  iv. The Centers for Medicare & Medicaid Services.
  - Cooperative group or center of any of the entities described in clauses (i)through (iv) or the Department of Defense or the Department of Veterans Affairs.
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  - Any of the following if the conditions described in paragraph (2) are met:
    - The Department of Veterans Affairs.
    - The Department of Defense.
    - The Department of Energy.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

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

- To be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and
- Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

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

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

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

15. Definitions

Complications of Pregnancy:

1. Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.
2. Non-elective cesarean section, ectopic pregnancy, which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

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

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

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

Custodial Care: Services and supplies furnished primarily to assist an individual in the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a health care provider.

Deductible: The amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a plan year or benefit year) before the carrier will cover expenses. The specific expenses that are subject to deductible may vary by policy.

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

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

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

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

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

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

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

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

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

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

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

15. Definitions

General Hospital: A health institution planned, organized, operated, and maintained to offer facilities, beds, and services over a continuous period exceeding 24 hours to individuals requiring diagnosis and treatment for illness, injury, deformity, abnormality, or pregnancy. Clinical laboratory, diagnostic X-ray, and definitive medical treatment under an organized medical staff are provided within the institution.

Treatment facilities for emergency and surgical services are provided either within the institution or by contractual agreement for those services with another licensed hospital. Definitive medical treatment may include obstetrics, pediatrics, psychiatry, physical medicine and rehabilitation, radiation therapy, and similar specialized treatment.

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

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

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

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

Home Health Care/Agency: A program of care that is primarily engaged in providing skilled nursing services and/or other therapeutic services in the home or other places of residence; an approved home health agency:

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

Hospice Care: An alternative way of caring for terminally ill individuals that stresses palliative care as opposed to curative or restorative care. Hospice care focuses upon the patient/family as the unit of care.

Supportive services are offered to the family before and after the death of the patient. Hospice care is not limited to medical intervention, but addresses physical, social, psychological and spiritual needs of the patient. Hospice services include but are not necessarily limited to the following: nursing, physician, certified nurse aide, nursing services delegated to other assistants, homemaker, physical therapy, pastoral, counseling, trained volunteer and social services. The emphasis of the hospice program is keeping the hospice patient at home among family and friends as much as possible.

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

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

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

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

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

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

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

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

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

15. Definitions

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

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

Observation Stay: A hospitalization lasting 23 hours or less.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15. Definitions

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

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

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

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

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

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

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

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

Temporarily Absent: Circumstances in which the member has left the DHMP's service area, but intends to return within a reasonable period of time, such as a vacation trip.

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

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

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

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

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

Utilization Review: 'Utilization review' means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques include, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review. Utilization review shall also include reviews for the purpose of determining coverage based on whether or not a procedure or treatment is considered experimental or investigational in a given circumstance, and reviews of a covered person's medical circumstances when necessary to determine if an exclusion applies in a given situation.

15. Definitions

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

Well Baby Care: In-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together; there are not separate copayments, unless mother and baby are discharged separately.

Language Access Services

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

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

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

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

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

(Amharic) እርስዎ፣ ወይምእርስዎየሚያግዙትግለሰብ፣ ስለDenver Health Medical Plan, Inc. ጥያቄካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1---855---823---8872 ይደውሉ።

1---855 823---8872. تكلفة ةاايي ددوونن ننم ككبلغت ننكا ككيبددل أأوو بدل بدش صصخ ددههعاست ئلةسأأ. ب للصاات ممجررمت مع تثددللتح ووصصصخب Inc. Plan, Medical Health Denver ككيبددفل

(Arabic) ن إ نايف وولصحاال نتماوومعلووال ددةةلمساعاا بعل ةووررييررضلاا

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

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

(Tagalog) Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Denver Health Medical Plan, Inc. may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-855-823-8872.

(Japanese) ご本人様、またはお客様の身の回りの方でもDenver Health Medical Plan, Inc. についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料 金はかかりませ ん。通訳とお話される場合、1-855-823-8872 までお電話ください。

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

بهه تتعالااطط وو ككم كهه دداارريدد ررا اايينن قح ييددباش ررگاهتشددا شما ,, ايي يكس كهه شما بهه اوو ككم ددكنييميي ,, لوس رودررا ل دوم ر د I رn وc. Plan, Medical Health Denver

(Persian) ددماييين للصحا سستما 1---855---823---8872 ددماييين تتررييافدد ننگارراايي ططوورر بهه ررا ووددخ ننبازز

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

DENVER HEALTH MEDICAL PLAN INC.™

MEMBER COMPLAINT AND APPEAL FORM

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

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

DHMP PLAN TYPE (PLEASE CHECK ONE):

Denver Health and Hospital Authority (DHHA)
O Denver Health Plan HMO
O Denver Health Extended Plan

Elevate Health Plans
O Bronze HDHP
O CO Option Gold
O CO Option Silver
O CO Option Bronze

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

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

Home Address

City, State, Zip Code | Telephone #

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

If other than member is listed above, please provide the following information for the person submitting the complaint or appeal. You must include a completed Designation of Personal Representative (DPR) Form with your request. Without this form, we will be unable to process your complaint or appeal. The DPR Form can be obtained by visiting our website, or calling 303-602-2661.

