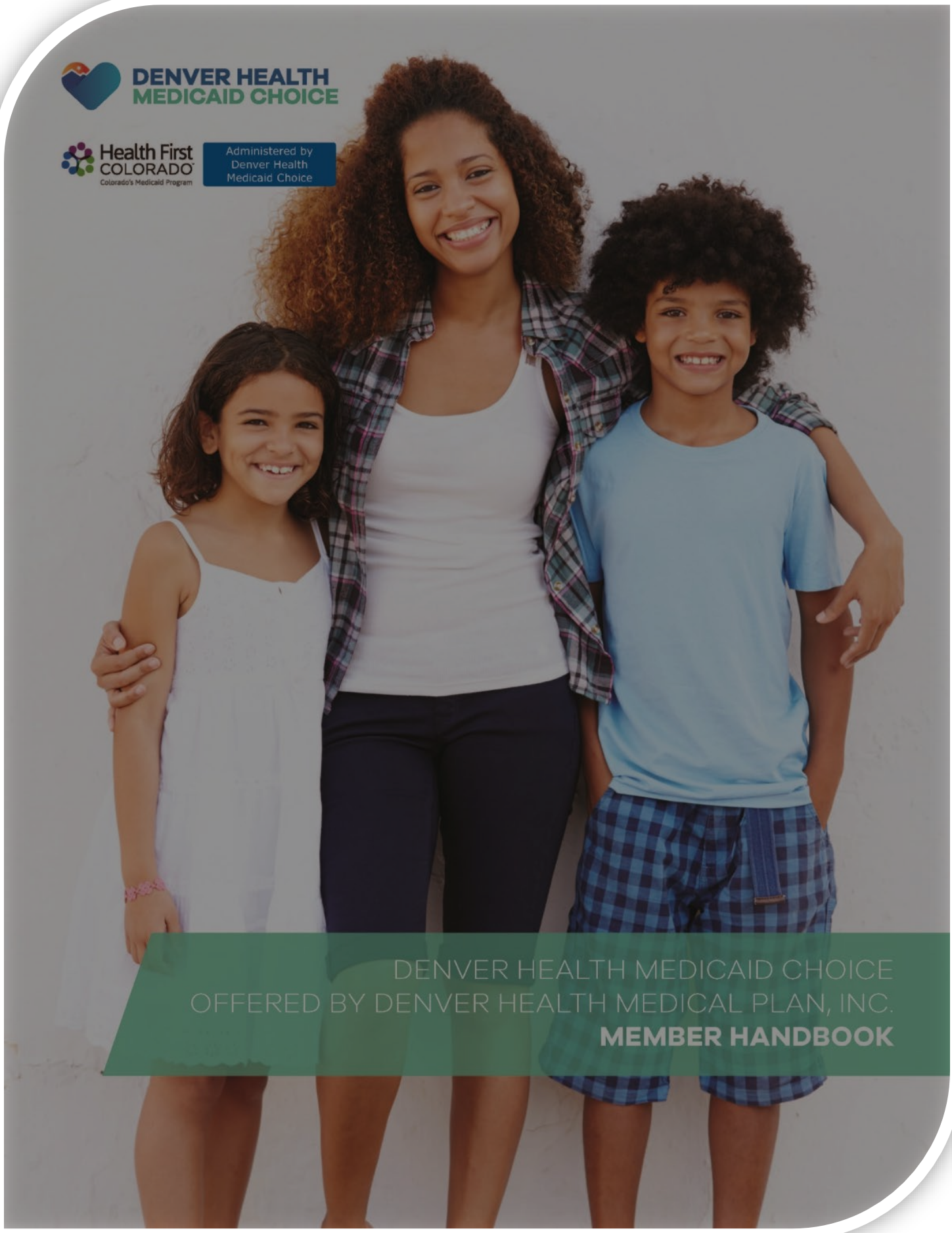

DENVER HEALTH MEDICAID CHOICE
OFFERED BY DENVER HEALTH MEDICAL PLAN, INC.
MEMBER HANDBOOK

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

LARGE PRINT OR OTHER LANGUAGES:

If you need this handbook in large print, in other formats or languages, read aloud, or need another copy, call 303-602-2116 or 1-855-281-2418. For TTY, call 711. Call Monday to Friday, 8 a.m. to 5 p.m. at no cost to you.

Si usted habla español, tenemos a su disposición servicios de asistencia, gratuitos, en su idioma. Llame al 1-855-281-2418 (State Relay 711).

>> TERMINOLOGY

Appeal: A request for a review for an action, if you are denied a benefit, or disagree with any decision about your health insurance

Co-payment: A fixed amount you pay when you get a covered health care service

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

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

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

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

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

Emergency Services: Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under Colorado Medicaid and needed to evaluate or stabilize an emergency medical condition.

Excluded Services: Services that DHMC does not cover. For members 21 and under, this service may be covered under additional State benefits (EPSDT).

Grievance: A formal complaint you may submit if you are unhappy with your service, or think you were treated unfairly

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

Health Insurance: Covers your costs for check-ups or if you get sick

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

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

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

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

Inpatient Hospitalization: Care at a hospital when you stay overnight

Medically Necessary or "Medical Necessity":

Includes services that will (or are reasonably expected to) prevent, diagnose, cure, correct, reduce or improve the following(This may include only observation or no treatment at all):

- Pain and suffering
- Physical, mental, cognitive, or developmental effects of an illness, injury or disability

This includes any program, product or service that is delivered in the most appropriate setting required by the member's condition and does not cost more than other equally effective treatment choices. Medically necessary services should be appropriate in terms of type, frequency, extent, site and duration. Services should be provided in a manner consistent with accepted standards of medical practice.

Medically necessary services do not include:

- Treatments that are untested or still being tested
- Services or items not generally accepted as effective
- Services outside the normal course and length of treatment or services that don't have clinical guidelines
- Services for caregiver or provider convenience

For EPSDT rules, see 10 CRR 2505-10, section 8.280.4.E.