Name (Last, First, Middle Initial) Telephone #

Mailing Address

City, State, Zip Code

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

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

DENVER HEALTH MEDICAL PLAN INC.™

MEMBER COMPLAINT AND APPEAL FORM

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

Is this in regards to a denied claim? O Yes O No

If yes, please provide the Claim #: _____

Date(s) of Service: _____

Provider Name: _____

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

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

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

Member Signature Date

Designated Personal Representative Signature Date

If you have any questions or need help completing this form, please contact the DHMP Grievance & Appeals Department at 303-602-2261 from 8:00 a.m. to 5:00 p.m. Monday through Friday. If we are unable to take your call, please leave a message and we will return your call within 24 to 48 hours.

Internal Use Only – Please do not write below this line

Receipt Date: _____ O Complaint O Appeal Received By: _____

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

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DENVER HEALTH MEDICAL PLAN INC.™

APPOINTMENT OF PERSONAL REPRESENTATIVE FORM

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

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

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

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

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

_____

_____

_____

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

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

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

Mailing Address:
Denver Health Medical Plan
Attn: Health Plan Services
777 Bannock Street, MC 6000
Denver, CO 80204

Secured Fax #:
303-602-2138

SECTION F: MEMBER/SUBSCRIBER'S SIGNATURE:

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

_____ _____

Signature of Member/Subscriber **Date**

SECTION G: PERSONAL REPRESENTATIVE'S ACCEPTANCE OF APPOINTMENT

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

_____ _____

Signature of Personal Representative **Date**

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

SECTION H: REVOCATION OF APPOINTMENT OF PERSONAL REPRESENTATIVE

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

_____

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

_____ _____

Signature of Member/Subscriber **Date**

Please mail or fax form to:
Denver Health Medical Plan
Attn: Health Plan Services
777 Bannock St., MC 6000
Denver, CO 80204
Fax: 303-602-2138
Email: DHMPMemberServices@dhha.org

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DENVER HEALTH MEDICAL PLAN INC.™

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

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

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

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

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

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

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

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

SECTION D: TIME PERIOD Unless noted below, the authorized individuals in Section B can obtain your PHI from the coverage date of your plan with Denver Health Medical Plan, Inc.
◯ **Only respond to inquiries from (insert date) to (insert date)**

SECTION E: SCOPE OF AUTHORIZATION (CHECK ALL THAT APPLY; THIS SECTION MUST BE COMPLETE)
◯ The individual(s) in Section B may **discuss orally** my PHI with Denver Health Medical Plan, Inc.
◯ The individual(s) in Section B may **inspect and/or obtain copies** of my PHI from Denver Health Medical Plan, Inc.
◯ The individual(s) in Section B may **change my Primary Care Physician (PCP and address)** maintained by Denver Health Medical Plan, Inc.

SECTION F: PERSONAL REPRESENTATIVE INFORMATION

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

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

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

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

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

SECTION G: SIGNATURE/DATE Please read the following carefully before you sign.	
By signing this form, I understand the following: (1) if the entity authorized to receive my PHI is not a health plan, health care provider or other covered entity as described by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, the released information may no longer be protected by federal and state law governing the use/disclosure of protected health information; (2) I may revoke this authorization at any time by notifying Denver Health Medical Plan, Inc. in writing; (3) if I do revoke this authorization, my revocation will have no effect on any action Denver Health Medical Plan, Inc. took according to this authorization before Denver Health Medical Plan, Inc. received my revocation; (4) it is my choice to sign this form and I do so voluntarily. Signing or not signing this authorization form will not affect any payment, enrollment, eligibility, or benefit coverage decisions made by Denver Health Medical Plan, Inc. I sign this authorization under penalty of perjury and attest that the information contained in this authorization is true and correct and may be relied upon by Denver Health Medical Plan, Inc.	
Signature of Member or Personal Representative:	**Date:** | |
Print Name:	**Relationship to Member:**
IMPORTANT NOTE ◯ **Yes, I would like a copy of this form for my records.** ◯ **No, I do not need a copy of this form for my records.**	

SECTION H: RETURN THIS COMPLETED FORM AND SUPPORTING DOCUMENTATION TO:	
Mail: Denver Health Medical Plan ATTN: Privacy Officer 777 Bannock Street, Mail Code 1919 Denver, CO 80204	**Secure Fax:** (303) 602-2025 **Email:** Privacy@dhha.org

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17. Index

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

YOU HAVE THE RIGHT TO DESIGNATE ANY PRIMARY CARE PROVIDER WHO PARTICIPATES IN OUR NETWORK AND WHO IS AVAILABLE TO ACCEPT YOU OR YOUR FAMILY MEMBERS.

For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Health Plan Services at 303-602-2090 or visit our website at https://www.denverhealthmedicalplan.org/. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Denver Health Medical Plan, Inc. or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Health Plan Services at 303-602-2090 or visit our website at https://www.denverhealthmedicalplan.org/. The lifetime limit on the dollar value of benefits under Denver Health Medical Plan, Inc. no longer applies. Dependents may be covered up to the age of 26.

For forms and additional information visit:

https://www.denverhealthmedicalplan.org/exchange-colorado-option-forms-documents-links.

For claims data, EOBs, replacement cards, etc. create an account in our Member Portal.

DENVER HEALTH MEDICAL PLAN INC.™

777 Bannock St., MC 6000
Denver, CO 80204
Health Plan Services: 303-602-2090
denverhealthmedicalplan.org