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

Non-participating provider: A provider, facility or supplier that does not give health care services and products to plan members

Post-stabilization care services: covered services, related to an emergency medical condition, that are provided after a Member is stabilized in order to maintain the stabilized condition or to improve or resolve the Member's condition when the Contractor does not respond to a request for pre-approval within one (1) hour, the Contractor cannot be contacted, or the Contractor's representative and the treating physician cannot reach an agreement concerning the Member's care, and a Denver Health physician is not available for consultation

Preauthorization: Also known as a preapproval or referral: to get approval for a service before you use them

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

Participating Provider: A provider who is in the employ of, or who has entered into an agreement with, the Contractor to provide medical services to the Contractor's member

Premium: Monthly cost of coverage

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

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

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

Primary Care Physician: A doctor licensed to practice medicine or osteopathy in the State of Colorado or in the state in which such medical care is rendered

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

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

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

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

Specialist: A provider who works in one area of medicine, like a surgeon

Urgent Care: A sickness or injury that needs medical care quickly

>> IMPORTANT PHONE NUMBERS

EMERGENCY: CALL 9-1-1

Nurse Advice Line: 303-739-1261

Appointment Center:

- To make an appointment: 303-436-4949

For help, questions or concerns:

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

To refill your prescriptions at a Denver Health Pharmacy:

- Prescription Refill Service: 303-389-1390

To check the status of your Pharmacy authorization request:

- Pharmacy Department: 303-602-2070

To ask enrollment/disenrollment questions:

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

To get information on state fair hearings:

- Office of Administrative Courts: 303-866-2000

Other phone numbers:

- Colorado Medical Assistance Program: 1-800-359-1991
- DentaQuest: 1-800-278-7310
- Department of Health Care Policy and Financing (HCPF): 1-800-221-3943
- Rocky Mountain Poison and Drug Center: 1-800-222-1222

>> QUICK TIPS FOR ACCESSING CARE AT DENVER HEALTH

Denver Health Medicaid Choice is now your medical home. You may choose from clinics at Denver Health's Main Campus, the community health centers or various school-based health centers to receive your medical care. See a complete list of clinic locations here: https://www.denverhealth.org/locations.

Urgent Care clinics:

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

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

- Pediatric Emergency Room (777 Bannock St.)
- Adult Emergency Room (777 Bannock St.)
- Denver Health NurseLine (free medical advice) available by telephone at 303-739-1261.

If you have trouble finding a Primary Care Provider (PCP) or wish to change your PCP, please call the **Appointment Center** at **303-436-4949**.

New Patients:

If you have not been seen at a Denver Health clinic in the past 12 months or if you have never been seen at a Denver Health clinic, call the Denver Health **Appointment Center** at **303-436-4949** to make your first appointment.

You can also make a primary care visit with STRIDE. STRIDE (formerly known as Metro Community Provider Network or MCPN) offers medical, behavioral health, and dental care for members. To make an appointment with a provider please contact the main number at: 303-360-6267 or email: https://stridechc.org/new-patients

Existing Patients:

Once you have been seen at your Denver Health clinic, you can schedule an appointment at Denver Health online by registering for MyChart at https://mychart.denverhealth.org/mychart/, or the Denver Health

Appointment Center at **303-436-4949** to make all future appointments. MyChart allows you to message your doctor, view test results, refill medications and schedule appointments.

If you need to cancel your appointment, please be sure to call the Appointment Center and let them know. Call at least one day before your appointment date, if possible.

Bring your Denver Health Medicaid Choice ID card and picture ID to all of your appointments.

In most cases, you need a referral from your PCP to see a Specialist (a provider who is an expert in one or more areas of health care). You do not need a PCP referral to see a Specialist in Optometry or OB/GYN.

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

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

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

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

>> WELCOME TO DHMC!

Welcome to Health First Colorado (Colorado's Medicaid Program) Administered by Denver Health Medicaid Choice (DHMC)!

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

If you would like to get more details on the structure and operation of DHMC, please call Health Plan Services.

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

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

This handbook, and all other member information, is available in other languages, Braille, large print, and audiotapes. Please call **Health Plan Services** at **303-602-2116** if you need this handbook or any other member information in a different language or form.

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

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

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), message with your health plan, check a claim status and more — all right from your computer.

Sign up today - visit denverhealthmedicalplan.org and select 'Member Login' to get started!

Here are some benefits the portal can offer:

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

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

As a DHMC member, you should:

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

As your health plan, we promise to:

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

Watch the New Member Orientation Video

Please watch our New Member Orientation video for important information about the services and benefits that are available to you through your Denver Health Medicaid Choice plan. You will find the video at https://www.denverhealthmedicalplan.org/medicaid-choice.

Your DHMC ID card

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

DENVER HEALTH
MEDICAID CHOICE

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

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

COLORADO
Department of Health Care Policy & Financing

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

Language:

Prior authorization may be required for some services.

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

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

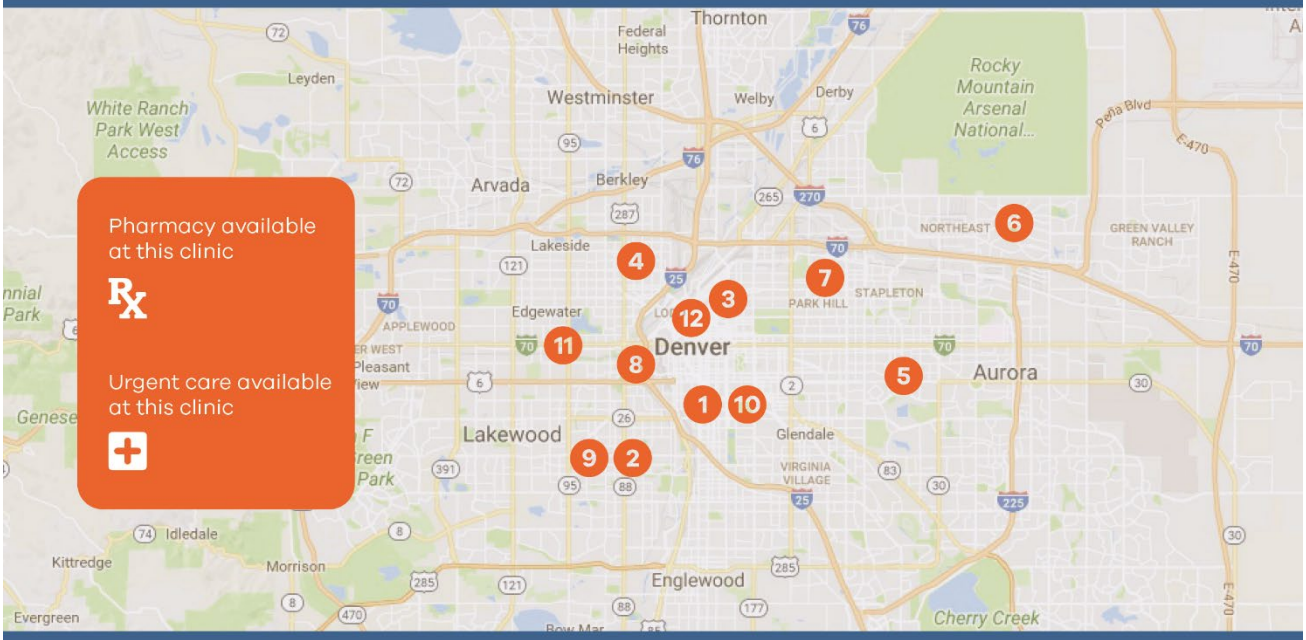
DENVER HEALTH MEDICAL PLAN INC.

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

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

DENVER HEALTH est. 1860

NETWORK LOCATIONS



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

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

Where you can get care:

Above is a list of Denver Health Clinics where you can get care. These clinics are part of the contracted DHMC Network. You may see any Provider in the DHMC Network. In most cases you must go to these Denver Health Clinics for your health care needs. Some specialist providers require a referral first – See Getting an Approval or Referral to See a Specialist.

>> 1) HOW YOUR PLAN WORKS

How to get information about providers:

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

What is a PCP?

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

Why is your PCP important?

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

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

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

Choosing or changing your DHMC PCP:

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

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

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

The STRIDE network is also an option for making a PCP appointment. If you would like to see a PCP from the STRIDE network, make an appointment by contacting the main number at: 303-360-6267 or emailing: https://stridechc.org/new-patients

Getting an approval or referral to see a specialist:

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

An approval from Utilization Management is necessary before you see any provider or specialist outside of DHMC.

You do not need an approval:

- For a routine eye exam with a DHMC eye provider.
- To see a DHMC OB/GYN (a provider who treats only women for reproductive reasons) for yearly exams.
- For family planning services or family planning providers (in or outside of DHMC).
- For emergency or urgent care (in or outside of DHMC).

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

If your benefits, provider or services change:

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

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

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

Enrolling and Disenrolling:

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

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

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

- You move out of the DHMC network area (Adams, Arapahoe, Jefferson, and Denver Counties);
- DHMC is not able to give you a service because of any moral or religious objections;
- You need to get two (2) or more services at the same time, but one of the services is not available in the DHMC network, and your provider tells DHMC that you need to get the services at the same time;
- You are enrolled in DHMC by mistake;

- You feel, and Health First Colorado agrees, that you are getting poor quality of care, lack of access to DHMC services, or lack of access to the types of providers that you need;
- Your PCP leaves the DHMC network;
- You are a resident of long-term institutional care (like hospice or a skilled nursing facility);
- Your primary insurance is a Medicare plan that is not one of the Denver Health Medicare plans (and your DHMC plan is your secondary insurance);
- You are a foster child;
- You are in long-term community based care (care that you get at your home or in your community); or
- Other reasons that are approved by Health First Colorado.

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

- You are no longer a permanent resident in the DHMC service area, or you have been living outside of the DHMC service area for ninety (90) or more days in a row;
- You are put in an institution because of a mental illness, drug addiction;
- You are put in a correctional institution (jail, prison);
- You have health coverage other than Health First Colorado (Colorado's Medicaid Program);
- You are in a Medicare plan or other health plan that is not a DHMC plan;
- Child welfare eligibility status or receipt of Medicare benefits;
- You knowingly give DHMC incorrect or incomplete information about yourself, and this information affects your enrollment status; or
- Any other reason given by DHMC that Health First Colorado agrees with.

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

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

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

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

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

Open Enrollment:

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

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

When are you NOT able to be a DHMC member?

You are not able to get services through DHMC when:

- You lose Health First Colorado (Colorado's Medicaid Program) eligibility;
- You move out of Colorado for more than thirty (30) days;
- You join some other health plan; and/or
- You move to a county outside the DHMC service area (Denver, Arapahoe, Adams, and Jefferson counties).

Other Insurance:

If you currently have other health insurance, or later become enrolled in another health insurance plan, you must notify DHMC by calling **Health Plan Services** at **303-602-2116** or fill out the form at the back of this handbook and return to the address listed on the form. You can find additional forms online at https://www.denverhealthmedicalplan.org/coordination-benefits. Your enrollment in a comprehensive health plan other than DHMC, may result in disenrollment from DHMC.

Medical Bills:

DHMC pays for all your covered benefits. You should never get a bill from a provider if the service is a DHMC covered benefit. You may have to pay for a service you get if DHMC does not cover the service. Please call Health Plan Services if you get a bill from a provider.

Protect Yourself and Health First Colorado (Colorado's Medicaid Program) from Billing Fraud:

Most health care providers who work with Health First Colorado are honest. Unfortunately, there may be some who are not honest. Health First Colorado works to protect you. Health First Colorado fraud happens when Health First Colorado is billed for services or supplies you never got. Health First Colorado fraud costs Health First Colorado a lot of money each year. This makes health care cost more for everyone.

These are examples of possible Health First Colorado fraud:

- A health care provider bills Health First Colorado for services you never got.
- A supplier bills DHMC for equipment that is different from the equipment they gave you.
- Someone uses another person's Health First Colorado card to get medical care, supplies, or equipment.
- Someone bills Health First Colorado for home medical equipment after it has been returned.
- A company uses false information to mislead you into joining a Health First Colorado plan.

If you believe a Health First Colorado plan or provider has misled you, call **DHMC Special Investigations Unit (SIU)** at **1-800-273-8452**or email to complianceDHMP@dhha.org.

When you get health care services, you may want to save the receipts you get from providers. Use your receipts to check for mistakes. These include any records that list the services you got or the drug orders you filled. If you suspect billing fraud, here's what you can do:

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

1) Call your health care provider to be sure the receipt is correct.
2) Call **DHMC Special Investigations Unit** at**1-800-273-8452**.
3) Call the **Colorado Department of Health Care Policy and Financing** at **303-866-2993**, **1-800-221-3943**; TTY users should call **1-800-659-2656**.
4) Call the **Inspector General's hotline** at **1-800-447-8477**. TTY users should call **1-800-377-4950**. You can also send an email to HHSTips@oig.hhs.gov.

When will you have to pay for your care?

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

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

When are you not required to pay for services?

If a provider does not get approval from DHMC when you receive services, they cannot ask you to pay for these services. Providers cannot make you pay because they did not get paid from DHMC for the services you received.

Physician Incentive Plans:

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

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:

- Health First Colorado Administered by Denver Health Medicaid Choice may collect paid benefits directly from the liable party or the liable party's insurance company.
- You will tell DHMC, within 30 (thirty) 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 any lawyer that you hired to collect from the liable party.
- You or your lawyer will notify the liable party's insurance company that, DHMC has paid, and/or is in the process of paying, your medical bills.
- The insurance company must contact DHMC to discuss payment to DHMC.
- The insurance company must pay DHMC before it pays you or your lawyer.
- Neither you nor your lawyer will make an agreement with the insurance company that does not provide for full payment to DHMC.

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

- Neither you nor your lawyer will collect any money from the insurance company until after DHMC is paid in full. This applies even if the insurance money to be paid is referred to as damages for pain and suffering, lost wages, or other damages.
- If the insurance company pays you or your lawyer and not DHMC, you or your lawyer will pay the money over to DHMC up to the amount of benefits paid out. DHMC will not pay your lawyer any attorney's fees or costs for collecting the insurance money.
- DHMC will have an automatic lien (a right to collect) on any insurance money that is owed to you by the insurance company, or that has been paid to your lawyer. DHMC may notify other parties of the lien.
- DHMC may give the insurance company and your lawyer any DHMC records necessary for collection. If asked, you agree to sign a release to provide DHMC records to the insurance company and your lawyer. If asked, you agree to sign any other papers that will help DHMC collect.
- You and your lawyer will give DHMC any information asked about your claim against the liable party. You and your lawyer will notify DHMC of any dealings with, or lawsuits against, the liable party and that party's insurance company.
- You and your lawyer will not do anything to hurt the ability of DHMC to collect paid benefits from the insurance company.
- You will owe DHMC any money that DHMC is unable to collect because of your, or your lawyer's, lack of help or interference. You agree to pay to DHMC any attorney's fees and costs that DHMC must pay in order to collect this money from you. If you or your lawyer do not help, or interfere with, DHMC in collecting paid benefits, then DHMC may contact the State of Colorado and ask that you be disenrolled for cause from DHMC and placed in Medicaid Fee-for-Service.
- DHMC will not pay any medical bills that should have been paid by another party or insurance company.
- You must follow the rules of the other insurance company to have your medical bills paid. DHMC will not pay any medical bills the other insurance company did not pay because you did not follow their rules.

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

What are Advance Care Directives?

Advance Care Directives (or Directives, for short) are specific instructions, made in advance, that are used to your medical care if you become unable to do so because of illness, injury, or life-threatening condition. Directives can also appoint (allow) someone to make decisions about medical care if you become unable to make (or tell someone about) these decisions.

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

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

Here are some different types of Advance Care Directives forms:

- Living Will - this form tells medical providers what types of care you do and do not want to receive in life-threatening situations.

- Medical Durable Power of Attorney (MDPOA) - this form lets you appoint (allow) someone to make your medical decisions if you are unable to make decisions for yourself.
- Five Wishes - this form allows you to think about 'five wishes' or areas of care and make decisions that are best for you.

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

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

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

303-692-2000 or **1-800-866-7689** (In-State),

for TTY call **303-691-7700**.

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

Proxy Decision-Maker:

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

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

Using a Designated Personal Representative (DPR):

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

Privacy:

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

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

Being on the Consumer Advisory Forum:

The DHMC Consumer Advisory Forum is a group of DHMC staff, members, and other community health workers who meet regularly to talk about the DHMC Plan. Please call **Health Plan Services** at **303-602-2116** to be part of the DHMC Consumer Advisory Forum.

DHMC Member Newsletter

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

>> 2) YOUR RIGHTS AND RESPONSIBILITIES

Your Rights:

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

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

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

- To get complete benefit information from DHMC. This information includes covered services, how to get all types of care like emergency care, detailed information about providers, and your disenrollment rights.
- To use your rights above, without fear of being treated poorly by DHMC, network providers or the State Agency.

Your Responsibilities:

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

As a DHMC member, you are also responsible for:

- Choosing a Primary Care Physician (PCP) or Medical Home that is in the Denver Health Network.
- Following all of the rules in this member handbook.
- Getting an approval from your PCP before you see a Specialist (unless one is not needed).
- Following the rules of the DHMC appeal and grievance process.
- Calling the Denver Health Appointment Center to change your PCP.
- Paying for any health care that you get without referral from your PCP (unless the services are emergency or urgent care services, or if they are "Wrap-Around" benefits).
- Paying for any services that are not covered by DHMC or Health First Colorado (Colorado's Medicaid Program).
- Telling DHMC about any other insurance you have other than Health First Colorado.
- Calling the Appointment Center 24 hours before your appointment date if you need to cancel your appointment.
- Updating your address when you move.

>> 3) HOW TO GET CARE

Emergency Care:

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

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

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

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

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

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

Urgent Care:

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

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

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

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

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

Post-Stabilization Care:

Post-Stabilization care services are covered services that you get after an emergency medical condition and after you are stabilized. A provider may give you Post-Stabilization care to keep you stabilized or improve or resolve

your health problem. DHMC will pay for your Post-Stabilization care if you are at Denver Health. If you are at a non-Denver Health hospital for an emergency, your Post-Stabilization care must be pre-approved by DHMC. Once you are stabilized, you or a family member should call DHMP at the number on the back of your member card to notify DHMP of your admission to a non-network hospital.

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

- The provider at the non-Denver Health hospital asks DHMC to approve your Post-Stabilization care services, and DHMC does not get back to the non-Denver Health provider within one (1) hour;
- DHMC cannot be contacted; or
- DHMC and the provider at the non-Denver Health hospital cannot agree on how to handle your treatment and a limited managed care initiative physician is not available for consultation.

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

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

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

Preventive Care and Routine Care:

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

Making an Appointment:

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

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

DHMC Appointment Standards

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

Pharmacy:

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

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

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

Eastside Pharmacy
501 28th St.
Denver, CO 80205

Westside Pharmacy
1100 Federal Blvd.
Denver, CO 80204

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

Public Health Pharmacy
605 Bannock St.
Denver, CO 80204

La Casa Pharmacy
4545 Navajo St.
Denver, CO 80211

Lowry Pharmacy
1001 Yosemite St.
Denver, CO 80230

Montbello Pharmacy
12600 Albrook Dr.
Denver, CO 80239

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

You may also take your prescriptions to any other pharmacy that accepts DHMC insurance. Some pharmacies outside of Denver Health take DHMC insurance, like King Soopers, Safeway, Rite-Aid, Walmart and Walgreens. You can go online to

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

When you use Denver Health pharmacies you may order your prescriptions by calling **the Denver Health Refill Request Line** at **303-389-1390**, or by visiting https://mychart.denverhealth.org/MyChart/. You can also use the MyChart smart phone app. You should always order your refills at least five (5) working days before you run out of your prescription. If your provider tells you to take your prescription in a way that is different from the directions on your prescription bottle, please let your pharmacy know. The pharmacy may need extra time to talk to your provider to get a new prescription or permission to fill it early. For more information about how to refill your prescription visit the DHMC website.

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

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

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

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

If your provider gives you drug samples to start treatment, find out if the medication is on the formulary. If you take samples before you ask DHMC to pay for the drug first, it does not mean that DHMC will pay for that non-formulary drug.

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

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

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

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

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

Pharmacy by Mail:

DHMC offers Pharmacy by Mail. Pharmacy by mail saves you time by sending your 90-day supply prescriptions to your home. Because Pharmacy by Mail prescriptions are for a 90-day supply, you will only need to have your prescriptions filled (four) 4 times a year. You can sign up for Pharmacy by Mail by using the MyChart application or by calling the Pharmacy Call Center at 303-436-4488.

Medications that are covered by DHMC are $0. You do not need to keep a credit card on file if you only want to have medications that are covered by DHMC sent to your home with Pharmacy by Mail. If your address changes call **Pharmacy Call Center** at **303-602-2326** or fill out and mail a new SIGN-UP FORM to **500 Quivas St., Suite A, Denver, CO 80204**. Be sure to mark on the form that this is a change of address. The pharmacy can only ship your prescriptions within the state of Colorado.

Controlled substances or specialty medications cannot be filled through the Denver Health Retail by Mail Program. To refill by Mail prescriptions call the **Denver Health Refill Request Line** at **303-389-1390**.

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

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

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

- Click the Formulary/Drug List link to see the list of covered drugs (the formulary). This link also explains the formulary restrictions, limits or quotas, how your provider can request a prior authorization or exception request, and your plan's process for generic substitution, therapeutic interchange, and step therapies. All together these topics are known as the Pharmaceutical Management Procedures.
- Access the Prior Authorization Form (PAR)/Exception Request Form to start a prior authorization. This is also called an exception request
- Click link to the member portal (register with your member ID to log in) to:
    - Search the formulary to see if your drug is covered.
    - Locate a pharmacy close to you.
    - Search for drug-drug interactions and common drug side effects.

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

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

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

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

DHMC will work with the providers at the hospital to make sure you are getting the care you need. When you are healthy enough, the other hospital providers will allow DHMC to transfer you to Denver Health. If you say no to the transfer to Denver Health, you may have to pay for the rest of the services you get at the other hospital.

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

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

Prescriptions When You Are Away From Home:

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

>> 5) WOMEN'S HEALTH CARE

Seeing an OB/GYN (Obstetrics and Gynecology):

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

If you are more than three (3) months pregnant and you are a new DHMC member, you may keep seeing your current OB/GYN, even if your OB/GYN is outside of the DHMC network. If you have an out of network provider, they will need to submit a prior authorization for services, and should contact Health Plan Services for more information.

Family Planning:

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

You may go to a DHMC provider or any provider who accepts Health First Colorado (Colorado's Medicaid Program) for family planning. You do not have to get approval from DHMC first. Examples of family planning providers include: a gynecologist or OB/GYN, a certified nurse midwife, a family planning clinic, a nurse practitioner or your regular doctor.

Cervical Cancer Screening:

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

Breast Cancer Screening:

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

Pregnancy Care:

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

How to Sign Your Newborn Up for DHMC:

All babies born to moms in DHMC are covered from the time they are discharged from the hospital up to 60 calendar days, or until the last day of the first full month following birth, whichever is sooner. Your child can be enrolled in DHMC, same as you, and receive their care at Denver Health. You can contact your local human services or call the **Colorado Medical Assistance Program** at **1-800-359-1991** to add the newborn to your Medicaid case.

>> 6) CHILDREN'S HEALTH CARE

Childhood and Adolescent Immunizations:

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

Age	Shots
Birth to 1 year	• Hepatitis B • DTaP (prevents diphtheria, tetanus and whooping cough) • IPV - Polio • Hib (Haemophilus influenza Type b) • PCV - Pneumococcal (prevents pneumonia) • RV - Rotavirus (stomach virus) • Influenza – seasonal flu (starting at 6 months old)
1 to 3 years	• Hepatitis A • Hepatitis B • Hib • Polio • MMR (prevents measles, mumps & rubella) • Varicella (prevents Chicken Pox) (if child has not had chicken pox) • DTaP • Pneumococcal • Meningococcal (prevents meningitis) • Influenza (every 6 months)

Age	Shots
4 to 6 years	• DTaP • Polio • MMR • Varicella (Chicken Pox) • Influenza (every 6 months)
11 to 12 years	• Tdap (prevents tetanus, diphtheria, pertussis) • HPV - Human Papillomavirus (prevents genital warts) • Meningococcal (prevents meningitis) • Influenza (yearly)
13 to 21 years	• All shots above that have not been done will need to be completed. • Influenza (yearly)

EPSDT:

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a Health First Colorado (Colorado's Medicaid Program) that covers prevention, diagnostic and treatment services for members age 21 and under. This program is set up to find health problems early. The program goal is for children to get the physical, mental, vision, hearing and dental care they need for their health.

Your child can get these services at no cost to you. Services include:

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

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

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

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

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

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

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

EPSDT services that require a PCP referral and/or prior authorization (PAR):

- Speech (PCP referral)
- Physical Therapy/Occupational Therapy (PCP referral)
- Home Health (PCP referral and PAR)
- Substance Use Disorders Treatment (PCP referral and PAR)

Special Considerations or Limitations:

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

- Experimental care and methods.
- Care or items that are not accepted in the health care community.
- Over-the-counter drugs (drugs that do not need a doctor's prescription) unless needed for care and are approved.

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

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

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

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

Flu Shots:

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

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

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

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

Please see a list of recommended shots under "Childhood and Adolescent Immunizations".

Early Intervention Services:

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

>> 7) SPECIAL HEALTH CARE PROGRAMS

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

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

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

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

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

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

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

If you have a special health condition that requires you to see a specialist (a doctor that is an expert in one or more areas of health care) often, then you could be eligible for a standing referral. This means that you will be allowed to access this specialist at any time, get approval for a certain number of visits to see the specialist, or use this doctor as your PCP.

Please call Health Plan Services if you have any questions about standing referrals.

Case Management:

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

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

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

To establish these services or get in touch with your Care Coordinator, please call Health Plan Services at 303-602-2116 and choose the Care Coordination prompt.

Transitions of Care:

If you have an inpatient stay at a hospital, DHMC offers a transitions of care program to help you transition out of the hospital to your next destination (home, rehab, etc.). This program lasts for the 30 days after your discharge. Please call Health Plan Services if you have questions about this program or need additional help.

Utilization Management:

Utilization Management reviews requests for care your provider feels is medically necessary for you which cannot be provided in the DHMC network (if you need the care or service(s) because of health reasons). These authorizations when approved are called authorizations. Authorizations are required for payment of services and treatment that are either not available at Denver Health or are provided at Denver Health, but have a limit on the benefit.

Examples of things that require authorization include home health services, durable medical equipment (DME) and care at all non-Denver Health facilities. See the section, "Your DHMC Benefits" in this handbook to find out which covered services require DHMC authorization. Your provider will work with Utilization Management staff to get an authorization if it is needed.

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

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

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

Medically Necessary:

DHMC decides which services will be covered based on if they are medically necessary. Throughout this handbook, you might see the term "medically necessary" or "needed for treatment" used when talking about what benefits will be covered for you under this plan. This means that DHMC will only provide care that is needed to diagnose, treat or monitor a condition in the most appropriate place, by the most appropriate person. For example, if a member has a social event coming up, an urgent, out of network visit to treat acne would not be medically necessary.

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

Clinical Practice Guidelines:

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

If you have any questions about what Clinical Practice Guidelines are or how they are used, please call Health Plan Services. You can also ask to get a copy of any of these guidelines at no cost to you.

>> 8) YOUR DHMC BENEFITS

This is a list of your Health First Colorado (Colorado's Medicaid Program) benefits with DHMC. If you need a service that is not covered, you or your PCP can work with DHMC to get it covered.

Benefits	Covered Services	What is Needed?
Abortion	Covered only in these circumstances: • When the pregnancy is the result of an act of rape or incest • In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, place the woman in danger of death unless an abortion is performed	Authorization is needed to cover this procedure. Written letter from the physician certifying the danger to mother's life, if applicable.
Ambulance Services	Covered when it is an emergency.	
Birth of Baby in Hospital	Covered in full.	
Dental Treatments for Adults with an existing medical condition worsened by a condition in your mouth	Allowable existing medical conditions include: • Disease requiring chemotherapy or radiation • Organ transplants • Pregnancy • A medical condition worsened by an oral condition. Emergency treatment can be provided if you would be hospitalized if no immediate care is provided.	This is a "wrap around" benefit. See "wrap around" benefits section in this handbook for more information.
Durable Medical Equipment and Supplies	• Wheelchairs • Crutches • Other supplies	Equipment to be provided by a contracted provider. Approval from DHMC is needed. Please call Health Plan Services for details.

Benefits	Covered Services	What is Needed?
Emergency Services	Covered.	In emergencies, no referral from DHMC is needed. If you have an emergency, call 9-1-1 or go to the nearest hospital. See the "Terminology" section in this handbook for the definition of "Emergency".
EPSDT Benefits	See "EPSDT" section in this handbook for a list of covered services.	Child must be 21 years or younger to qualify for EPSDT services.
Family Planning Services	• Family planning counseling, treatment and follow-up • Birth control pills • Insertion and removal of approved contraceptive devices • Measurement for diaphragms • Male/female surgical sterilization	For sterilization, you must: • Be at least 21 years old. • Be mentally competent (you have never been declared mentally incompetent by a federal, state or local court). • Give your informed consent. You do this by filling out the form your provider will give you 30 days before your sterilization procedure.* *There are exceptions to this. Please ask your provider or call **Health Plan Services** at **303-602-2116** for details.
Home Health Care Services	DHMC covers Home Health services for the first 60 consecutive days. After 60 consecutive days, Home Health services are covered as a "wrap around" benefit by Health First Colorado (Colorado's Medicaid Program).	Must be ordered by a DHMC provider. Approval from DHMC is needed.

Benefits	Covered Services	What is Needed?
Hospital Services and Inpatient Admissions	Hospitalization must be at Denver Health Medical Center.	Must be ordered by a DHMC provider. Any elective procedures or inpatient admissions not done at Denver Health must be approved by DHMC. DHMC will approve inpatient stay for a specific number of days and will review any cases where more days are needed. If DHMC finds that more days are needed then an approval will be made. You may have to pay for any inpatient stays that are not pre-approved by DHMC.
Immunizations (shots) for Members 21 years of age and older	• TD (prevents tetanus and diphtheria) – every 10 years • Influenza – yearly • Pneumococcal – after the age of 65 years • Zoster (prevents shingles) – after the age of 65 years	Provided by a DHMC provider.
Immunizations (shots) for Members under 21 years of age	All recommended immunizations (shots).	Provided by a DHMC provider.
Inpatient Substance Abuse Treatment	See the section below on Behavioral Health Services	
Nursing Home	This is a "wrap around" benefit and is covered by Health First Colorado (Colorado's Medicaid Program" after certification is approved. See "wrap around" benefits section in this handbook for more information.	Must be referred by a DHMC provider.
Oral Surgery for Adults	Limited to treating certain conditions, such as: • Accidental injury to jawbones or surrounding areas; or • Fixing a problem with your mouth, which causes a functional problem like treatment for lumps on the jaws, cheeks, lips, tongue, roof or floor of mouth.	Must be referred by a DHMC provider. Approval from DHMC is needed.

Benefits	Covered Services	What is Needed?
Outpatient Substance Abuse Treatment	See the section below on Behavioral Health Services	
Over-The-Counter (OTC) Medications	DHMC pays for some OTC medications. Your DHMC provider must write you a prescription for any OTC medication to be covered and it must be filled at a Denver Health pharmacy.	Pre-approval required only for drugs not on the drug list.
Pharmacy – Changing from Generic to Brand Name	You can get a Brand Name drug when a Generic is prescribed.	You can ask the pharmacy for a Brand Name drug even if your provider prescribed a Generic, but you will have to pay part of the drug cost. DHMC will only pay for the Brand Name drug if your provider fills out a prior authorization form and tells DHMC why the Brand Name drug is needed. See the "Pharmacy" section in this handbook for details.
Prenatal Care	Covered in full.	Provided by your DHMC OB/GYN If you are new to DHMC and more than 3 months pregnant, you may continue to see your non-DHMC provider until your baby is born. Your provider will need to submit a prior authorization. See the "Women's Health Care" section in this handbook for more information.
Prescription Drugs	Prescription drugs that are on the DHMC formulary are covered. There is no copay (cost) to member on any covered DHMC prescription drug. Members may use any Denver Health pharmacy or any other pharmacy that accepts DHMC insurance.	Some prescription drugs are not on the DHMC formulary. Your provider must ask DHMC to pay for a prescription drug if it is not on the DHMC formulary. See the "Pharmacy" section in this handbook for details.
Primary and Preventive Care	Covered in full – physicals, health screenings like mammograms, prostate screening, flu shots, etc.	Given by your DHMC PCP

Benefits	Covered Services	What is Needed?
Specialty Care	Special types of care covered by participating providers.	Must be referred by a DHMC PCP. Must be offered by a DHMC specialist. If not offered by DHMC providers, authorization is required.
Substance Abuse Treatment	Limited to medical treatment of drug effects. Medications to treat this are a covered benefit	Must be referred by a DHMC PCP. Approval from DHMC is needed.
Tobacco Cessation	Includes all FDA approved prescription medications and over-the-counter (OTC) tobacco cessation products. Does not include any group or individual counseling services. Group or individual counseling services and all FDA approved prescription medications and OTC products related to tobacco cessation are available for pregnant women as a "wrap around" benefit.	Medications related to tobacco cessation (as described under the "covered services" column) are provided through a prescription from your PCP. Services provided to pregnant women are a "wrap around" benefit.
Therapies	• Speech therapy • Occupational therapy • Physical therapy • Cardiac rehabilitation	Must have DHMC PCP referral. Any therapy done outside of DHMC requires authorization.
Vision Therapy	Eye exercises	Referral from a provider needed (adults and children).
Vision: "Buy Ups"	Frames for glasses that cost more than Health First Colorado (Colorado's Medicaid Program) pays.	You pay the difference between approved glasses and the more expensive glasses.
Vision: Adult (age 48 and older)	Routine exams and eyeglasses. Exams and eyeglasses are covered once every year with a provider.	No provider authorization is needed for Denver Health Eye Clinic and other vision service providers in the DHMC Provider Directory.
Vision: Adult (ages 21 – 47)	Regular check-ups and eyeglasses. Exams are covered once every two years with a provider.	No provider authorization is needed for Denver Health Eye Clinic and other vision service providers in the DHMC Provider Directory.

Benefits	Covered Services	What is Needed?
Vision: Children (ages 0 – 20)	Routine checks and eyeglasses covered. Contact lenses or vision therapy treatment services shall be a benefit when needed for treatment and shall require approval submitted by an eye doctor.	No provider authorization is needed for Denver Health Eye Clinic and other vision service providers in the DHMC Provider Directory.

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

If you have questions about whether or not a service is included or excluded, please call **Health Plan Services** at **303-602-2116.**

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

Medical Care:

- NO COST or copays for office visits, diagnostic tests, emergency/urgent care (in network or out of network) for children and adults of DHMC.
- NO COST for non-emergency medical transportation (rides to and from your clinic appointments) – see "Transportation" section of this handbook to learn more.

Eye Care:

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

Pharmacy:

- NO COPAYS for covered prescriptions on the DHMC formulary.
- NO COST for certain over-the-counter (OTC) drugs when a prescription for the OTC drug is written by a Denver Health provider and filled at a Denver Health pharmacy.

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

- 90-day supplies of many drugs you take every day, at NO COST to you. See the DHMC formulary for details.

>> 9) EXTRA SERVICES

Behavioral Health Services:

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

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

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

Benefits with a star (*) may need preapproval.

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

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

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

Transportation:

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

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

Intelliride may require pre-approval before rides can be scheduled (please call Intelliride to find out if your trip needs to be pre-approved). Intelliride is a benefit to anyone who has Health First Colorado (Colorado's Medicaid Program).

To set up a ride to your next health care appointment, please call:

Intelliride: 1-855-489-4999 (please call 48 hours before your appointment).

Denver Health NurseLine:

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

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

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

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

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

"Wrap Around" Benefits:

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

- Hearing aids, training, testing, and evaluation for children;
- Dental services for children (ages 0 to 21);
- Dental services for adults (diagnostic procedures, preventative procedures, restorative procedures, periodontal care, endodontic treatment and oral surgery);
- Extra EPSDT Home Health Services (see the "EPSDT" section in this handbook for more information on these and other EPSDT services);
- Some Home and Community-Based (HCBS) services;
- Hospice care – you may still get all of your other non-hospice care with DHMC, but you may also disenroll from DHMC if you call **Health First Colorado Enrollment** at **303-839-2120** or toll-free at **1-888-367-6557**;
- Home Health services after 60 days are covered by Health First Colorado (first 60 days are covered by DHMC);

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

- Intestinal transplants;
- Non-emergency medical transportation (NEMT) – see "Transportation" section of this handbook;
- Pediatric Behavioral Therapies
- Private Duty Nursing;
- Some Skilled Nursing Facility (SNF) services;
- Tobacco Cessation services - group or individual counseling services and all FDA approved prescription medications and over-the-counter products related to Tobacco Cessation are available for pregnant women.

If you need any of the services listed above, please call **Health First Colorado Enrollment** at **1-800-221-3943** outside of the Denver metro area. A Health First Colorado Enrollment agent will help you get your "wrap around" benefits. If you would like more information, visit https://www.healthfirstcolorado.com. You can access the Health First Colorado (Colorado's Medicaid Program) Member Handbook there too!

>> 10) QUALITY

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

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

To view the quality program for DHMC, please visit: https://www.denverhealthmedicalplan.org/medicaid-choice-chp-quality-improvement-program-description . Please call Health Plan Services for details or concerns about our Quality Program.

>> 11) GRIEVANCES

What is a Grievance?

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

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

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

What to do if you have a Grievance:

If you have a grievance, you or your Designated Personal Representative (DPR) can call **Grievance and Appeals** at **303-602-2261**. You or your DPR can also write to Grievance and Appeals. Please be sure to include your name, Medicaid ID number (a letter and 6 numbers located on your card), address and phone number to your letter if you write to DHMC Grievance and Appeals. You may also fill out the Complaint and Appeal form in the back of this handbook and send it in.

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

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

After You File a Grievance:

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

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

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

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

If You Need Help Filing a Grievance:

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

DHMC will help you file a grievance. If you need help filling out any forms or taking any of the steps to file a grievance, including using an interpreter or TTY services, please call **Grievance and Appeals** at **303-602-2261**.

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

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

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

>> 12) APPEALS

What is a Notice of Adverse Benefit Determination Letter?

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

- When DHMC denies or limits a type or level of service you ask for;
- When DHMC reduces, suspends, or stops authorizing a service that you have been getting;
- When DHMC denies full or partial payment or your services;
- When DHMC does not give you a service in a timely manner;
- When DHMC does not resolve your appeal or grievance within the required timeframes; and/or
- The denial of your request to dispute your cost for medical services.

A Notice of Adverse Benefit Determination Letter includes:

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

Advance Notice of Adverse Benefit Determination:

DHMC must let you know about an Adverse Benefit Determination before the action happens. If DHMC plans to stop paying for or reducing any services you have been getting, it has to send you a Notice of Adverse Benefit Determination letter ten (10) calendar days before the date it stops paying for or reducing services.

DHMC can shorten the timeframe to five (5) calendar days if:

- There is fraud;

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

- The Member has passed away;
- The Member is institutionalized and is not eligible for Medical Assistance services;

- The Member's whereabouts are unknown and there is no forwarding address;
- The Member has moved out of state or outside metropolitan Denver or has become eligible for Medicaid benefits out of state;
- The Member's doctor orders a change in the level of care;
- The notice involves an adverse determination about preadmission screening requirements;
- You must be discharged or transferred to another facility quickly;
- The adverse benefit determination is a denial of payment.

What is an Appeal?

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

How to File an Appeal:

You have sixty (60) calendar days to file an appeal after you get a notice of Adverse Benefit Determination letter. If you want to DHMP to continue paying for your care during the appeal process, you must file your appeal sooner. See the section called "**Continuation of Benefits During an Appeal or State Fair Hearing"** for additional information.

To appeal an Adverse Benefit Determination you may:

- Call **DHMC Grievances and Appeals** at **303-602-2261**, TTY users should call 711. If you appeal an Adverse Benefit Determination verbally, you must also send in a written appeal (unless you have requested an expedited appeal).
- Fill out the Complaint and Appeal form in the back of this handbook and fax to **303-602-2078** or mail to **DHMC Grievance and Appeals, 777 Bannock St., MC 6000, Denver, CO 80204.**

Filing an Expedited (Quick) Appeal:

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

If DHMC denies your request for an expedited appeal, DHMC will call you to let you know your request was denied. DHMC will also send you a letter within two(2) calendar days of your request to let you know that your request was denied. The letter will let you know that you have the right to file a grievance if you are unhappy with DHMC's decision. You will get a written version of your appeal with this denial letter (if you filed your appeal verbally) that you must sign and send back to DHMC.

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

After You File an Appeal:

After you file an appeal, DHMC will send you a letter within two (2) working days (unless you file an expedited appeal) to let you know your appeal was received.

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

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

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

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

- Your right to ask for a State fair hearing and how to ask for one;
- Your right to ask DHMC to continue your services while the State fair hearing is pending and how to make that request; and
- That you may have to pay for those services you get while the State fair hearing is pending if the State agrees with DHMC's decision.

Extending Appeal Timeframes:

You or DHMC can extend the timeframe for DHMC to make a decision on your expedited or standard appeal. If you ask for more days or if DHMC believes that more facts are needed to make a decision on your appeal, DHMC may add fourteen (14) more calendar days. DHMC will only extend this timeframe if it is in your best interest. If DHMC extends the timeframe to decide on your appeal and you did not ask for the extension, DHMC will send you written notice of the reason for the delay. This written notice will also explain that you have the right to file a grievance if you do not agree with DHMC's decision to extend the timeframe. During the extended timeframe, DHMC will make a decision and send you written notice of the decision no by the end of the extension time frame.

Getting Help Filing an Appeal:

To get help filing your appeal, you can:

- Call **DHMC Grievances and Appeals** at **303-602-2261**; TTY call 711.
- Call the **Health First Colorado (Colorado's Medicaid Program) Ombudsman** at **303-830-3560** or **1-877-435-7123**.

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

State Fair Hearing:

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

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

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

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

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

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

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

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

Continuation of Benefits During an Appeal or State Fair Hearing:

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

- You file your appeal within ten (10) calendar days from the date on your notice of Adverse Benefit Determination letter or by the effective date of DHMC's action.
- Your appeal involves the termination, suspension or reduction of a previously authorized course of treatment;
- The service(s) you are getting are from an authorized provider; and
- Your original authorization timeframe on your service(s) is not expired.

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

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

Again, you must still call **DHMC Grievances and Appeals** at **303-602-2261** and tell them that you want DHMC to keep covering your services. Your services will continue until:

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

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

Health First Colorado (Colorado's Medicaid Program) Ombudsman:

The Ombudsman is independent from all of the Health First Colorado health care plans. If you have a problem or concern the Ombudsman will work with both you and your doctor or health plan to find a solution that works for everyone.

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

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

  Metro area: 303-830-3560

  Out of metro area: 1-877-435-7123

Call the Ombudsman Program when:

- You cannot get an appointment or have to wait too long for an appointment.
- You cannot see a specialist.
- You are not happy with care provided to you or a family member.
- Your health plan denied a service.
- You need help filing a grievance, complaint or appeal.
- You are not sure whom to call.
  If you have a question, call **Health Plan Services** at **303-602-2116** or toll-free at 1-855-281-2418.

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

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

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

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

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

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

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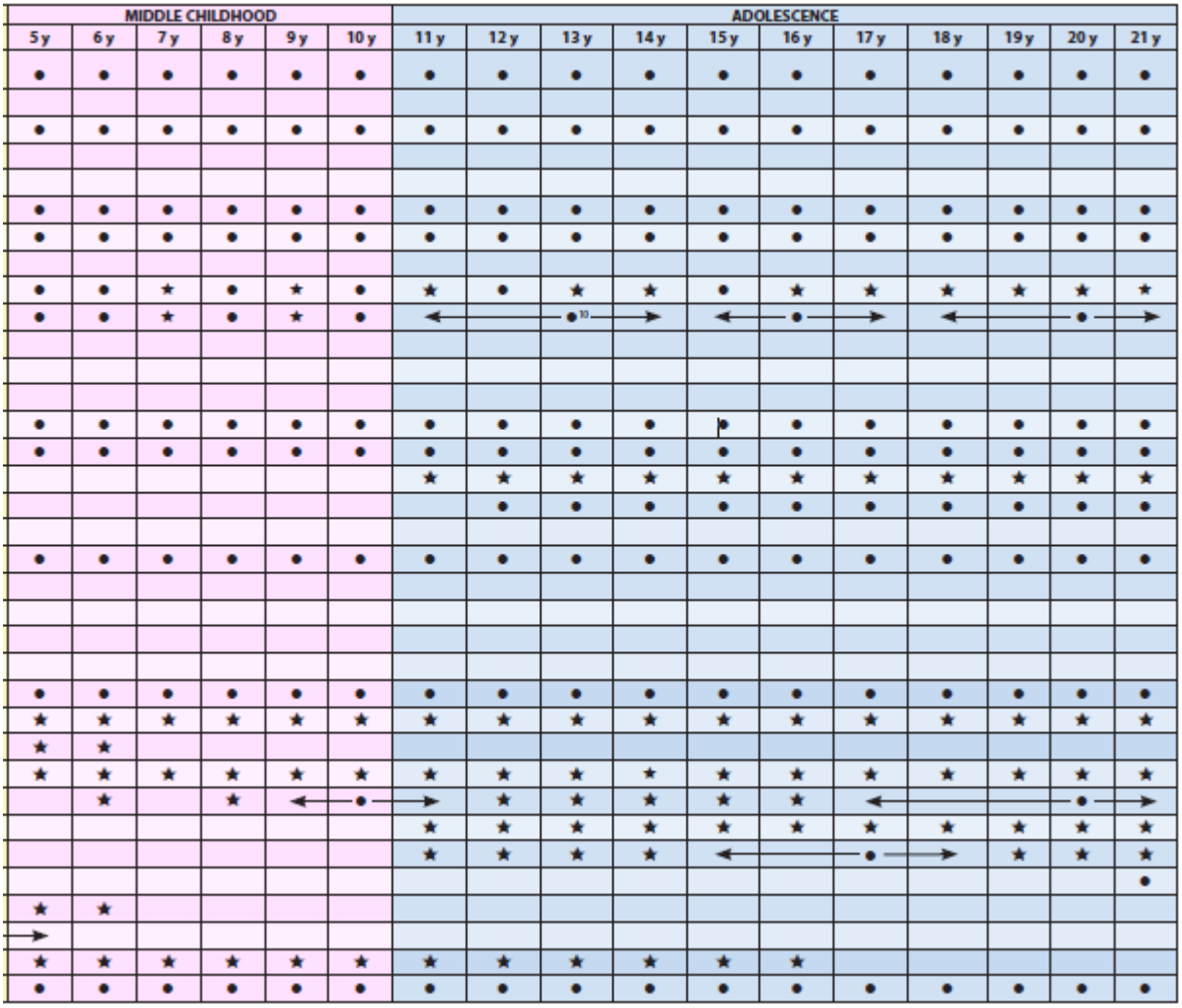
Recommendations for Preventive Pediatric Health Care
Bright Futures/American Academy of Pediatrics (Cont'd)

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



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